AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MAY 2, 2022

2:30 PM, STATE CAPITOL, ROOM 127

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. All are encouraged to watch the hearing from its live stream on the Assembly's website at https://www.assembly.ca.gov/todaysevents.

The hearing room will be open for attendance of this hearing. Any member of the public attending a hearing is strongly encouraged to wear a mask at all times while in the building. The public may also participate in this hearing by telephone after all witnesses on all panels and issues have concluded, and after the conclusion of member questions.

To provide public comment, please call toll-free:
877-692-8957 / Access Code 131 51 27

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4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 1: MULTICOUNTY LOCAL EMERGENCY MEDICAL SERVICES AGENCY FUNDING INCREASE – APRIL 1 BUDGET CHANGE PROPOSAL (BCP)

PANEL 1 - PRESENTERS

- **Louis Bruhnke**, Chief Deputy Director, Emergency Medical Services Authority
- **Rick Trussell**, Chief of Administration, Emergency Medical Services Authority

PANEL 1 – Q&A ONLY

- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

ISSUE 2: HEALTH WORKFORCE PROGRAMS AND CENTRAL SERVICES RESOURCES – APRIL 1 BCP

PANEL 2 – PRESENTERS

- **Caryn Rizell**, Deputy Director, Healthcare Workforce Development Division, Department of Health Care Access and Information

PANEL 2 – Q&A ONLY

- **James Regan**, Assistant Deputy Director, Healthcare Workforce Development Division, Department of Health Care Access and Information
- **Katherine Clark**, Assistant Program Budget Manager, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 3: OFFICE OF HEALTH CARE AFFORDABILITY – APRIL 1 BCP

PANEL 3 - PRESENTERS

- **Elizabeth Landsberg**, Director, Department of Health Care Access and Information

PANEL 3 – Q&A ONLY

- **Scott Christman**, Chief Deputy Director, Department of Health Care Access and Information
- **Ryan Buckley**, Chief Counsel, Department of Health Care Access and Information
- **Katherine Clark**, Assistant Program Budget Manager, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 4: REDUCING THE COST OF INSULIN: CALRX BIOSIMILAR INSULIN INITIATIVE – APRIL 1 BCP

PANEL 4 – PRESENTERS

- **Vishaal Pegany**, Assistant Secretary, California Health and Human Services Agency
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 4 – Q&A ONLY

- **David Toppelberg**, Project Manager, Cal Rx, California Health and Human Services Agency
- **Ryan Buckley**, Chief Counsel, Department of Health Care Access and Information
- **Katherine Clark**, Assistant Program Budget Manager, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: BEHAVIORAL HEALTH BRIDGE HOUSING PROGRAM – APRIL 1 BCP

PANEL 5 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services

PANEL 5 – Q&A ONLY

- **Marlies Perez**, Chief, Community Services Division, Department of Health Care Services
- **Kelly Pfeifer, MD**, Deputy Director, Behavioral Health, Department of Health Care Services
- **Guadalupe Manriquez**, Assistant Program Budget Manager, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 6: CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM) IMPLEMENTATION – APRIL 1 BCP

PANEL 6 - PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services

PANEL 6 – Q&A ONLY

- **Jacob Lam**, Assistant Deputy Director, Health Care Financing, Department of Health Care Services
- **Susan Philip,** Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Kelly Pfeifer, MD**, Deputy Director, Behavioral health, Department of Health Care Services
- **Tyler Sadwith,** Assistant Deputy Director, Behavioral health, Department of Health Care Services
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 7: CALIFORNIA MEDI-CAL ENTERPRISE SYSTEMS MODERNIZATION – APRIL 1 BCP

PANEL 7 – PRESENTERS

- **Lori Walker**, Deputy Director & Chief Financial Officer, Fiscal, Department of Health Care Services
- **Brian Metzker**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 7 – Q&A ONLY

- **Chris Riesen,** Deputy Director & Chief Information Officer, Enterprise Technology Services, Department of Health Care Services
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 8: COVID-19 PUBLIC HEALTH EMERGENCY – RESUMING REGULAR OPERATIONS – APRIL 1 BCP

PANEL 8 – PRESENTERS

- **Lori Walker**, Deputy Director & Chief Financial Officer, Fiscal, Department of Health Care Services

PANEL 8 – Q&A ONLY

- **René Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 9: MANAGED CARE PLAN COMPLIANCE AND OVERSIGHT PROGRAM – APRIL 1 BCP

PANEL 9 – PRESENTERS

- **Lori Walker**, Deputy Director & Chief Financial Officer, Fiscal, Department of Health Care Services

PANEL 9 – Q&A ONLY

- **Susan Philip,** Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 10: OPIOID SETTLEMENTS FUND OVERSIGHT AND STATE-DIRECTED PROGRAMS – APRIL 1 BCP

PANEL 10 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services

PANEL 10 – Q&A ONLY

- **Kelly Pfeifer, MD**, Deputy Director, Behavioral Health, Department of Health Care Services
- **Marlies Perez**, Chief, Community Services Division, Department of Health Care Services
- **Robin Christensen**, Chief, Substance and Addiction Prevention Branch, California Department of Public Health
- **Maria Ochoa**, Assistant Deputy Director, Operations Center for Healthy Communities, California Department of Public Health
- **Dr. Diana Ramos**, Assistant Deputy Director, Chronic Disease Prevention, California Department of Public Health
- **Dana Moore**, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Kia Cha**, Program Budget Analyst, Department of Finance
- **Jaleel Baker**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 11: INFORMATION TECHNOLOGY, DATA SCIENCE, AND INFORMATICS FRAMEWORK FOR A 21ST CENTURY PUBLIC HEALTH SYSTEM – APRIL 1 BCP

PANEL 11 – PRESENTERS

- **John Roussel**, Chief Technology Officer/(Acting) Chief Information Officer, California Department of Public Health
- **Dana Moore**, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health
- **Brian Metzker**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 11 – Q&A ONLY

- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Rob Trojan**, Oversight Manager, Department of Finance
- **Tulika Srivastava**, Branch Chief, California Department of Technology

ITEMS TO BE HEARD

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 1: MULTICOUNTY LOCAL EMERGENCY MEDICAL SERVICES AGENCY FUNDING INCREASE – APRIL 1 BUDGET CHANGE PROPOSAL (BCP)

PANEL 1 – PRESENTERS

- **Louis Bruhnke**, Chief Deputy Director, Emergency Medical Services Authority
- **Rick Trussell**, Chief of Administration, Emergency Medical Services Authority

PANEL 1 – Q&A ONLY

- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

The Emergency Medical Services Authority (EMSA) requests $2,010,000 General Fund ongoing, to support California's multicounty Local Emergency Medical Services Agencies (LEMSA). This funding would augment existing resources for multicounty LEMSAs to continue statutorily-mandated responsibilities and address service delivery gaps driven by cost increases from increased tourism, population growth, and increased mandates over time.

BACKGROUND

EMSA was established in 1980 to provide statewide coordination and leadership for the planning, development, and implementation of local Emergency Medical Services (EMS) systems. Each LEMSA jurisdiction is comprised of multiple agencies (e.g., LEMSA, dispatch centers, law enforcement, fire departments, ambulance companies, and hospitals, including specialty care centers) working together to form an effective system to provide rapid emergency medical response, treatment, and transport to those in need of immediate medical attention. A LEMSA serves as the lead agency for the local EMS system designated by the county and is responsible for planning, implementing, and evaluating the local EMS system, and integrating all system participants in its jurisdiction. Each LEMSA must address and maintain the following eight EMS system components as defined in HSC section 1797.103:

1. System Organization and Management – Develop and maintain an effective management system to meet the emergency medical needs and expectations of the total population served.

2. Manpower and Training – Make sure LEMSA authorized personnel functioning within the EMS system are properly trained, licensed, certified, authorized, and/or accredited to safely provide medical care to the public.

3. Communications – Develop and maintain an effective communications system that meets the needs of the EMS system.

4. Transportation – Develop and maintain an effective EMS response and ambulance transportation system that meets the needs of the population served.

5. Assessment of Hospitals and Critical Care Centers – Establish and/or identify appropriate facilities to provide for the standards and care required by a dynamic EMS patient care delivery system.

6. Data Collection and Evaluation – Provide for appropriate system evaluation using quality data collection and other methods to improve system performance.

7. Public Information and Education – Provide programs to establish an awareness of the EMS system, how to access and use the system, and provide programs to train members of the public in first aid and Cardiopulmonary Resuscitation (CPR).

8. Disaster Response – Collaborate with the Office of Emergency Services, Department of Public Health, and EMS responders in the preparedness and response of the region's EMS systems in the event of a disaster or catastrophic event within the regions or a neighboring jurisdiction.

Currently, there are 33 LEMSAs that provide EMS services throughout the state. There are 26 single county LEMSAs and 7 multicounty LEMSAs. The 7 multicounty LEMSAs contain 32 of the state's 58 counties and provide EMS services to a resident population of 6,774,503.

According to EMSA, these multicounty LEMSAs face a large annual tourist influx but have a disproportionate revenue base. Tourists and vacationers are attracted to these rural regions because they are desirable travel destinations for outdoor and recreational activities. Public safety agencies estimate that some areas periodically experience a 500 percent or more increase in population size because of vacationers, and at least 30 percent of ambulance responses are for non-residents. These multicounty LEMSAs were developed to improve the existing level of emergency medical services and to establish coordinated emergency medical service delivery mechanisms, but they lack sufficient

EMS infrastructure and fee-generated revenue to support the increased tourist population.

In accordance with state law, EMSA provides supplemental General Fund of $2.2 million in assistance to the multicounty LEMSAs located in large rural areas with smaller populations and limited financial and health care resources. This supplemental state funding is to be used to provide only essential minimum services necessary to operate the local emergency medical system. Multicounty LEMSAs have not received an increase in General Fund since 1999-2000.

In order to receive the supplemental state funding, each multicounty LEMSA must contain at least three counties and also provide matching funds of at least $1 for each dollar of state funds received, except multicounty LEMSAs with a population of 300,000 or less which receive the full amount of funding for which they are eligible if they provide a match of at least $0.41 per capita. During 2021-22, all eligible multicounty LEMSAs received supplemental General Fund allotments.

EMSA states that county LEMSA operational costs have increased over the past two decades while state funding for essential services that the multicounty LEMSAs provide was reduced from $2.4 million to $2.182 million in 2008. With no offsetting state General Fund augmentation, multicounty LEMSAs have been forced to continually increase local provider fees and certification fees. LEMSAs are facing choices about which EMS services they must reduce or eliminate. These reductions will undermine the LEMSA's ability to plan, implement, and evaluate their EMS systems, including crisis support and general disaster preparedness and response. Therefore, EMSA states that multicounty LEMSAs need additional funding to meet increased EMS responsibilities, sustain and enhance core critical components of an EMS System, and maintain statutory and regulatory compliance.

Additional statutory and regulatory requirements for EMS have resulted in increased costs for LEMSAs. EMSA explains that the lack of additional state resources would jeopardize the integrity of the multicounty LEMSAs that represent predominantly rural and remote California counties. Without additional funding, multicounty LEMSAs may be forced to reduce essential EMS county services, including but not limited to: disaster, trauma, stroke, cardiac, and EMSC planning, and independent EMS system quality improvement and medical control oversight. Planning and participation in statewide responses to disasters and overall multicounty coordination would be decreased, and California will be unable to meet the requirements of Division 2.5 of the HSC, to develop a high-quality patient care driven EMS System promoting statewide public safety.

Examples of service reductions and eliminations may include the following:

- Discontinuance of monitoring non-exclusive operative areas (EOA); decrease in ambulance inspections for appropriate equipment; delay of approval of new ambulance providers; elimination or reduction of on-site monitoring of approved providers; decrease in assurance of quality EMS response and transports;
- Reduction of on-site monitoring of base and receiving centers, including specialty care;
- Delay of approval of new training programs and classes, and decrease or elimination of monitoring approved training programs and classes, delay of certifying and accrediting personnel, delay of updates to protocols and training policies;
- Reduction of public information and education services;
- Reduction of approval and monitoring of Emergency Medical Dispatch (EMD) training;
- Delay of dispatch investigations;
- Reduction of participation in disaster planning, training, and exercises;
- Decrease in Quality Improvement (QI) and ability to provide data to EMSA; and
- Reduction of staff hours, resulting in a decrease of fiscal accounting, budgeting, and contract maintenance, elimination of travel, disapproval of staffing salary increases, inability to fill vacant staff positions.

EMSA states that multicounty LEMSAs have attempted to obtain necessary funding to support daily operations, yet have been largely unsuccessful. Examples of attempts to obtain funding include:

- Annual assessment of first responder accreditation and certification fees and revenues to cover real costs;
- Increased fees for trauma center contracts;
- Increased local revenues by increasing EMS System fees;
- Doubled fees charged to counties for LEMSA services (being part of a region);
- Annual cost price index adjustment to trauma centers, base hospitals, ambulance providers, and county contract fees;
- Annual adjustment of franchise fees to reflect workload costs;
- Collection of ambulance permit fees upon initial approval; and
- Annual rate study conducted to assure fees cover costs of services.

Multicounty LEMSA's have been forced to continually move resources to the most critical issues at a given time leaving other critical components without any or limited resources in areas such as disaster preparedness. To exhibit the actual needs of the multicounty LEMSAs, each one has provided an assessment of their current unmet funding needs and the amount of funding needed to "right size" their allocations. The following table reflects the funding request by each multicounty LEMSA based on EMS System Component needs.

Multicounty LEMSA Funding Request

EMS System Component	Central California	Inland Counties	Mountain-Valley	North Coast	Northern California	Sierra-Sacramento Valley	Totals
Communications	$192,000	$0	$0	$0	$0	$0	$192,000
Data Collection and Evaluation	$25,000	$210,000	$0	$0	$0	$75,000	$310,000
Disaster Response	$122,000	$10,000	$210,000	$10,000	$68,000	$60,000	$480,000
Assessment of Hospitals and Critical Care Centers	$0	$0	$0	$0	$102,000	$0	$102,000
Transportation	$0	$0	$51,000	$0	$0	$0	$51,000
System Organization and Management	$195,000	$0	$123,000	$245,000	$137,000	$175,000	$875,000
Totals	$534,000	$220,000	$384,000	$255,000	$307,000	$310,000	$2,010,000

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA present this proposal and respond to the following:

- The BCP cites the large tourism industry in many of these small, rural counties as the basis for increased EMS costs; aren't natural disasters, such as wildfires, an equal (or larger) contributor to EMS costs and needs in these counties?

Staff Recommendation: Hold open to allow for additional review and discussion, with likely approval after May Revise.

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

ISSUE 2: HEALTH WORKFORCE PROGRAMS AND CENTRAL SERVICES RESOURCES – APRIL 1 BCP

PANEL 2 – PRESENTERS

- **Caryn Rizell**, Deputy Director, Healthcare Workforce Development Division, Department of Health Care Access and Information

PANEL 2 – Q&A ONLY

- **James Regan**, Assistant Deputy Director, Healthcare Workforce Development Division, Department of Health Care Access and Information
- **Katherine Clark**, Assistant Program Budget Manager, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

The Department of Health Care Access and Information (HCAI) requests 32 positions in 2022-23 and ongoing to support new and significantly expanded health workforce development programs. This proposal requests position authority and will use existing resources to fund the positions.

BACKGROUND

In 2021-22, the Office of Statewide Health Planning and Development was recast as HCAI. This recast recognized HCAI's growing responsibilities, especially in the area of health workforce development. These changes substantially increased HCAI's workforce programs funding from approximately $170 million in 2020-21 to over $800 million annually beginning in 2021-22, a four-fold increase. In addition to increased funding, recent budgets have increased the type of workforce programs HCAI is administering. For example, HCAI is now responsible for programs supporting the development of certified nursing assistants and substance use disorder counselors, as well as a new behavioral health coach classification; significantly more work in behavioral health fields; and proposed initiatives to develop a new community health workforce, accelerate training of social workers and support the broader care workforce beyond the health arena. In 2020-21, HCAI made over 1,300 program awards to providers and organizations. In addition, the proposed 2022-23 Governor's Budget provides approximately $1.0 billion General Fund over three years to invest in California's health workforce programs that is available for encumbrance and expenditure through June 30,

2028. With substantially increased funding for new and expanding programs, HCAI will significantly increase the number of awards made.

The programmatic and funding changes for HCAI in 2022-23 include the following:

- Community Health Workers to recruit, train and certify 25,000 new community health workers by 2025, with specialized training to work with varying populations, such as people who are justice-involved, people who are unhoused, older adults and people with disabilities.
- Comprehensive Nursing Initiative to increase the number of registered nurses, licensed vocational nurses, certified nursing assistants, certified nurse midwives, certified medical assistants, family nurse practitioners, and other related health professions.
- Social Work Initiative to increase the number of social workers trained in the state by supporting social work training programs and providing stipends and scholarships for working people to create a new pipeline for diverse social workers who cannot otherwise afford the financial or time investment required to complete training programs.
- Psychiatric Resident Program to increase the number of behavioral health providers, such as psychiatrists, psychiatric nurse practitioners, and psychologists.
- Multilingual Health Initiatives to increase the linguistic and cultural competencies in the workforce by expanding scholarships and loan repayment for multilingual applicants.
- Health Workforce Education and Training Council to leverage HCAI's Health Workforce Education and Training Council to research health workforce shortages and support research on best practices and strategies to build a diverse, culturally competent health workforce.

HCAI explains that the increase of 32 permanent positions in this proposal will support ongoing operational capacity needed to build and administer HCAI's health workforce development programs and the central services necessary to support those programs. These programs will allow HCAI to award additional scholarships and loan repayment awards to the public and additional grant awards to organizations that administer health workforce training and certification programs. The increased central services capacity will meet operational needs, and programmatic and statutory requirements. Specifically, HCAI requests the following positions:

Workforce for a Healthy California for All Program (twelve positions)

- Health Program Specialist I to serve as a policy specialist to assist with ongoing policy and program support, including social work and community health worker professions.
- Health Program Specialist I to provide health workforce policy support to the Health Workforce Education and Training Council.

- Research Data Specialist I to provide data analysis and data management support to the Health Workforce Education and Training Council.
- Associate Governmental Program Analyst and Staff Services Analyst to implement and administer community health worker, nursing, social work, multilingual grant, scholarship, and stipend programs.
- Staff Services Analyst to implement and administer social work grant, scholarship, and stipend programs.
- Two Program Technician II positions to process grant agreements, scholarship agreements, and loan repayment agreements associated with these programs.
- Staff Services Manager I (Specialist) to serve as the Health Equity coordinator ensuring program goals are realized, specifically to recruit, train, hire, and advance an ethnically and culturally inclusive health and human services workforce, with improved diversity, compensation, and health-equity outcomes.
- Two Contract Analysts (Associate Governmental Program Analysts) to perform all contract support activities.
- Budget Analyst to perform all budget support activities including but not limited to budget development and maintenance functions.

Capacity to Successfully Implement and Administer New Programs (five positions)
The requested positions correspond with workload of new and recently expanded programs. This includes one Health Program Specialist II and three Staff Services Analysts to support implementation and ongoing administration of Children and Youth Behavioral Health programs, and one Staff Services Analyst to support the new HPCOP suite of programs.

Children and Youth Behavioral Health Initiative Support
HCAI received more than $800 million over three years in one-time funding to implement the Children and Youth Behavioral Health Initiative (CYBHI) with the goal of increasing behavioral health care access and quality for children and youth ages 0-25. CYBHI workforce components include creating a behavioral health coach workforce, expanding the substance use disorder workforce, and creating a behavioral health workforce pipeline. HCAI states that it will need four dedicated staff to successfully implement these programs. HCAI also asserts that, although HCAI is using consultant support for program planning and design, staff with behavioral health focus are also needed for successful implementation of these new programs.

Specifically, HCAI requests the following positions funded by the CYBHI General Fund appropriation starting in 2022-23 and continuing through 2026-27:

- One Health Program Specialist II that will serve as HCAI's behavioral health specialist, supporting implementation of new behavioral health workforce programs.
- Three Staff Services Analysts that will support administration of loan repayment, scholarship, stipend, and grant programs for behavioral health professions.

Health Professions Careers Opportunity Program (HPCOP)

In 2021-22, HCAI received $16 million ongoing funding to establish the Health Careers Opportunity Program (HPCOP). HPCOP will be the state's suite of health workforce pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers. HPCOP represents new programmatic workload for HCAI, including an increase in the number of grant agreements HCAI administers. HCAI requests the following, funded through the existing HPCOP General Fund appropriation in 2022-23 and ongoing:

- One Staff Services Analyst to support successful implementation and long-term sustainability.

Alignment of Existing Programs (twelve positions)

Eight of the requested positions correspond with existing programmatic workload that historically has been supported through temporary positions. This includes one Staff Services Manager I position that currently supervises the Small Rural Hospital Improvement Program, two Associate Governmental Program Analysts that serve as program officers and administer components of Song-Brown; and three Associate Governmental Program Analysts and two Staff Services Analysts that serve as program officers to administer the seven loan repayment and scholarship programs.

Four of the requested positions correspond with existing operational workload of HCAI's workforce programs that are supported through temporary positions. This includes one Staff Services Manager I that provides day-to-day supervision of the Health Workforce Development Division's Operations Unit; one Associate Governmental Program Analyst that supports budgetary planning and accounting workflows such as invoicing and expenditures tracking; one Associate Governmental Program Analyst that coordinates communications and outreach to stakeholders and potential applicants to HCAI's health workforce financial assistance programs, including press releases, newsletters, webinars, and communications blasts; and one Staff Services Manager I that provides project management services for HCAI's long-term, statewide program implementations and expansion efforts.

Small Rural Hospital Improvement Program (SHIP)

Transition of the State Office of Rural Health (SORH) and SHIP programs from the Department of Health Care Services required HCAI to internally redistribute work so that the new programs were functionally integrated with existing programs, including the Primary Care Office. The existing Staff Services Manager I position that now supervises the SHIP program has been historically funded as temporary and must be made permanent to sustain capacity for the SHIP program.

HCAI requests the following, that will be funded jointly through SHIP federal funds and the Health Data Planning Fund (0143) within existing expenditure authority in 2022-23 and ongoing:

- One Staff Services Manager I position to supervise the SHIP program.

Song-Brown Program

HCAI received an increase in one-time funding of $60 million in 2021-22 and $33.3 million ongoing funding for the Song-Brown Healthcare Workforce Training Program (Song-Brown).

The Song-Brown program provides grant funding to organizations that provide health workforce education and training, including primary care residencies, registered nurse training, family nurse practitioner training, and physician assistant training. Two of the existing positions that support Song-Brown have historically been funded as temporary and will be made permanent to support long-term capacity supporting the Song-Brown program.

HCAI is requesting the following, funded by the Song-Brown General Fund appropriation within existing expenditure authority in 2022-23 and ongoing:

- Two Associate Governmental Program Analyst positions to support program administration and monitoring of the awarded organizations.

Loan Repayment and Scholarship Programs

Six positions were abolished in 2018-19 that supported the Mental Health Loan Assumption Program (MHLAP). 2017-18 was the last year of funding for MHLAP awards. The six staff in these positions supported seven other existing programs. These programs provide loan repayment and scholarship opportunities to allied health, nursing, mental health, and physician professions. It was determined that five staff were needed to continue the operations of these programs. These staff were placed in blanket positions and as funding increased or decreased the temporary help need was adjusted accordingly. HCAI is requesting these five positions be made permanent for long-term sustainability of these programs.

HCAI requests the following, funded from the Health Data Planning Fund (0143) within existing expenditure authority in 2022-23 and ongoing:

- Three Associated Governmental Program Analysts to support ongoing administration of scholarship and loan repayment programs, such as Steven M. Thompson Physician Corps Loan Repayment Program and Allied Healthcare Loan Repayment and Scholarship Programs.
- Two Staff Services Analysts to support the ongoing administration of scholarship and loan repayment programs, such as Bachelor of Science Nursing Loan Repayment Program, Associate Degree Nursing Scholarship Program, and Vocational Nurse Scholarship Program.

Workforce Development Division Operations

HCAI's substantially expanding workforce program portfolio over the past two years generates a significant increase in operational support needs, including human

resources, budgetary, accounting, and contracting workflows. Increased workloads driven by a rapidly expanding program portfolio requires sufficient staffing allocations to support the needs of the Department.

Four existing positions that support the operational needs of HCAI's workforce programs have been funded as temporary and will be made permanent to support operational capacity long-term. Specifically, HCAI requests the following positions funded by the California Health Data and Planning Fund within existing expenditure authority in 2022-23 and ongoing:

- One Staff Services Manager I to manage the operational support needs in the division.
- Two Associate Governmental Program Analyst positions: one will support communications and outreach efforts to generate awareness for prospective applicants of HCAI's workforce programs and one will support budget, accounting, invoicing, and contracting workflows across health workforce programs.
- One Staff Services Manager I to provide long-term internal project management services to HCAI's new and growing workforce programs.

Central Services Staff in the Administrative Services Division (three positions)

Two of the requested positions will provide leadership, direction, and oversight of a broader administrative infrastructure to support the overall mission, operational needs and organizational plans of the department. The Human Resources organization will also align the Equal Employment Office responsibilities, training functions and expand the program to support diversity, equity, and inclusion efforts in health workforce programs and across the department.

One position is requested for the Accounting Services Section due to the increased workload in the federal program. In 2021-22, the State Office of Rural Heath and J-1 Visa Waiver Program were transferred to HCAI. The increase in workload for the accounting area is associated with the processing of federal grants. Specifically, HCAI requests the following two positions be funded by the General Fund and one position be funded by Federal Funds within existing expenditure authority in 2022-23 and ongoing:

- One Staff Services Manager III, Human Resource Relations Officer, to provide administrative support to the growing HCAI workforce.
- One Staff Services Manager II, Budget Officer, to support the growing budgetary needs of HCAI.
- One Accounting Officer, to support the growing grant program of HCAI.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests HCAI present this proposal and respond to the following:

- Please explain how HCAI already has the resources within its budget for 32 new positions.

- Please provide an implementation update on HPCOP; does HCAI know of colleges and universities that are interested in operating the program?

- When will HCAI be able to share data on progress on increasing medical residency slots in the state as a result of Song-Brown funding? How will HCAI increase accountability in the Song-Brown program to ensure proper use of the grants by hospitals?

Staff Recommendation: Hold open to allow for additional discussion and review.

ISSUE 3: OFFICE OF HEALTH CARE AFFORDABILITY – APRIL 1 BCP

PANEL 3 – PRESENTERS

- **Elizabeth Landsberg**, Director, Department of Health Care Access and Information

PANEL 3 – Q&A ONLY

- **Scott Christman**, Chief Deputy Director, Department of Health Care Access and Information
- **Ryan Buckley**, Chief Counsel, Department of Health Care Access and Information
- **Katherine Clark**, Assistant Program Budget Manager, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

HCAI requests 59 positions in 2022-23, 117 positions and $13.0 million General Fund in 2023-24, and 142 positions and $31.6 million General Fund in 2024-25 and annually thereafter to implement the proposed Office of Health Care Affordability (OHCA).

The 2021 Budget Act included $30 million General Fund to begin implementation of the Health Care Affordability Program. A related request proposes to re-appropriate the $30 million and includes corresponding provisional language. Proposed trailer bill would, if approved, establish the Health Care Affordability Program and OHCA. The Subcommittee heard the proposed OHCA trailer bill on February 7, 2022.

The chart below displays the total cost of the program:

ESTIMATED COSTS	BUDGET YEAR	BUDGET YEAR+1	BUDGET YEAR+2	BUDGET YEAR+3	BUDGET YEAR+4
Estimated Personal Services	$ 10,715,000	$ 19,693,000	$ 23,996,000	$ 23,996,000	$ 23,996,000
Estimated Operating Expenses and Equipment	$ 4,838,000	$ 7,775,000	$ 7,634,000	$ 7,634,000	$ 7,634,000
Total State Operations Expenditures	$ 15,553,000	$ 27,468,000	$ 31,630,000	$ 31,580,000	$ 31,580,000

This request includes $1,650,000 in 2022-23, $1,150,000 in 2023-24, and $900,000 in 2024-25 and annually thereafter in information technology costs.

This request also includes $1,300,000 in 2022-23, $3,350,000 in 2023-24, and $2,850,000 in 2024-25 and annually thereafter in contracting resources.

BACKGROUND

The resources approved in the 2021-22 Budget Act do not provide permanent resources required for the Program. HCAI is requesting permanent positions to implement the program and additional resources are needed in FY 2023-24 and ongoing. The $30 million in previously-approved resources will provide funding for the first and partial second year of implementation. HCAI states that this is an entirely new business function for HCAI and therefore requires dedicated staff resources as well as expert consultation and technical assistance for planning, implementation, and ongoing operations. Resources are also needed to integrate these new business functions into HCAI's existing programmatic infrastructure and to leverage existing shared HCAI technology, data, administrative, and legal services.

HCAI states that the most comparable staffing model for this effort is the Massachusetts HPC. For the Fiscal Year 2019 Budget, the Massachusetts HPC had a total annual budget of $9 million and employed 59.0 full-time equivalent (FTE) staff. After excluding staff positions not related to the work of the Office of Health Care Affordability, 32.0 FTE staff support the HPC's work on research and analysis on health care cost trends, quality performance and cost and market impact reviews of transactions.

The state of Massachusetts has a population of nearly 7 million people and a statewide health care spend of $70 billion annually as compared to California which has nearly six-times the population of Massachusetts, and a significantly higher statewide health care spend of approximately $300 billion annually. Moreover, California is much larger geographically and far more diverse. It has a complex marketplace with a significant volume of diverse capitated, delegated, and other managed care arrangements. As such, California has many more times the number of providers and other health care entities.

HCAI states that, for 2022-23, fifty-nine (59) key staff positions are needed to establish the Program. This includes one (1) Deputy Director at the Career Executive Assignment (CEA B), one (1) Chief Medical Officer at the exempt appointment level, one (1) Pharmaceutical Consultant II (Specialist), two (2) branch chiefs at the Career Executive Assignment (CEA A) managing the Health Care Cost Trends, Quality Performance, and Investigations & Enforcement branches, one (1) Deputy Chief Counsel at the Career Executive Assignment (CEA B), one (1) Assistant Chief Counsel, seven (7) managers, and forty-five(45) staff level positions. For subsequent years, the phase-in of staffing is expected to grow to one hundred sixteen (116.0) staff positions in 2023-24 and one hundred forty-one (141) staff positions in 2024-25.

HCAI states that a fully-staffed Program of 141.0 positions would include the establishment of Program Areas (117.0 positions) and Shared Services (24.0 positions) as follows:

Health Care Affordability Division:

- Deputy Director (CEA B) (1.0 position)
- Chief Medical Officer (1.0 position)
- Pharmacy Consultant (Pharmaceutical Consultant II Specialist) (1.0 position)

Acquisitions and Management Support Unit:

- Acquisitions and Management Support Unit Supervisor (Staff Services Manager 1)(1.0 position)
- Administrative and Management Support Associate (Associate Governmental Program Analyst) (1.0 position)
- Administrative and Management Support Analyst (Staff Services Analyst) (1.0 position)
- Administrative and Management Support Assistant (Office Technician (Typing)) (2.0 positions)

Health Care Cost Trends Branch:

- Branch Chief, Health Care Cost Trends (Career Executive Assignment CEA A) (1.0 position)

Research and Analytics Section:

- Health Policy Research Manager (Research Scientist Manager) (1.0 position)
- Senior Health Policy Researcher (Research Scientist II) (1.0 position)
- Senior Health Policy Specialist (Research Data Specialist III) (3.0 positions)
- Health Policy Specialist, (Research Data Specialist II) (4.0 positions)

Planning and Management Section:

- Section Chief, Planning and Management (Health Program Manager II) (1.0 position)
- Program Policy Coordinator (Health Program Specialist II) (1.0 position)
- Board Coordinator (Health Program Specialist II) (2.0 positions)

Quality and Equity Performance Branch:

- Branch Chief, Quality Performance (Career Executive Assignment Level A) (1.0 position)
- Quality and Equity Analysis Unit Manager (Health Program Manager II) (1.0 position)
- Senior Quality and Equity Specialist (Health Program Specialist II) (5.0 positions)
- Payment Reform Unit Manager (Health Program Manager II) (1.0 position)
- Payment Reform Specialist (Health Program Specialist II) (4.0 positions)
- Workforce and Primary Care Unit Manager (Health Program Manager II) (1.0 position)
- Health Care Workforce Specialist (Health Program Specialist II) (2.0 positions)

- Primary Care and Behavioral Health Specialist (Health Program Specialist II) (2.0 positions)

Investigations & Enforcement Branch:

- Deputy Chief Counsel (Career Executive Assignment Level B) (1.0 position)
- Assistant Chief Counsel (3.0 positions)
- Attorney IV (8.0 positions)
- Attorney III (16.0 positions)
- Administrative Assistant (Office Technician (Typing) (1.0 position)
- Supervising Corp. Examiner (1.0 position)
- Corporation Examiner IV (Sup) (3.0 positions)
- Corporation Examiner (9.0 positions)
- Auditor I (6.0 positions)
- Staff Services Manager (1.0 position)
- Associate Governmental Program Analyst (5.0 positions)
- Staff Services Analyst (2.0 positions)

Contracting Resources:

The contracting resources requested include:

- $1,250,000 in 2022-23 for IT consulting for systems development and continuous operation; $750,000 in 2023-24; and $500,000 annually thereafter.

- $400,000 in 2022-23 for IT software, services, and infrastructure and $400,000 annually thereafter.

- $1,300,000 in 2022-23 for program planning and management consulting, $550,000 in 2023- 24, and $50,000 annually thereafter.

- $2,800,000 in 2023-24 for enforcement consulting contracts and $2,800,000 annually thereafter.

The following are staff being requested to augment HCAI shared services organizations to support the new Program:

Office of Legislative and Public Affairs

- Associate Governmental Program Analyst (1.0 position)

Administrative Services Division:

- Classification and Pay Analyst (Associate Personnel Analyst) (2.0 positions)
- Exams Analyst (Associate Governmental Program Analyst) (1.0 position)
- Personnel Specialist (1.0 position)
- Office Technician (1.0 position)
- Facility Services Analyst (Associate Governmental Program Analyst) (1.0 position)

- Budgets Analyst (Associate Budget Analyst) (1.0 position)
- Contracts Analyst (Associate Governmental Program Analyst) (1.0 position)
- Accounting Officer Specialist (2.0 positions)
- Associate Administrative Analyst (1.0 position)

Information Services Division:

- IT Specialist II (2.0 position)
- IT Specialist I (10.0 position)
- IT Associate (7.0 position
- Associate Governmental Program Analyst (1.0 position)
- Senior Data Integrity Specialist (Research Data Specialist II) (2.0 positions)
- Associate Data Integrity (Research Data Specialist I) (2.0 positions)
- Health Program Specialist II (1.0 position)
- Health Program Specialist I (1.0 position)
- Senior Research Data Specialist (Research Data Specialist III) (2.0 positions)
- Associate Research Data Specialist (Research Data Specialist II) (2.0 positions)
- Prescription Drug Policy Lead (Health Program Specialist II) (1.0 position)
- Prescription Drug Data Lead (Research Data Specialist II) (1.0 position)

STAFF COMMENTS/QUESTIONS

The Subcommittee requests HCAI present this proposal and provide an update on the status of the proposed OHCA trailer bill.

Staff Recommendation: Hold open to allow for additional discussion and review.

ISSUE 4: REDUCING THE COST OF INSULIN: CALRX BIOSIMILAR INSULIN INITIATIVE – APRIL 1 BCP

PANEL 4 – PRESENTERS

- **Vishaal Pegany**, Assistant Secretary, California Health and Human Services Agency
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 4 – Q&A ONLY

- **David Toppelberg**, Project Manager, Cal Rx, California Health and Human Services Agency
- **Ryan Buckley**, Chief Counsel, Department of Health Care Access and Information
- **Katherine Clark**, Assistant Program Budget Manager, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

HCAI requests $100 million one-time General Fund, available until 2025-26, for the CalRx Biosimilar Insulin initiative. Through a contract partnership, the State would invest $50 million towards the development of low-cost biosimilar insulin products, and an additional $50 million towards a California-based insulin manufacturing facility. HCAI also requests $2.8 million General Fund, over four years, for state operations to fulfill requirements of the partnership, including monitoring, oversight, and legal compliance. The insulin products are expected to be widely available to Californians through a variety of outlets.

BACKGROUND

The insulin market has long epitomized the market failures that plague the pharmaceutical industry, such as excessively high barriers for new market entrants, exertion of market power, and leveraging of the legal-regulatory system to maintain market dominance. A recent bipartisan U.S. Senate Finance Committee investigation into insulin pricing found that insulin manufacturers and pharmacy benefits managers (PBMs) work in tandem and respond to incentives to keep insulin prices high and rising. The Committee's report described the dynamic between the two industries as follows:

> "Higher list price increases the dollar value of rebates, discounts, and other fees that a manufacturer can offer to a PBM and health plans, which are based on a percentage of the list price… PBMs have an incentive for manufacturers to keep list prices high, since the rebates, discounts, and fees PBMs negotiate are based on a percentage of a drug's list price—and PBMs retain at least a portion of what

> they negotiate… [T]he investigation found instances in which insulin manufacturers were dissuaded from setting lower list prices for their products, which would have likely lowered out-of-pocket costs for patients, due to concerns that PBMs and health plans would react negatively. ”

As the U.S. Senate Finance Committee's report found, hyper-consolidation along the insulin supply chain and dysfunctional incentive structures have essentially constrained the insulin market of any opportunity for true competition. As a result, both list (also known as wholesale acquisition cost or WAC) and net prices for insulin have risen dramatically over the last decade.

The downstream impacts of the market failure for affordable insulins impacts California and its residents directly. Based on national data, as many as 1 in 4 diabetics cannot afford their insulin, and thus ration or have ceased taking insulin altogether. Affordable insulin is critical for black, brown, and lower income Americans as they are much more likely to have severe diabetes-related complications, such as renal disease and amputations.

Other efforts to reform insulin pricing have been limited in their effectiveness in addressing structural issues in the market for insulins. The federal Biologics Price Competition and Innovation Act (BCPIA), for instance, has not yet delivered on its promise of low-cost biosimilars for drugs like insulin. Under the framework, biosimilar insulins are treated like branded products, which has resulted in manufacturers engaging in the same tactics of charging of high list prices and rebates to lock-in market share. The only recently approved biosimilar insulin, Semglee, carries a list price of $269.38 per vial, which is only $14 cheaper than its chief competitor, Lantus (for a five-pen pack, the list price for Semglee is $404.04 compared to $425.31 for Lantus). The proposed federal Build Back Better legislation calls for a $35 monthly cap on out-of-pocket (OOP) costs for Medicare Part D and commercially insured enrollees only. While the $35 monthly cap provides predictability in consumer OOP costs for eligible enrollees, the federal proposal would not lower the actual price paid for insulin and would not benefit uninsured consumers.

According to the administration, CalRx enables California to manufacture generic drugs in highly concentrated, low competition drug markets. CalRx has the potential to become a “Producer of Last Resort,” remedying drug shortages and addressing what researchers have described as oligopolistic market structures and other market failures that plague the pharmaceutical industry. Under this proposal, CalRx would identify a partner to bring to market low-cost interchangeable biosimilar insulins with the goal of providing Californians with access to insulin products that are a fraction of the $300 per vial prices charged by insulin manufacturers in the United States. The administration states that injecting such steep price competition in the market would ease the financial burden for millions of diabetics in the State.

Manufacturing of Insulin

This proposal will use $50 million in funding to enter into a partnership with a contract manufacturer to develop and bring to market interchangeable biosimilar insulin products in both vial and pen form. CalRx biosimilar insulin products are expected to be widely available through a variety of major outlets, generating significant system wide savings. Many Californians, such as the uninsured, underinsured, and those with high deductible plans, are exposed to high list prices, and would benefit enormously from broadly available low-cost insulin. In the long run, all consumers would also benefit if the branded insulin manufacturers lower their prices in response to the entry of a low-cost option.

While patients with good insurance coverage may pay very little cost-sharing for their insulin, many diabetics do not fall into this category, or are at risk of paying high out-of-pocket costs during coverage disruptions, such as unemployment or aging out of dependent coverage. Uninsured or underinsured diabetics (often due to enrollment in plans with high deductibles) oftentimes must pay the list (WAC) price for their insulin, spending thousands of dollars per year to afford their lifesaving medications. Even diabetics with moderate deductible plans, such as individual market enrollees in Bronze level plans, still spend substantial sums for their insulin.

Some people may point to Patient Assistance Programs (PAPs) as a solution for low-income uninsured or underinsured patients. PAPs are manufacturer-funded programs that pay all or nearly-all of the prescription cost for qualifying patients. Patients typically apply directly to the drug manufacturer for assistance. In practice, though, patients applying for PAPs face strict eligibility and qualification criteria, including, but not limited to, income limits, rules for qualification, application processes, and program duration, that can be opaque for patients.

Beyond their potential for inaccessibility and unreliability, PAPs are problematic for economic reasons. As one health economist described it, “Assistance programs are a triple boon for manufacturers: they increase demand, allow companies to charge higher [list and net] prices [for non-PAP patients], and provide public-relations benefits.” Importantly, PAPs are not charitable programs by drug manufacturers; the final price of a drug actually “bakes in” the operating costs of PAPs. Many manufacturers strategically use these programs as part of their negotiations with PBMs and insurers. The federal government has even warned manufacturers that PAPs may violate the Anti-Kickback Statute. These ongoing issues have led some industry observers to label patient assistance programs as “shams” that only worsen the crisis of drug affordability. Due to these issues, PAPs are unlikely to be a scalable solution for the financial burden of prescription drugs.

Insulin Manufacturing Facility

This proposal also includes an additional $50 million for the construction of an insulin manufacturing facility based in California. CalHHS will partner with the Governor’s Office of Business and Economic Development (GO-Biz), leveraging its expertise in business

investment services such as site review, permit assistance, and other related activities. CalHHS will lean on GO-Biz's expertise to mitigate risk and properly execute the proposed manufacturing facility, if CalRx proceeds with this component of the project.

Development of this facility may spur economic development and create highly technical positions for Californians, thus expanding skilled employment in the State. Furthermore, it will support and strengthen insulin supply chains within the State. The location of the California-based insulin manufacturing facility would be jointly determined by the State and the contract manufacturer.

In addition to the consumer savings associated with low-priced CalRx biosimilar insulins, the State seeks the following benefits as part of a potential biosimilar insulin partnership:

- ***Priority Access***: California will have priority of supply, so that the state's volume needs are met. However, no minimum volume commitment would apply to the state.

- ***Branding***: CalRx insulin products sold within California will be labeled with California-related branding, such as the logo with a California Golden Bear, or verbiage, such as "CalRx Insulin" or "CalRx Insulin – Brought to you by the State of California." As a highly utilized drug, this labeling will create brand awareness among stakeholder and grassroots supporters, as well as demonstrate the State's commitment to providing low-cost prescription drugs.

- ***Low-Cost Implementation***: Compared to direct manufacturing, partnerships in contract manufacturing are likely the lowest cost and most feasible option for the State to bring affordable biosimilar insulin products to market. The contract manufacturer will be responsible for product roll-out and distribution, so that the products are widely available to Californians, through a variety of retailers, pharmacies, and other outlets, as well as mail order pharmacy.

The administration states that the total funds the State is providing for drug development, manufacturing and distribution is fair and reasonable because it is consistent with independent estimates for biosimilar insulin product development. A U.S. Federal Trade Commission report on the emerging biosimilar insulin market estimated that the cost of bringing a biosimilar product to market (development, capital expenditure and regulatory costs) at $100–200 million in markets such as the U.S.

To quickly effectuate an agreement with the contract manufacturer, statutory changes are also proposed that would provide contract exemption authority for HCAI, the implementing department for CalRx.

State Operations Administrative Resources

The resource requirements are new business functions and require state operations resources as well as expert consultation and technical assistance for planning, implementation, and ongoing operations. The request of $700,000 each year, for four fiscal years, will support the following resources:

- Staff Services Manager I (Specialist) to perform all contract support activities including but not limited to drafting the contract, contract negotiation functions, and compliance with contract deliverables.
- Attorney IV to serve as the legal expert and monitor corporate governance, advise on contractual compliance, and review and advise on contract amendments.
- Pharmacy Program Consultant to serve as the subject matter expert to advise the CalRx program; assess and analyze pharmaceutical data and information necessary for oversight of contract deliverables; research, analyze, and prepare various reports to inform ongoing program priorities and feasibility of prescription drug development considerations.

LAO Findings and Recommendations

"***Viability of Proposal to Improve Insulin Affordability Subject to Some Uncertainty***. The administration intends to find a partner for this contract that does not currently have a biosimilar insulin product on the market. As such, there could be regulatory and other implementation challenges to bringing an FDA-approved and interchangeable biosimilar insulin product to market and to be able to sell this product at a low cost to consumers. Notably, the administration notes that the only recently approved biosimilar insulin product carries a list price that is only slightly cheaper than its chief competitor. However, if the partnership is viable and results in insulin products being sold at a low cost, there could be significant savings to consumers and other buyers of insulin—including the state.

Unclear How State Interests Would Be Protected Both in Near- and Long-Term. Given the relatively large state investment the proposal would require and the uncertainty of the partnership's success, protecting the state's near- and long-term interests is be important. In the near-term, the administration has indicated that the release of funding to the contracted partner would be tied to hitting certain milestones. However, the administration has not provided details on the funding schedule or what these specific milestones would be. In addition, once the contracted partner has received the full amount of funding, what leverage the state would have to protect its long-term interests is unclear. While the administration has stated that it intends to continue the partnership beyond the funding period and have a long-term role in keeping prices low, the governance structure of the relationship remains unclear and potentially could create additional legal liabilities for the state.

Lack of Transparency and Oversight. As currently structured, the contracting process and resulting partnership would lack transparency and the Legislature would have no clear mechanism to provide oversight. The administration intends to work with an

independent auditor to monitor the contracted partner's progress, but this information would not necessarily be available to the public or the Legislature.

The lack of transparency and oversight would be further compounded by the administration's request for an exemption from the state's contracting rules through the end of 2032. While the unique nature of the partnership could justify exemption from state contracting rules, why this exemption should extend beyond 2025-26, when the funding availability would expire, is unclear.

Recommendation

Take Steps to Protect State Interests and Ensure Legislative Oversight. Reducing the cost of insulin can be of significant benefit to the state and its residents. However, this proposal carries considerable uncertainties regarding its viability and how state interests would be protected. If the Legislature chooses to move forward with this proposal, we recommend taking steps to protect state interests and ensure legislative oversight. Below, we provide a number of steps that the Legislature could take in this regard.

Prior to the state entering into the contract and as a condition of its approval, the Legislature could, for example, (1) require that the administration provide a preliminary list of milestones that would be included in the contract, including steps providing a viable path to FDA approval; (2) require a provision in the contract to grant the state the right to purchase insulin at-cost at least until state savings exceed the state's investment in the partnership; (3) require a provision in the contract that provides for penalties if the contracted partner fails to meet the terms of the contract to ensure the state's interests are protected; (4) require a review by legal counsel—such as the Attorney General—of the contract language following negotiation with a potential partner but before the contract is entered into, with an emphasis on ensuring there are provisions to protect the state's interests and minimize liability; (5) make the allocation of funding contingent on a 30-day review period by the Joint Legislative Budget Committee (JLBC) of the contract terms and milestones; and (6) require that the contracted partner demonstrate an ability to raise sufficient capital to cover any remaining costs—aside from the state's investment—to bring the insulin products to market.

Once the contract is entered into, we recommend that the Legislature require quarterly updates to JLBC on progress toward the contract milestones. Doing so would help ensure some level of transparency in the process and create an opportunity for the Legislature to provide any necessary oversight.

Finally, while the unique nature of the proposed contractual partnership—as well as the stated desire to bring biosimilar insulin to market in a timely manner—provides some rationale for providing an exemption to the state's contracting rules during the four years of developing and readying the biosimilar insulin to enter the marketplace, the Legislature might wish to ask the administration about the benefits and tradeoffs of its proposal to continue the exemption to state contracting rules through 2032."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Health and Human Services Agency present this proposal, and LAO provide findings and recommendations, and respond to the following:

For CalHHS:

- Please provide reactions to the concerns and recommendations raised by the LAO.

- Please explain the justification for the proposed PCC exemption being for such a long period of time.

- Would the state own the manufacturing facility that would be built?

- What legal liability would the state face as a result of its involvement with the manufacturer?

- How will the state be able to protect its financial investment if any component of this project fails?

Staff Recommendation: Hold open to allow for additional discussion and review.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: BEHAVIORAL HEALTH BRIDGE HOUSING PROGRAM – APRIL 1 BCP

PANEL 5 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services

PANEL 5 – Q&A ONLY

- **Marlies Perez**, Chief, Community Services Division, Department of Health Care Services
- **Kelly Pfeifer, MD**, Deputy Director, Behavioral Health, Department of Health Care Services
- **Guadalupe Manriquez**, Assistant Program Budget Manager, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

The Department of Health Care Services (DHCS), Community Services Division (CSD), and Health Care Delivery Systems (HCDS), request 16.0 permanent positions and five-year expenditure authority of $42,064,000 General Fund (GF) in fiscal year (FY) 2022-23 to administer the Behavioral Health Bridge Housing (BHBH) program. DHCS also requests corresponding provisional language.

The request includes one-time contract authority of $30,000,000 GF to provide training and technical assistance to counties on real estate acquisition and rehabilitation, conduct outreach and education activities, and develop and manage the contracting process.

The purpose of the BHBH expansion is to provide immediate housing and treatment needs for people experiencing unsheltered homelessness with serious behavioral health conditions, including mental health and/or substance use disorders (SUDs). BHBH implementation focuses on providing time-limited operational supports in various bridge housing settings, including existing assisted living settings, senior care facilities, and tiny homes.

To support qualified entities with investments in behavioral health bridge housing, the 2022 Governor's Budget proposed $1.5 billion one-time GF, over two years, to support BHBH time-limited operational supports in various bridge housing settings, including

existing assisted living settings and senior care settings, and to qualified entities to purchase and install tiny homes. The 2022 Governor's Budget proposed corresponding provisional language under Item 4260-101-0001 Provision 17 authorizing funds to be available for encumbrance or expenditure until June 30, 2027. The corresponding provisional language also authorized, upon order of the Department of Finance, up to 5 percent of the local assistance funds to be transferred to state operations for administration of BHBH and those transferred funds to be available for encumbrance or expenditure until June 30, 2027.

Requested Resources

To administer BHBH, DHCS requests the following resources and contract authority:

Positions

- Community Services and Development (CSD) - (15.0 Permanent Positions with Five-Year Limited-Term Funding):
  - Staff Services Manager III (1.0 position)
  - Staff Services Manager II (1.0 position)
  - Staff Services Manager I (2.0 positions)
  - Health Program Specialist I (1.0 position)
  - Associate Governmental Program Analyst (10.0 positions)

- Health Care Delivery Systems (HCDS) - (1.0 Permanent Position with Five-Year Limited-Term Funding)
  - Career Executive Assignment (1.0 position)

Contracting Resources

CSD Administrative Consultant Contract (Support External) - $30,000,000 GF in FY 2022-23, available over five years.

DHCS resources, in collaboration with the administrative consultants, will implement the BHBH and develop training and educational materials for grantees to address key components of BHBH activities. The administrative consultants will provide subject matter expertise on capital infrastructure projects, and support DHCS with BHBH administrative functions. Administrative consultants are necessary to provide expert training and technical assistance to DHCS staff and grantees on land use zoning, permitting, rehabilitation, local stakeholder engagement, and/or new construction costs and real estate acquisition. Workload includes:

- Provide comprehensive TA and training, regarding real estate, rental subsidies and behavioral health bridge housing implementation.
- Assist DHCS in verifying all land acquisition and real estate documents are secured and provided.
- In collaboration with DHCS, provide annual quality assurance review of awardees over five years.

- Assist qualifying entities in preparing the RFAs, especially for small and rural entities.
- Subcontract with a tribal entity or subject matter experts with tribal experience. Subcontractor will provide tribal insight for grantees, land acquisition, tribal needs and board approval and will also assist DHCS with any tribal inquiries.
- Develop and deliver training and TA on topics, including but not limited to: land use, zoning, permitting, rehabilitation, and/or new construction costs and real estate acquisition, as well as navigating California environmental regulations.

BACKGROUND

According to DHCS' Assessing the Continuum of Care for Behavioral Health Services in California, there is an acute need for housing and housing support services across the board, including supportive housing options that provide wraparound behavioral health services. Social model residential services in home-like environments have been proven an effective mechanism to support recovery, build resilience and independence, and avoid the trauma of institutionalization, yet many California counties lack this type of alternative to institutional care for people whose mental health and SUDs make it difficult to live independently. While the Behavioral Health Continuum Infrastructure Program will expand facility capacity in residential and outpatient settings, it will take years for the facilities to be renovated and constructed. Hence, DHCS states that bridge housing for this population is needed immediately; especially for individuals with behavioral health conditions who are also experiencing unsheltered homelessness.

California had the highest rate of individuals experiencing homelessness in the nation, as reported by Continuums of Care to the U.S. Department of Housing and Urban Development. Specifically, California had an estimated 161,548 individuals experiencing homelessness on any given day in 2020. Of that total, 51,785 were individuals experiencing chronic homelessness, 37,599 were severely mentally ill, and 35,821 reported chronic substance use.

Behavioral Health Continuum Infrastructure Program (BHCIP)

The BHCIP, approved and funded through the 2021 budget, is planned to include $2.2 billion, over three years, to provide competitive grants to qualified counties, cities, tribal entities, nonprofit organizations, for-profit organizations, and other private organizations to construct, acquire, and expand properties and invest in mobile crisis infrastructure related to behavioral health. DHCS intends to release these funds through six grant rounds targeting various gaps in the state's behavioral health facility infrastructure.

DHCS explains that, although the 2021 Budget Act provided $5.8 billion in infrastructure funding through the California Department of Housing and Community Development's Homekey, the BHCIP, and the Department of Social Services' Community Care Expansion (CCE) programs to create new units and treatment beds for individuals

experiencing or at risk of homelessness, there is a need for immediate bridge solutions as these new units come online.

The BHBH will allow California to fund clinically enhanced bridge housing settings for people experiencing homelessness who have serious behavioral health conditions. Funding will be administered by DHCS and made available to counties and tribes to be used to stand up and operate these bridge housing settings. One such bridge housing setting is the creation of housing capacity by building tiny homes -- either "cabin communities" or "tiny home villages."

The administration believes that tiny homes provide a quick effective solution for the creation of housing, and that there are many successful tiny home villages in CA. A 2021 Bay Area Council Economic Institute report estimates that the cost of tiny home village units are approximately $72,000 and include amenities such as heating and cooling systems and shared bathroom, laundry and kitchen facilities. Alternatively, hotel/motel conversions, such as those used for Project Roomkey, cost approximately $174,000 per unit.

DHCS/Medi-Cal Strategies to Address Homelessness

California Advancing and Innovating Medi-Cal (CalAIM)

Effective January 1, 2022, CalAIM includes Enhanced Care Management (ECM) and Community Supports – programs focused on addressing social drivers of health as a means of improving patient outcomes and reducing health care costs, including efforts to address the housing needs of Medi-Cal members. ECM and Community Supports are a Medi-Cal managed care plan (MCP) benefit. Enhanced Care Managers will engage Medi-Cal members experiencing, or at risk of, homelessness to help them access coordinated health care, housing services, and other services, collectively known as Community Supports.

MCPs are encouraged to offer as many of the 14 Community Supports approved by DHCS as possible. Several Community Supports focus on housing and homelessness in particular, including:

- *Housing Transition/Navigation Services*: Assistance with finding and securing stable housing.
- *Housing Deposits*: Assistance with identifying, coordinating, securing, or funding onetime services, including first and last months' rent payments, and making necessary changes to enable a person to establish a basic household.
- *Housing Tenancy and Sustaining Services*: Support for maintaining safe and stable tenancy once housing is secured.
- *Recuperative Care (Medical Respite):* Short-term residential care for individuals without stable housing who no longer require hospitalization, but still need to heal from an injury or illness.

- *Short-Term Post-Hospitalization Housing*: A recovery setting after institutional care for people who do not have a secure place to stay and who have high medical or behavioral health needs.
- *Day Habilitation*: Support for acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to live successfully at home.
- *Additional Supports*: Support for successful transitioning to housing, including sobering centers, medically supportive foods and transitioning to assisted living facilities.

Providing Access and Transforming Health (PATH)
DHCS has received federal approval on the Home and Community Based Services (HCBS) Spending Plan to make PATH funding available to expand the home and community based services and homeless system of care. PATH funding may support, but is not limited to, housing- and homelessness-focused activities, such as:

- Workforce training to support expansion of services to newly eligible populations or vulnerable populations (e.g., individuals who are experiencing homeless);
- Developing and distributing, in-depth guidance for implementing data sharing processes between providers and housing services organizations to connect members to housing community support services; and
- Detailed training on how to connect justice-involved individuals to housing services.

Homelessness and Housing Incentive Program
As part of the HCBS Spending Plan, DHCS will also implement a Homelessness and Housing Incentive Program through the MCPs for making investments and progress in addressing homelessness. DHCS will require MCPs to partner with local public health jurisdictions, county behavioral health, public hospitals, county social services, and local housing departments to submit a Homelessness Plan in order to qualify for these incentive payments.

BHBH Provisional Language
DHCS proposes to modify the 2022 Governor's Budget Item 4260-101-0001 Provision 17. In lieu of authorizing up to 5 percent of the proposed Behavioral Health Bridge Housing local assistance funding to be transferred to state operations for administration of the program, the program funding would be budgeted under both local assistance and state operations in the 2022 Budget Act. DHCS also proposes to modify the 2022 Governor's Budget Item 4260-001-0001 by adding Provision 8, to administer BHBH.

Proposed Provision Language to Item 4260-101-0001

17. (a) Of the funds appropriated in this item, ~~$1,000,000,000~~$957,936,000 in Schedule (3) is available to implement the Behavioral Health Bridge Housing Program to award competitive grants to qualified counties and tribal entities to

address the immediate housing and treatment needs of people experiencing unsheltered homelessness who have serious behavioral health conditions and shall be available for encumbrance or expenditure until June 30, 2027. ~~Upon order of the Department of Finance, up to 5 percent of the funds made available pursuant to this provision may be transferred to Schedule (1) of Item 4260-001-0001 for administration of the program and are available for expenditure or encumbrance until June 30, 2027~~. (b) The State Department of Health Care Services shall determine the methodology and distribution of the grant funds appropriated for the Behavioral Health Bridge Housing Program. (c) An entity shall expend funds to supplement and not supplant existing funds provided for the housing and treatment needs of people experiencing unsheltered homelessness who have serious behavioral health conditions to receive grant funds.

(d) The Behavioral Health Bridge Housing Program shall be implemented only if, and to the extent that, the department determines that federal financial participation under the Medi-Cal program is not jeopardized.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this provision, in whole or in part, by means of information notices or other similar instructions, without taking any further regulatory action.

(f) For purposes of implementing the Behavioral Health Bridge Housing Program, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

Proposed Provision Language to Item 4260-001-0001

8. Of the funds appropriated in Schedule (1) of this item, $42,064,000 is available for encumbrance or expenditure until June 30, 2027, for the State Department of Health Care Services to implement the Behavioral Health Bridge Housing Program.

Comprehensive Technical Assistance and Training to Counties and Tribal Entities

DHCS states that this initiative is unprecedented in scope and scale within the behavioral health continuum of care, both nationally and within California. Therefore, although DHCS is administering the BHCIP, the activities proposed through BHBH vary significantly and will require specialized training and technical assistance (TA) to counties and tribal entities.

BHBH focuses on providing time-limited operational supports in various bridge housing settings, including tiny homes, existing assisted living settings, and senior care settings. While counties and some tribal entities will have experience with providing operational supports within these settings, most county and tribal behavioral health departments and

organizations will have limited expertise and experience developing and implementing these bridge housing activities and will require extensive technical assistance and training from DHCS.

Technical Assistance for Tribes and Counties

DHCS will also be required to coordinate and leverage expertise in designing and implementing real estate acquisition and capital improvement projects, and to deploy technical experts to help county and tribal entity grantees move through legal, operational and technical challenges that reduce or delay success of the program. In order for a tiny house to have legal occupancy, the structures must receive one of several types of government approvals, depending on the construction design and its location. The standards that tiny homes must comply with depend on the type of structure that the tiny home may meet the definition for, including recreational vehicle (including park trailer), manufactured home, factory-built housing, or a site-constructed California Building Standards Code dwelling. Project success will be dependent upon collaboration with contractors with real estate acumen and experience, while DHCS staff also develop this level of expertise to support efforts and sustainability of BHBH. DHCS will also require the expertise of a Community Development Financial Institutions Fund organization that specializes in behavioral health bridge housing, tiny homes, and working with tribal entities.

DHCS will be required to provide significant training, TA, and resources directly to tribal entities that are reflective of the distinct culture and needs of American Indian and Alaska Native populations. Moreover, DHCS will be required to provide comprehensive TA to most counties and tribal entities around navigating the unique requirements of constructing cabin communities and tiny home villages. Specifically, both counties and tribal entities must receive TA around land use zoning, permitting, and new construction costs and real estate acquisition.

DHCS plans to release BHBH competitive grant funding through multiple Request for Application (RFA) cycles. The BHBH expansion estimates up to 167 participating grantees (58 counties and 109 diverse federally-recognized tribal entities in California) over the period of the grant. Planning at the local level will be a required component in order to verify that all impacted stakeholders are involved in the expansion effort. Counties and tribal entities must demonstrate how they will connect those served by bridge housing to longer-term supports, including but not limited to, those created under Homekey, BHCIP, CCE, and other local, state, and federally funded housing supports. DHCS will be required to provide significant technical assistance to counties and tribal entities with implementing the most effective and expedient solutions.

Monitoring and Oversight

DHCS staff workload will consist of providing housing services and oversight of the program through the length of required ownership of the tiny homes. DHCS will need to monitor up to 167 awardees through comprehensive desk and on-site reviews to confirm

compliance with BHBH requirements and funding. DHCS will need to develop extensive monitoring tools in partnership with an administrative consultant to fulfill oversight and monitoring responsibilities, as well as assist counties and tribal entities with appropriately expending funds, implementing the efforts of BHBH, and sustainability efforts. This will require development of a service contract to support a detailed tracking system capable of separately tracking funding allocations, distributions, expenditures, and categories of expenditures for BHBH. Policies, procedures, and mechanisms will also need to be developed to return funding to the State if the funds are not expended within the identified timeline.

Stakeholder Engagement

DHCS will perform continuous engagement with a diverse set of stakeholders, including all participating counties and tribal entities; State and federal departments, authorities, and agencies; associations; and the general public regarding BHBH activities and implementation. DHCS staff will be required to respond timely to a significant number of verbal and written inquiries, as well as host webinars, calls, and if appropriate, in-person meetings. DHCS will additionally develop and publish policy guidance, notifications, frequently asked questions (FAQs), and Information Notices, which will require stakeholder engagement and input.

RFA, Contracting, and Invoicing

DHCS staff, in partnership with an administrative consultant contractor, must develop and release several RFAs across multiple rounds. This will necessitate substantial research, stakeholder input, and coordination across Departmental and state agencies and organizations. DHCS must then engage in the contracting process with each awarded organization to verify timely contract execution and project implementation. While the administrative consultant will be responsible for entering into, and managing contracts, DHCS staff will review and approve the contracts. The administrative consultant will also be required to complete invoice processing of grantees. The requested DHCS staff will review and approve more than 600 annual invoices, assuming about 300 tiny homes are constructed annually in 2022-23 and 2023-24. DHCS staff will also be required to review and approve the grantee and administrative consultant contract invoices.

Data Collection and Reporting

Grantees will be required to submit quarterly reports detailing quantitative and qualitative activities, such as project progress, successes, and challenges. Administrative consultants must collect and aggregate all submitted quarterly reports into a concise single quarterly report to DHCS. DHCS staff will review reports in detail to track project progress and verify contractor and county and tribal entity grantee compliance.

Sustainability Activities

DHCS staff will verify wraparound services and activities within the Department and across partnering State departments are leveraged with BHBH and applicable funding sources. Staff will also monitor and oversee counties and tribal entities through desk and

on-site reviews of tiny homes to verify appropriate use of BHBH funding during the five-year period, and serve as subject matter expert on further implementation and expansion of behavioral health bridge housing services through the use of State and Federal funding.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to the following:

- The BHBH is described as providing an immediate or short term solution to creating appropriate supportive housing for the specified target population; given this, can the state resources needed and being requested to implement and manage the project be hired quickly enough?

- Did the administration consult with homelessness and housing experts in the development of the proposal, leading to its prioritization/focus on “tiny homes” as compared to other types of housing?

- The proposal acknowledges the significant expertise that DHCS does not currently have and will need to acquire, which it plans to do in part through external contracts; is this expertise not available through other state departments outside of the Health and Human Services Agency, which could be partners and contractors with DHCS?

Staff Recommendation: Hold open to allow for additional discussion and review.

ISSUE 6: CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM) IMPLEMENTATION – APRIL 1 BCP

PANEL 6 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services

PANEL 6 – Q&A ONLY

- **Jacob Lam**, Assistant Deputy Director, Health Care Financing, Department of Health Care Services
- **Susan Philip,** Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Kelly Pfeifer, MD**, Deputy Director, Behavioral health, Department of Health Care Services
- **Tyler Sadwith,** Assistant Deputy Director, Behavioral health, Department of Health Care Services
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

DHCS requests 95.0 permanent positions, the conversion of 2.0 limited term (LT) resources to permanent positions, LT resources equivalent to 9.0 positions, contract resources, and expenditure authority of $107,785,000 ($53,893,000 General Fund (GF); $53,892,000 Federal Fund (FF)) for fiscal year (FY) 2022-23 and $17,974,000 ($8,987,000 GF; $8,987,000 FF) in FY 2023-24 and ongoing. The request includes corresponding provisional language to allow multiyear expenditure authority of $88,875,000 in contract resources through June 30, 2029.

The resources are to support the implementation of the comprehensive set of proposals that encompass DHCS' California Advancing and Innovating Medi-Cal (CalAIM) initiative, including external evaluations and assessments as required by CalAIM waiver Special Terms and Conditions (STCs), implementation of the CalAIM Justice Package, Dual Eligible Special Needs Plan (D-SNP) plans and new reporting requirements, and the Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) waiver.

BACKGROUND

The first launch of CalAIM initiatives went live on January 1, 2022 and included transformative program changes such as Enhanced Care Management, Community Supports (formerly referred to as "in lieu of services"), managed care enrollment and

benefit standardization, and new dental benefits and dental pay for performance. The beginning of 2022 also marked the renewal of Medi-Cal's 1915(b) waiver and 1115 demonstration, reflecting major changes to the program's federal authorities which are necessary to authorize and implement CalAIM.

DHCS explains that this BCP includes requests for resources—staffing and contract funding—which will support efforts that DHCS was not able to initially plan for in the 2021-2022 CalAIM BCP. DHCS' need for global project management and technical assistance support is greater than originally anticipated. Consequently, this BCP includes a request for additional funding that will assist with the implementation of all aspects of the CalAIM initiative. The federal Centers for Medicare & Medicaid Services (CMS) approved the renewal of California's 1915(b) waiver and 1115 demonstration, effective January 2022. CMS' approval cemented CalAIM's federal authorities, the final terms of which are documented in the Special Terms and Conditions (STC) of the Section 1915(b) waiver and 1115 demonstration. The STCs were finalized during negotiations in December 2021, after the January Budget process was complete, and they imposed several new evaluation requirements. Therefore, DHCS is requesting additional funding to enter into contractual agreements with capable research institutions to conduct these independent evaluations.

Moreover, this CalAIM BCP includes staffing resources that will support several initiatives slated to launch in 2023 and beyond. For instance, the CalAIM justice-involved package, long-term care (LTC) managed care carve-in, D-SNP transition, and SMI/SED waiver, were all part of the original CalAIM vision, but DHCS had not progressed enough in policy development and negotiations with the federal CMS to include these resources in the initial CalAIM BCP. Consequently, DHCS has now identified the requisite additional resources needed to support stakeholder engagement, policy development, implementation, monitoring, and administrative demands in implementing these CalAIM initiatives.

The following tables detail the CalAIM state operations resources being requested:

Division Staffing Request Summary	Proposal
Administration (ADMIN) • 2.0 permanent positions effective 7/1/2022 • Human Resources Division (HRD) - 1.0 Associate Personnel Analyst (APA) • Program Support Division (PSD) - 1.0 Associate Governmental Program Analyst (AGPA)	• Administrative support for CalAIM proposals
Business Operations Technology Services Division (BOTSD) • 5.0 permanent positions effective 7/1/2022 - 4.0 Information Technology Specialist II (ITS II) - 1.0 Information Technology Specialist I (ITS I)	• CalAIM Enterprise Technology Services (ETS) support
Capitated Rates Development Division (CRDD) • 12.0 permanent positions effective 7/1/2022 - 1.0 Staff Service Manager III (SSM III) - 1.0 Staff Service Manager II (SSM II) - 1.0 Staff Service Manager I (SSM I) - 1.0 Research Data Specialist I (RDS I) - 2.0 Research Data Analyst II (RDA II) - 6.0 AGPA	• State Oversight of Medical Loss Ratio
Data Management and Analytics Division (DMAD) • 8.0 permanent positions effective 7/1/2022 - 1.0 Research Scientist Supervisor II (RSS II) - 1.0 Research Scientist Supervisor I (RSS I) - 4.0 Research Scientist III (RS III) - 1.0 Research Data Specialist III (RDS III) - 1.0 Research Data Specialist II (RDS II)	• Data support for CalAIM Waiver Evaluations and Special Terms and Conditions (STC) requirements (1115 and 1915(b)) • Data support for D-SNPs • Data support for Managed Long-Term Supports and Services (MLTSS)
Managed Care Operations Division (MCOD) • 2.0 permanent positions effective 7/1/2022 - 2.0 AGPA	• CalAIM Justice Package
Managed Care Quality and Monitoring Division (MCQMD) • 21.0 permanent positions effective 7/1/2022 - 1.0 SSM III	• CalAIM Justice Package • CalAIM 1915(b) – Assurances of Adequate Capacity and Services • CalAIM D-SNPs

Division Staffing Request Summary	Proposal
- 2.0 SSM II - 1.0 Health Program Specialist II (HPS II) - 1.0 Health Program Specialist I (HPS I) - 3.0 SSM I - 13.0 AGPA	
Medi-Cal Behavioral Health Division (MCBHD) • 36.0 permanent positions effective 7/1/2022 - 1.0 Career Executive Assignment (CEA) - 1.0 SSM III - 3.0 SSM II - 5.0 SSM I - 9.0 HPS II - 2.0 HPS I - 13.0 AGPA - 2.0 Staff Services Analyst (SSA)	• MCBHD CalAIM Behavioral Health Data Liaison • SMI/SED Waiver • CalAIM Justice Package
Medi-Cal Dental Services Division (MDSD) • 6.0 permanent positions effective 7/1/2022 - 1.0 SSM III - 1.0 SSM II - 2.0 HPS I - 1.0 SSM I (Limited Term to Permanent) - 1.0 AGPA (Limited Term to Permanent) • 9.0 limited term positions effective 7/1/2022 - 1.0 SSM I - 8.0 AGPA	• CalAIM 1915 (b) – Dental Managed Care Program Improvement
Medi-Cal Eligibility Division (MCED): • 2.0 permanent positions effective 7/1/2022 - 2.0 HPS I	• CalAIM Justice Package
Office of Legal Services (OLS) • 1.0 permanent position effective 7/1/2022 - 1.0 Attorney IV	• State Oversight of Medical Loss Ratio
Quality and Population Health Management (QPHM) • 2.0 permanent positions effective 7/1/2022 - 1.0 AGPA - 1.0 HPS I	• CalAIM Waiver Evaluations • CalAIM D-SNPs

Division	Proposal	Duration	*FY 2022-23 Contract Amounts
MDSD	Dental Managed Care (DMC) Procurement Consultant Contract	5-Year	$1,375,000
CD	CalAIM Technical Assistance	2-Year	$25,000,000
QPHM	CalAIM 1115 Waiver Evaluations	7-Year	$19,500,000
QPHM	1915(b) Waiver Independent Assessments and Consumer Satisfaction Surveys	5-Year	$24,000,000
QPHM	1915(b) and 1115 Waiver Community Supports Independent Evaluation	5-Year	$5,000,000
QPHM	EQRO work for LTSS	Ongoing	$2,000,000
QPHM	SMI/SED 1115 Waiver Evaluation Contract	6-Year	$9,000,000
MCQMD	Annual Report on Community Supports	5-Year	$5,000,000
	Total		**$90,875,000**

**FY 2022-23 contract amount consists of $88,875,000 for multiyear appropriation through June 30, 2029 and $2,000,000 beginning in 2022-23 and ongoing.*

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal, provide an overview of the STCs that are a part of the federal approvals of California's waivers, and provide a general implementation update on CalAIM.

Staff Recommendation: Hold open to allow for additional discussion and review.

ISSUE 7: CALIFORNIA MEDI-CAL ENTERPRISE SYSTEMS MODERNIZATION – APRIL 1 BCP

PANEL 7 – PRESENTERS

- **Lori Walker**, Deputy Director & Chief Financial Officer, Fiscal, Department of Health Care Services
- **Brian Metzker**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 7 – Q&A ONLY

- **Chris Riesen,** Deputy Director & Chief Information Officer, Enterprise Technology Services, Department of Health Care Services
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

DHCS requests 5.0 permanent positions and limited term (LT) contract expenditure authority of $20,794,000 ($2,721,000 General Fund (GF); $18,073,000 Federal Fund (FF)) in fiscal year (FY) 2022-23, $14,214,000 ($2,886,000 GF; $11,328,000 FF) in FY 2023-24, and $1,007,000 ($205,000 GF, $802,000 FF) in FY 2024-25 and ongoing to support information technology (IT) modernization projects.

This funding request supports activities for the following approved projects and efforts: 1) California Automated Recovery Management (CalARM) solution's design, development, and implementation; 2) Behavioral Health Modernization (BHM) solution design and project readiness assessment as part of the Project Approval Lifecycle (PAL); and 3) FY 2022-23 will continue to utilize the resources approved for Medi-Cal Enterprise Systems Modernization strategy and architecture planning in developing/refining the modernization approach, architecture, roadmap, and a modernization product/module portfolio.

A summary of LT contract dollars being requested in FY 2022-23:

Product/Effort	Duration	Contract Amounts
CalARM	2-Year	$12,790,000
MES Modernization Support (Engineering/ DevOps/ Organizational Change Management/ Oversight)	2-Year	$2,125,000
BHM	1-Year	$1,425,000
MES Modernization Strategy and Architecture Planning	2-Year	$3,402,000
Total		**$19,742,000**

BACKGROUND

Over time, the Medi-Cal beneficiary population has shifted from the fee-for-service delivery model to the managed care delivery model. Currently, more than 83 percent of Medi-Cal beneficiaries are in managed care and this number continues to grow. To keep pace with these service delivery changes, and to improve outcomes and resource efficiencies, for the past two years, DHCS has changed its modernization approach from focusing on individual IT systems to focusing on the entire Medicaid Enterprise System, where Medicaid Management Information System (MMIS) and Eligibility and Enrollment (E&E) systems are handled in coordination as Medi-Cal Enterprise Systems (MES). This approach aligns with CMS' Medicaid Information Technology Architecture (MITA) framework. MES Modernization efforts have transitioned to the new enterprise approach of focusing on project scope linkage with enterprise business drivers. More broadly, this shift to a MES Modernization approach has enabled DHCS resources to support the portfolio of efforts within MES Modernization. Execution of the approach utilizes an Agile based system development methodology.

Various individual modernization projects received funding through prior budget augmentations, including the following (with additional detail below): 4260-501-BCP-2017-MR, 4260-402-BCP2018-MR, 4260-406-BCP-2018-MR, 4260-308-BCP-2019-A1, 4260-193-BCP-2020-MR, and 4260-052BCP-2021-GB. The positions and expenditure authority approved in these prior BCPs support the MedCompass project, Federal Draw and Reporting (FDR) project, CalARM project, BHM project, the Claims Modernization effort, and Modernization Strategy and Architecture planning. Prior BCPs include:

- 4260-501-BCP-2017-MR approved resources for 7.0 permanent positions and funding for consultants and hardware, software and hosting services for CA-MMIS modernization efforts. The requested expenditure authority for FY 2017-18 and ongoing was $5,754,000 ($575,000 GF and $5,179,000 FF).

- 4260-402-BCP-2018-MR approved resources to strengthen fiscal oversight of the Mental Health Services Act, the Medi-Cal Mental health Managed Care Program and for the planning effort for BHM. The approved expenditure authority for FY 2021-22 and ongoing was $4,045,000 ($1,042,000 Mental Health Services Fund (MHSF), $1,502,000 GF and $1,501,000 FF).

- 4260-406-BCP-2018-MR approved resources for 17.0 permanent positions for FY 2018-19, 2.0 LT funded positions and multiyear funding for consultants and hardware, software and hosting services. 8.0 permanent positions were also approved to begin in FY 2019-20. Per BCP 4260-406-BCP-2018-MR, $4,000,000 for FDR Project and $4,549,000 for CalARM Project was available in FY 2020-21.
    - Additionally, provisional language was included that authorizes augmenting the amount appropriated up to a maximum of $52,980,000, contingent on lessons

learned or completion of milestones related to CA-MMIS modernization modules.

- 4260-308-BCP-2019-A1 approved the re-appropriation of expenditure authority of $2,053,000 ($808,000 GF, $1,245,000 FF) in FY 2019-20 to cover the planning costs of the BHM project.

- 4260-193-BCP-2020-MR, approved funding for the FDR project. The requested expenditure authority for FY 2020-21 is $11,152,000 ($1,115,000 GF; $10,037,000 FF).

- 4260-052-BCP-2021-GB, approved funding for the FDR, CalARM, BHM project and Modernization Strategy and Architecture. The request is a LT expenditure authority of $22,279,000 ($4,016,000 GF; $18,263,000 FF) in FY 2021-22 and $1,275,000 ($128,000 GF; $1,147,000 FF) in FY 2022-23.

LAO Findings and Recommendations

"No Specific Concerns With Budget Proposal. We raise no specific concerns with the budget proposal. The proposed funding and positions for each of the proposal's activities and IT projects appear reasonable. The proposal also leverages enhanced federal financial participation available to states that redesign their Medicaid IT systems to align with the recommended federal frame-work known as the Medicaid Information Technology Architecture (MITA).

DHCS Expects to Finish Initial MES Modernization Strategy in 2022-23. A recent timeline presented by DHCS shows the department expects to complete an initial version of the strategy for the MES Modernization effort in 2022-23. DHCS expects to finish several "strategy sections" for the effort such as (1) goals, outcomes, and targets; (2) operational workflows and processes; (3) roles and responsibilities; and, (4) an implementation roadmap. While DHCS' development of the strategy sections will be iterative and change over time, the first implementation roadmap expected at the end of 2022-23 likely will provide a high-level overview of the entire effort.

Initial Strategy Important Due to Breadth and Complexity of MES Modernization Effort. The high-level overview of the entire MES Modernization effort that DHCS expects to complete by the end of 2022-23 is important because this effort is unlike any other IT project portfolio in the state due to its breadth and complexity. The effort's unique magnitude will require continued legislative oversight to ensure the department's strategy for modernizing IT systems that operate the state's Medi-Cal program (1) identifies and mitigates the potential risks associated with the effort, and (2) provides the Legislature with important information about the cost, schedule, and scope of the entire effort. The anticipated implementation roadmap, together with several other strategy sections, will provide the Legislature with an opportunity to provide this oversight.

Recommend Approval of Budget Proposal With Provisional Budget Bill Language Requiring DHCS to Submit Initial Strategy to Legislature by End of 2022-23. We recommend the Legislature approve this budget proposal to continue existing Medi-Cal IT system modernization projects and leverage enhanced federal financial participation. We also recommend the Legislature adopt provisional budget bill language to require that DHCS submit its initial MES Modernization effort strategy (including completed strategy sections and the implementation roadmap) to the Legislature by the end of 2022-23."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal, and requests LAO provide findings and recommendations, and respond to the following:

For DHCS:

- The BCP states that the MES implementation "approach utilizes an Agile based system development methodology." What does this mean?

- Is there a discrepancy in the total funding being requested, as it is identified as $20,794,000 in the narrative but $19,794,000 in the table (as included in the "Proposal" section of this agenda item)?

- Please provide any reactions to the LAO recommendation that the Legislature require DHCS submit its initial MES Modernization effort Strategy to the Legislature by the end of 2022-23.

Staff Recommendation: Hold open for additional discussion and review.

ISSUE 8: COVID-19 PUBLIC HEALTH EMERGENCY – RESUMING REGULAR OPERATIONS – APRIL 1 BCP

PANEL 8 – PRESENTERS

- **Lori Walker**, Deputy Director & Chief Financial Officer, Fiscal, Department of Health Care Services

PANEL 8 – Q&A ONLY

- **René Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

DHCS, Medi-Cal Eligibility Division (MCED), requests three-year limited-term (LT) resources equivalent to 8.0 positions and expenditure authority of $26,234,000 ($13,117,000 General Fund (GF); $13,117,000 Federal Fund (FF)) in fiscal year (FY) 2022-23 and $1,162,000 ($581,000 GF; $581,000 FF) in FY 2023-24 and FY 2024-25.

DHCS states that the requested resources and contract dollars are needed to unwind the array of program policy and system-related changes that were put in place during the course of the COVID-19 Public Health Emergency (PHE), including resuming Medi-Cal redeterminations for all Medi-Cal beneficiaries and completing all pending case actions for any change of circumstances in such a way that minimizes any potential disruption in coverage for 14.4 million Medi-Cal and Children's Health Insurance Program (CHIP) beneficiaries, all within the 12-month timeframe outlined by State Health Official Letter 21-002, once the COVID-19 PHE is officially terminated at the federal level.

BACKGROUND

On January 31, 2020, the United States Department of Health and Human Services (US HHS) declared a federal COVID-19 PHE which led to a Presidential emergency declaration on March 13, 2020 in response to the global COVID-19 outbreak. US HHS has continuously extended its COVID-19 PHE declaration in 90-day increments since, most recently effective April 16, 2022 (through July 16, 2022). The declarations allowed states to utilize a variety of eligibility and enrollment flexibilities to assist with expedited Medi-Cal determinations and allow for continued health coverage to prevent barriers to accessing care. Subsequently, the President signed the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Families First Coronavirus Response Act

(FFCRA) which included provisions requiring the maintenance of Medi-Cal beneficiary eligibility and enrollment as a condition for states to receive the temporary increase in federal funding authorized in that section. Finally, in preparation for the eventual end of the COVID-19 PHE, the Centers for Medicare and Medicaid Services (CMS) issued State Health Official Letter (SHO) 20-004 (December 22, 2020) and SHO 21-002 (August 13, 2021) to provide guidance to states on planning for the resumption of regular Medicaid operations upon the conclusion of the COVID-19 PHE.

In the course of the COVID-19 PHE-related work, DHCS did not request any resources, as the length of the COVID-19 PHE was unknown. However, as the end of the PHE nears, DHCS states that it is critical to have sufficient resources to establish an adequate level of staffing to manage and support the policy and associated systems-related work prior to, and upon resumption of, regular operations. DHCS also states that this is especially critical given the high number of eligibility expansions that DHCS is simultaneously working on.

Due to disruptions to state operations during the COVID-19 PHE and the continuous enrollment requirement under FFCRA, DHCS expects that California will be faced with a large number of eligibility and enrollment actions (including change of circumstances, redeterminations, and verifications), which will need to be completed after the COVID-19 PHE ends. Per the current federal timelines, effective August 2022, counties will have 12 months from the COVID-19 PHE termination to work on processing accumulated Medi-Cal redeterminations and case changes. For context, Medi-Cal enrollment was approximately 14.4 million in December 2021, which is a 13 percent caseload increase (or 1.9 million more beneficiaries) since the start of the COVID-19 PHE. Based on the current Medi-Cal caseload, assuming approximately 35-40% of redeterminations go through an automatic redetermination process using historical trends, the remaining 60-65% of the total caseload would require a redetermination. DHCS explains that the volume of cases and complexity of adjudicating multiple years of accumulated case actions for each Medi-Cal beneficiary requires extensive management and coordination (which can only be done by DHCS, the Single State Medicaid Agency) to direct the statewide response and approach to normal resumption of Medicaid eligibility operations. According to DHCS, the scope of work generated by the COVID-19 PHE pending case actions is comparable with that related to implementing the Affordable Care Act (ACA), with its multiple prongs of eligibility work-streams.

Since March 2020, DHCS has responded to the COVID-19 PHE by implementing many flexibilities offered by CMS to maintain continuous coverage and access to health care for the Medi-Cal population. This included undertaking extensive efforts to implement a new coverage group for uninsured individuals to ensure equitable access to COVID-19 testing, testing-related, and treatment services for individuals who otherwise did not have access to care. DHCS has continually engaged and collaborated with counties and community stakeholders to provide detailed Medi-Cal policy guidance and develop system-based approaches to meet federal continuous coverage requirements. These

efforts, along with a myriad of other eligibility requirements, were undertaken without any additional resources, leveraging the expertise of existing staff while other workload was put on hold. DHCS is once again in the midst of equally demanding policy implementations that are key investments of the Administration and Legislature, such as Full Scope Medi-Cal Expansion to Older Californians, Postpartum Coverage, and more (enumerated below). DHCS explains that the requested resources would prevent DHCS from putting workload on hold, as it did in March 2020.

Based on historical trends, DHCS is estimating that up to 3 million beneficiaries could be found ineligible for Medi-Cal once redetermination processing resumes at the end of the COVID-19 PHE. DHCS plans to establish extensive policies and best practices to support continuous coverage of existing Medi-Cal beneficiaries, minimizing the loss of coverage in California. Additionally based on the federal FFCRA provisions, DHCS will be required to terminate coverage of over 273,000 individuals who have been enrolled into the COVID-19 Uninsured Coverage group by the end of the month in which the COVID-19 PHE ends. As a result of these requirements, there are a myriad of steps that must be taken relative to due process for these individuals in terms of ending their coverage as well as working to ensure claiming and enrollment systems are modified to reflect the end of this coverage program which will require extensive coordination and collaboration with internal DHCS divisions, county partners and providers.

DHCS also points out that this work effort will be occurring simultaneously when DHCS is also implementing critical, legislatively mandated eligibility policies relative to new coverage expansions of older adults, extension of post-partum coverage to 12-months, and taking the first step of a two-phased process relative to the elimination of assets for certain coverage groups under Medi-Cal. This work is coupled with other workload related to the consolidation of the county based eligibility and enrollment systems which requires extensive engagement and collaboration with DHCS, county partners, other state agencies (Office of Systems Integration and the Department of Social Services) and interested stakeholders. All of this work requires extensive and ongoing engagement of department eligibility subject matter experts while maintaining existing program operations relative to eligibility policies, procedures and program oversight.

The requested resources will develop, implement, and oversee the CMS required post-COVID-19 Eligibility and Enrollment Operations Plan for California. In order to minimize the burden on the 14.4 million Medi-Cal and CHIP beneficiaries, this plan addresses the resumption of annual Medi-Cal redeterminations for all Medi-Cal beneficiaries; and completing pending case actions for any change of circumstances. These tasks must be completed within the 12-month timeframe outlined by SHO 21-002, once the COVID-19 PHE is officially terminated at the federal level.

The key activities for the requested DHCS positions consist of the following:

Redeterminations:
Once the COVID-19 PHE ends, states must take appropriate steps to instruct counties to redetermine eligibility and terminate coverage, as appropriate, for individuals who remained enrolled due to the maintenance of eligibility continuous enrollment requirements in FFCRA, who gained or maintained coverage during the COVID-19 PHE through a temporary change in eligibility requirements, or whose redetermination was delayed as required by section 6008(b) (3) of the FFCRA. This will require DHCS to issue policy instruction and training to counties, provide on-going technical assistance, and track and monitor county progress to meet the CMS requirements. DHCS will provide oversight of the eligibility redeterminations for the following groups of beneficiaries:

- Redetermination of all Medi-Cal beneficiaries, currently 14.4 million, some of which will require processing of both the current annual redetermination and previous year(s) redeterminations during and after the COVID-19 PHE for individuals continuously enrolled
- Redeterminations based on changes in circumstances
- Redeterminations based on changes in state eligibility and enrollment policies
- Transitions of coverage between coverage programs

Outside of processing the current and ongoing redetermination requirements, there is outstanding case work that accumulated during the COVID-19 PHE that must be resolved. DHCS explains that processing outstanding case work is challenging because existing business operations are designed to take action “real time” when the information was initially provided to the county or state. Processing the casework at a later date (and in the case of the COVID-19 PHE, multiple years later) necessitates additional operations and policy instructions to counties to accurately and efficiently process the pending case actions. Comparing the COVID-19 PHE pending case actions with the case actions related to implementing the Affordable Care Act (ACA), this COVID-19 PHE work requires the same level, if not more, of additional resources to support the multiple prongs of eligibility work-streams.

Program Transitions and Continuing Program Oversight:

- Continued oversight of Medi-Cal, CHIP, and Breast and Cervical Cancer Treatment (BCCTP) Program policies related to eligibility and enrollment to safeguard accurate and timely access to care as DHCS moves to transition Medi-Cal populations out of the COVID-19 PHE.

- Coordinate with Covered California in the implementation of SB 260 (Hurtado, Chapter 845, Statutes of 2019) that provides auto plan selection in Covered California beginning in June 2022 for Medi-Cal beneficiaries transitioning to Covered California. This is a new workload for both DHCS and Covered California and it is necessary to prepare for the potential influx of transitioning individuals

from Medi-Cal to Covered California programs once case processing resumes. Going forward DHCS will provide ongoing guidance and support to counties to respond to beneficiaries questions and concerns regarding automatically enrolling in a Covered California health plan, confirm that cases have been determined ineligible for all Medi-Cal programs prior to transitioning; and collaborate with Covered California and other stakeholders on transitioning beneficiary enrollment data to identify enrollment issues and ameliorate process and policy issues as needed on a regional or statewide basis. DHCS and Covered California must monitor the usage of the new microsite pages in the Covered California portal which guides transitioning beneficiaries to confirm the health plan selection or choose another plan.

- Develop COVID-19-specific call scripts for county eligibility workers and Covered California service center representatives to assist households where the families' health care coverage is both with Medi-Cal and Covered California (e.g., parents are on Covered California and children are on Medi-Cal).

- DHCS implemented the COVID-19 Uninsured Group on March 2020 as part of the COVID-19 Disaster State Plan Amendment, with implementing statutory authority under FFCRA Section 6004 which authorized state Medicaid programs, at state option, to provide access to coverage for medically necessary COVID-19 diagnostic testing, testing-related services, and treatment services, including hospitalization and all medically necessary care, at no cost to the individual until the end of the COVID-19 PHE. CMS requires states to sunset the COVID-19 Uninsured Group at the end of the month in which the COVID-19 PHE ends and to cease claiming of federal funding used to support this program on the day the COVID-19 PHE ceases to be in place. This work effort consists of noticing individuals enrolled in the program, terminating coverage to the program, communicating program changes to Medi-Cal providers, and implementing system changes.

Policy Guidance, Training, and Outreach: Issue policy guidance related to the required processes and procedures related to Medi-Cal eligibility at the conclusion of the COVID-19 PHE:

- Develop and conduct a statewide training series for county staff on several key areas related to redetermination processing, addressing outstanding and newly reported changes, and transitioning beneficiaries between Medi-Cal and Covered California programs.

- Procure a vendor and conduct a marketing campaign around the resumption of normal operations for Medi-Cal with a target on updating beneficiary contact information that will potentially include the development of:

    - Social media posts

  - Call scripts for managed care plans, county eligibility workers, Covered California service center representatives, local legislative staff, and community based organizations for consistency in messaging throughout the state
  - Sample flyer language
  - Website banner messaging
  - Short YouTube videos
  - Print and radio ads

- Enhance the existing communication process between managed care plans and local county offices through conducting surveys, creating new information sharing templates, and researching system automation opportunities to streamline the current manual process of updating beneficiary contact information.

- Conduct frequent statewide and one-on-one meetings to provide technical assistance to counties on questions related to processing outstanding work that was generated during the COVID-19 PHE.

- Update and enhance existing policies and business processes to increase efficiencies in case processing and reduce barriers to continued coverage by exploring other federal eligibility flexibilities.

- Oversee administrative vendors responsible for the case management of the Medi-Cal Access Program and the County Children's Health Initiative Program to confirm compliance with DHCS' operational plan.

- Provide systems, program, operational, and technical knowledge to support functional changes as part of the unwinding of the COVID-19 PHE.

- Support development of system-related COVID-19 PHE strategies and contribute to content of the work products.

- Support the development of requirements affecting integration with all Medi-Cal Eligibility systems including business rules development, user acceptance testing, defect management, and other system-related eligibility and communication activities.

- Assist with formulating methodologies for developing data queries and analyzing those data sets to closely monitor the shifts in Medi-Cal enrollment, particularly vulnerable populations, such as pregnant individuals, as resumption of normal operations begins.

- Provide policy guidance for SAWS and CalHEERS for all eligibility system-related changes needed to resume regular business operations.

- Serve as the primary DHCS liaison to counties, SAWS, and the external stakeholder community for COVID-19 PHE unwinding effort.

- Develop informational notices, outreach materials, and update Medi-Cal notices of action. Written materials must go through multiple layers of stakeholder review, a readability assessment to confirm the materials are in plain language, meet the best practices identified in the California Health Care Foundation issue brief related to Medi-Cal communications, and be translated into threshold languages and alternative formats.

- Develop tools and resources for counties to utilize for developing strategies and documenting county-level operation plans for the resumption of regular business processes.

- Maintain communication with CMS regarding increased federal data services hub call volumes resulting from the resumption of Medi-Cal redeterminations processing.

- Participate in systems integration activities with business partners to facilitate scheduling of SAWS redetermination batches and ensure they do not adversely impact CalHEERS system performance.

Media and Outreach Campaign - $25,000,000 ($12,500,000 GF; $12,500,000 FF) in FY 2022-23

DHCS requests a one-time expenditure authority of $25 million in FY 2022-23 for the purpose of conducting a media and outreach campaign in preparation for the COVID-19 PHE-related work. Specifically, to complete a redetermination, counties require the most-up-to date information to reach the beneficiary to complete all necessary paperwork to renew coverage. However, since 2020, Medi-Cal beneficiaries have moved throughout the State. DHCS states that it is imperative that they procure a vendor to conduct a media and outreach campaign to encourage beneficiaries to update their contact information with their counties, and also to inform people of the implications of their eligibility once the COVID-19 PHE ends. The media and outreach campaign will require a vendor who will design outreach materials and letters to be mailed to 14.4 million Medi-Cal beneficiaries, and to disseminate these materials to Medi-Cal managed care plans, counties, enrollment navigators, and community partners.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to the following:

- Has DHCS been working with the County Welfare Director's Association on projecting the increase in workload that counties should expect, and ensuring the availability of increased resources needed to meet counties' increased workload?

- Given that the state anticipates as many as 3 million newly uninsured Californians as a result of the restoration of Medi-Cal redeterminations, what strategies can the state take to keep this population insured?

Staff Recommendation: Hold open to allow for additional discussion and review.

ISSUE 9: MANAGED CARE PLAN COMPLIANCE AND OVERSIGHT PROGRAM – APRIL 1 BCP

PANEL 9 – PRESENTERS

- **Lori Walker**, Deputy Director & Chief Financial Officer, Fiscal, Department of Health Care Services

PANEL 9 – Q&A ONLY

- **Susan Philip,** Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

DHCS requests the establishment of 14.0 permanent positions and expenditure authority of $3,210,000 ($1,605,000 General Fund (GF); $1,605,000 Federal Fund (FF)) in fiscal year (FY) 2022-23 and $3,105,000 ($1,553,000 GF; $1,552,000 FF) in FY 2023-24 and $3,090,000 ($1,545,000 GF; $1,545,000 FF) in FY 2024-25 and $2,590,000 ($1,295,000 GF; $1,295,000 FF) in FY 2025-26 and ongoing for staff resources and contractual support services for the new contract requirements and expectations of the Medi-Cal managed care plans (MCP), effective January 1, 2024.

BACKGROUND

DHCS contracts with Medi-Cal MCPs for the provision of health care services. Of the over 14 million Medi-Cal beneficiaries in all 58 California counties, approximately 93 percent of beneficiaries will be receiving their health care through MCPs as of January 1, 2023. DHCS utilizes the MCP contract to establish expectations of MCPs to advance equity, quality, access, accountability, and transparency. Therefore, DHCS must verify that MCPs and their Subcontractors, Downstream Subcontractors, and Network providers comply with federal, state, and contractual requirements in order to verify timely access and provide high quality health care services to which Medi-Cal members are entitled.

DHCS released a Request for Proposals (RFP) to procure its commercial Medi-Cal MCP contracts, the first statewide procurement of this magnitude. Through the Contract, DHCS is imposing new requirements and expectations of the Medi-Cal MCPs. Therefore, this necessitates DHCS assess the current MCP Compliance Programs and oversight capacity, and add the necessary resources to establish a robust compliance program that proactively monitors MCPs, their subcontractors and downstream subcontractors.

The positions that were approved under the Managed Care Statewide Procurement BCP are separate and apart from the resources requested in this BCP. The positions approved under the Procurement BCP are responsible for leading the effort to build and execute a statewide procurement for an effective date of January 1, 2024, as well as the ongoing workload that is required for a statewide procurement to occur every five years.

The positions requested in this current BCP are to monitor, oversee, and hold the MCPs accountable for the contract requirements that ultimately result from the Procurement efforts, legislative changes, federal changes, and other policy changes affecting the Medi-Cal population. DHCS states that these resources will enable them to hold the health care delivery system accountable for transparency, quality, and results, which will lay the foundation for more equitable health outcomes and a more efficient and responsive Medi-Cal program.

The 2024 RFP MCP Contract imposes new and added obligations on MCPs in areas of local engagement and member experience, at the MCP and subcontractor level, thereby requiring new and enhanced monitoring and oversight by DHCS of MCP compliance with these federal, state, and contractual requirements. Those monitoring activities include but are not limited to: MCP grievance and appeals, Memorandums of Understanding with many more local partners, a more robust Consumer Advisory Committee, Community Reinvestment Plan, Verification of Services Received by Members, and a new Compliance and Delegation Oversight Plan that specifies detailed requirements of the MCPs' compliance program. The new contract includes requirements for the MCP to report all delegation and a plan for how that delegation will be monitored. This plan will need to be reviewed for completeness. The review of the Delegation and Compliance Plan will necessitate submission of additional deliverables which will need review and tracking.

DHCS expects to review approximately 200 new deliverables per MCP that will be submitted by the MCPs on specified intervals throughout the year. Many of the new requirements are now expected to be monitored at the MCPs' subcontractor level. Some examples of the new mandated requirements include new Operational Readiness Deliverables intended to be reviewed and approved prior to contract implementation and new Ongoing Operational Deliverables to be reviewed and approved at regular monthly, quarterly, and annual intervals.

To supplement the contract language, MCQMD will need to issue more detailed guidance via memos and All Plan Letters resulting from the new mandated requirements and provide technical assistance during implementation. These efforts will involve broad collaboration and consultation with various internal and external partners and stakeholders, with a high level of legal, regulatory, and detailed work. Additionally, the regulatory and program policy materials and deliverables must be in compliance with federal and state laws, coalesce with other program provisions, and designed to achieve departmental goals and objectives. In addition to policy development and guidance,

MCQMD will need to develop new reporting mechanisms for MCPs. To verify internal staff are knowledgeable of new requirements and have the tools to monitor effectively, MCQMD will also be developing and conducting trainings for DHCS staff, developing compliance and monitoring tools that track to new APLs and contract language, and conducting technical assistance for MCPs as needed.

Consulting Resources for Systemic Compliance Assessment

Health Care Delivery Systems (HCDS) is requesting $1.5 million in total contract funding to engage a contractor who will assist DHCS in conducting an assessment to identify needed improvements in current processes, and systems, and recommend process and structural changes. A systemic review of current compliance capabilities is needed to fully implement a robust compliance and monitoring program for our health care delivery systems. The contractor will review monitoring and oversight of activities to test for completeness, thoroughness, efficiencies, and processes. For example, by identifying opportunities to automate reviews, staff can reallocate their efforts to functions that require direct human interaction. The assessment will also inform DHCS' monitoring capacity across other DHCS managed care program areas (i.e., Specialty Mental Health Plans, Drug Medi-Cal Organized Delivery System Plans, and Dental Managed Care Plans) and Quality and Population Health Management.

Office of Legal Services (OLS)

Under the statewide procurement of Medi-Cal managed care contracts, DHCS is significantly increasing its oversight and monitoring obligations over MCPs. These new contractual requirements will require DHCS program and legal staff to review plans' policies and procedures, monitor compliance, and take corrective or enforcement actions when necessary. The following components will be included and fully operationalized by January 1, 2024:

- New and more robust program integrity requirements, including an enhanced contract compliance program, a fraud prevention program, and new and more frequent fraud, waste and abuse reporting requirements;
- Oversight of all Subcontractors and downstream subcontractors, including DHCS' duty to process and oversee new managed care reporting requirements on plans' delegated structures;
- New conflict of interest avoidance requirements, including, when applicable, submission and review of a managed care plan's conflict avoidance plan;
- New policy and procedures and enforcement requirements in connection with the GO-lead CalAIM initiative, including population health management, enhanced care management, and community supports;
- Increased oversight to reduce health disparities and increase health equity in the delivery of care;
- Increased oversight of services for children; and,
- Increased oversight of substance use and behavioral health treatment and parity.

Additionally, OLS represents DHCS in administrative litigation and writ petitions concerning managed care plans, including but not limited to, contract disputes, overpayments, recoupments, and the imposition of various types of sanctions or other penalties. The increase in the oversight, assessment, and enforcement of MCPs will increase the number of administrative actions related to MCPs. Civil and administrative litigation matters related to managed care entities are among the most complex and time-intensive matters that OLS handles. Thus, the requested OLS positions, which will be dedicated to managed care house counsel and litigation matters, are needed for OLS to meet this new workload.

The requested resources are needed to establish a robust compliance and monitoring program for Medi-Cal MCPs and support the workload attributed to the new requirements and expectations set forth in the 2024 MCP Contract. The Department requires position and expenditure authority to successfully support the additional workload ahead of the contract effective date. An immediate need exists for the contractual effort to assess and conduct a compliance assessment and hire the new positions and have staff trained as soon as possible. The new positions will need to conduct the planning needed, develop the review tools, establish and/or revise existing processes, and to train DHCS staff to embed these new requirements within the established and new managed care processes.

These resources will be used for the following functions, but are not limited to: contract oversight; monitoring and enforcement; compliance mechanisms; legal support to provide authoritative legal opinions and advice on interpretation of contractual obligations related to MCPs; take enforcement actions such as corrective actions, and financial and nonfinancial sanctions for noncompliance; and information technology support for contract management, hardware and software support, system maintenance and operations, infrastructure support services, security architecture, compliance reviews, testing, and hardening.

The extensive updates, enhancements, and new contract requirements necessitate the Department to initiate efforts July 1, 2022, in order to have more robust compliance and oversight mechanisms in place in time. For example, DHCS is implementing new requirements to verify compliance not only of the prime Contractor that holds the MCP contract with DHCS, but of the Subcontractor or Downstream Subcontractor that provides services to our Medi-Cal members. The new and enhanced contract requirements are the result of an updated MCP contract going live January 1, 2024 in alignment with the MCP Statewide Procurement for Commercial Plans, as well as the federal Centers for Medicare & Medicaid Services (CMS)-approved California Advancing and Innovating Medi-Cal (CalAIM) CalAIM Section 1115 demonstration and CalAIM Section 1915(b) Waivers that were approved on December 29, 2021, both effective through December 31, 2026 as indicated in the CalAIM BCP request (4260-198-BCP-2022-A1).

In addition, DHCS will utilize the updated and restructured MCP contract to align managed care contracts across all plan model types, including those not included in the MCP Statewide Procurement (county plans and Kaiser). Therefore, DHCS must be prepared to monitor, oversee, and enforce new contract provisions across all 58 counties and across all plan model types. This includes development of policies and guidance to effectuate contractual requirements, development of monitoring and auditing tools, and trainings for staff across the Department to effectively and proactively monitor contractual provisions, and resources to effectively enforce provisions through corrective action plans and financial and nonfinancial sanctions during instances of non-compliance.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: Hold open for additional discussion and review.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 10: OPIOID SETTLEMENTS FUND OVERSIGHT AND STATE-DIRECTED PROGRAMS – APRIL 1 BCP

PANEL 10 – PRESENTERS

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services

PANEL 10 – Q&A ONLY

- **Kelly Pfeifer, MD**, Deputy Director, Behavioral Health, Department of Health Care Services
- **Marlies Perez**, Chief, Community Services Division, Department of Health Care Services
- **Robin Christensen**, Chief, Substance and Addiction Prevention Branch, California Department of Public Health
- **Maria Ochoa**, Assistant Deputy Director, Operations Center for Healthy Communities, California Department of Public Health
- **Dr. Diana Ramos**, Assistant Deputy Director, Chronic Disease Prevention, California Department of Public Health
- **Dana Moore**, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Kia Cha**, Program Budget Analyst, Department of Finance
- **Jaleel Baker**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

The Department of Health Care Services (DHCS), Department of Health Care Access and Information (HCAI), California Department of Public Health (CDPH), and the Department of Rehabilitation (DOR) request to shift specified one-time Opioid Settlements Fund (OSF) supported programs proposed in the 2022 Governor's Budget from HCAI and CDPH to DHCS and DOR. In addition, DHCS requests OSF resources to provide oversight of OSF, as required under two national opioid settlements. DHCS, CDPH, and DOR request corresponding provisional language changes.

DHCS: DHCS requests 11.0 permanent positions and expenditure authority of $33,916,000 OSF in 2022-23 and $2,617,000 OSF in 2023-24 and through the terms of the settlements. Of this amount, $2,716,000 in 2022-23 and $2,617,000 in 2023-24 and through the terms of the settlements, is to support the oversight of two of California's provisions of national opioid settlements. The $2,716,000 in 2022-23 is shifted from CDPH to DHCS. The request includes a shift from HCAI to DHCS of $22 million one-time, available over three years, included in the 2022 Governor's Budget to increase the provider workforce capable of screening for and treating opioid use disorder. The request also includes a shift from CDPH to DHCS of $9.2 million onetime, available over three years, included in the 2022 Governor's Budget to fund the launch of the Addiction Treatment Locator, Assessment, and Standards Platform (ATLAS), including an outreach campaign to raise awareness of the new resource and to support a 15-month California implementation of the Shatterproof anti-stigma campaign. DHCS also requests corresponding provisional language to provide three-year limited-term encumbrance and expenditure authority of the one-time OSF-supported programs.

DOR: DOR requests $4 million one-time OSF, available over three years, to establish the pilot Integrating Employment in Recovery Program to provide training on evidence-based practices to providers of behavioral health services to people with disabilities with substance use disorders (SUD) related to opioid use as a part of recovery. DOR will also provide vocational rehabilitation employment services co-located in treatment centers in targeted regions throughout the state to serve diverse communities as an integral part of behavioral health treatment. DOR requests corresponding provisional language to establish authority and provide three-year encumbrance and expenditure authority for the pilot program.

CDPH: CDPH requests to shift $9.2 million one-time OSF, available over three years, included in the 2022 Governor's Budget to DHCS to support the launch of ATLAS, including an outreach campaign to raise awareness of the new resource and to support a 15-month California implementation of the Shatterproof anti-stigma campaign. CDPH also requests to shift $2,716,000 one-time OSF, included in the 2022 Governor's Budget for public outreach, to DHCS to support 2022-23 oversight and monitoring functions required by the opioid settlement terms. CDPH requests corresponding provisional language to reflect these adjustments.

HCAI: HCAI requests to shift $22 million one-time OSF, available over three years, included in the 2022 Governor's Budget to DHCS to increase community-based SUD provider capacity. HCAI also requests to shift $4 million one-time OSF, available over three years, included in the 2022 Governor's Budget to DOR to establish the pilot Integrating Employment in Recovery Program to train the providers on evidence-based practices and provide vocational rehabilitation services for consumers with a SUD related to opioid use.

BACKGROUND

According to data provided by the administration, from 1999 to 2020, nearly 841,000 people died from a drug overdose, with prescription opioids serving as a factor in nearly 247,000 of those deaths. Overdose deaths involving opioids have increased six-fold since 1999. In California, opioid-related overdose deaths soared from 1,469 in 2006 to 5,502 in 2020 – a 275 percent increase. Overdose deaths spiked in 2020 nationally and continue to rise, with nearly 92,000 deaths attributed to substance misuse. California's all-drug overdose deaths mirrored this increase in 2020, surging by 43 percent to 8,894, with prescription opioids factoring in 54 percent of deaths.

McKinsey Settlement

The Governor's Budget proposal relies upon two different sets of nationwide settlements. In the first, the Attorney General settled claims against McKinsey in February 2021 related to services it provided to the opioid industry. The 2022 Governor's Budget reflects $50 million one-time OSF for the State to remediate the opioid crisis from the McKinsey Settlement. Additional funds are pending. The settlement includes language prohibiting the Legislature from supplanting existing funding.

Distributors and Janssen Settlements

The second set of settlements arise from numerous lawsuits and investigations brought by states, counties, and cities nationwide against pharmaceutical distributors and manufacturers. Two nationwide settlements have been reached and are close to being finalized that would resolve nearly all opioid litigation brought by states and local political subdivisions against the three largest pharmaceutical distributors: McKesson, Cardinal Health, and AmerisourceBergen, and one manufacturer, Janssen Pharmaceuticals, Inc., and its parent company Johnson & Johnson (J&J).

Settlement Structure and Amounts

The proposed settlements require the Distributors to pay up to $21 billion over 18 years and Janssen to pay up to $5 billion over no more than 9 years, for a total of up to $26 billion. Of the settlement amount, up to $22.7 billion will go to participating states and subdivisions to remediate and abate the impacts of the opioid crisis. California and its cities and counties could receive approximately $2.2 billion for substance use prevention, harm reduction, treatment, and recovery activities pursuant to the List of Opioid Remediation Uses, except as allowed by Section V(B)(2) of the Distributors settlement agreement and Section VI(B)(2) of the Janssen settlement agreement.

The actual amounts that will be received over these time periods will likely fluctuate depending on how many local governments, including special districts, sign onto the settlement—which could increase the amount California receives, and whether future litigation is brought against the defendants—which could reduce the amount. Because the settlements include multi-leveled bonus structures based on percentages of local government participation in the settlement, the total amount allocated to California

depends on how many local governments participate and thus agree not to bring future litigation against the defendants. California will not receive 100 percent of available settlement funds unless all required local governments and certain special districts participate, or the Legislature passes legislation that forecloses local governments and special districts' ability to bring litigation against the defendants.

As of March 2022, about 95 percent of local governments have signed on, representing approximately 99 percent of California's population. About 23 cities, litigating school districts, and litigating health plan districts have declined to participate in the settlements. Because local government participation is very significant, but not 100 percent, the Attorney General's Office currently estimates that California should receive around $1.6 billion of the estimated maximum $1.8 billion available in the Distributors settlement and $410 million of the estimated maximum of $423 million available in the Janssen settlement.

The Administration, in collaboration with the Attorney General's Office, will develop and update revenue projections for the 9-year and 18-year periods of Distributors and Janssen proposed settlement revenue to the state, counties, and cities as additional information is known, including that the settlement amounts are final.

Allocation and Use of the Settlement Funds

Payments to states and local governments will be made over the next 18 years by the Distributors and Janssen over no more than 9 years, starting in spring 2022. The more cities and counties that join, the more will be paid to California. As of March 2022, there were over 440 eligible California counties, cities, and litigating special districts. The majority have agreed to participate in the settlement, which increases the funding available. The settlement agreements for the Distributors and Janssen are identical in requirements regarding how the abatement funds can be used. The state-local allocation agreements for the Distributors and Janssen settlements further outline the requirements for use of funds by our local governments.

The Attorney General and a group of litigating and non-litigating California counties and cities negotiated state-local allocation agreements pursuant to the nationwide settlement agreements. The settlement fund payments to California, pursuant to both allocation agreements, are allocated as follows: 15 percent to the State Fund; 70 percent to the Abatement Accounts Fund; and 15 percent to the Subdivision Fund. The 15 percent fund allocated to the State must be utilized for State determined priorities that pertain to opioid remediation.

The 70 percent allocated to the California Abatement Accounts Fund will be allocated to counties and cities under the methodology developed in the nationwide agreements and our state-local allocation agreements, and be used for future opioid remediation in one or more of the areas described in the settlement List of Opioid Remediation Uses. According to the California State-Subdivision Agreement, participating counties and cities must use

no less than 50 percent of the funds received in each calendar year for one or more of the following High Impact Abatement Activities:

1. The provision of matching funds or operating costs for SUD facilities within the Behavioral Health Continuum Infrastructure Program (BHCIP);

2. Creating new or expanded SUD treatment infrastructure;

3. Addressing the needs of communities of color and vulnerable populations (including sheltered and unsheltered homeless populations) that are disproportionately impacted by SUD;

4. Diversion of people with SUD from the justice system into treatment, including by providing training and resources to first and early responders (sworn and non-sworn) and implementing best practices for outreach, diversion and deflection, employability, restorative justice, and harm reduction; and/or

5. Interventions to prevent drug addiction in vulnerable youth.

The 15 percent of funds allocated to the Subdivision Fund will be used by a smaller subset of litigating local governments for a broader set of uses, including opioid-related projects and recovery of past litigation costs and opioid related expenditures.

There is a possibility that other entities will be the subject of litigation and/or participate in national opioid settlements. If future litigation and/or settlements occur, additional funding pertaining to opioid remediation may become available to California.

DHCS is the state department designated by the Governor as the single state agency for the Substance Abuse and Mental Health Service Administration. This federal designation provides the majority of federal dollars for states for prevention, harm reduction, treatment, and recovery services for SUD. DHCS is also the State's Medicaid authority, which receives and provides federal Medicaid funding for SUD services. DHCS explains that, with these two designations, DHCS holds the federal funding, clinical and technical resources, and staff expertise in the area of SUD. DHCS states that California has been leading the nation in several key initiatives to combat the opioid epidemic including the MAT Expansion Project, Drug Medi-Cal Organized Delivery System, California Bridge Program, Naloxone Distribution Project, Expanding MAT in County Criminal Justice Settings, and Behavioral Health Response and Rescue Project. Through these initiatives and other pilot projects, DHCS believes it has experience and lessons learned that local counties and cities can leverage when implementing projects within their respective jurisdictions. DHCS also believes that it has the necessary expertise to assist counties and cities with determining the most effective utilization of opioid settlement funds.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to the following:

- Please explain the rationale for shifting resources and responsibility for public health goals and strategies, such as youth prevention efforts, an opioid public awareness campaign, and data collection and analysis, away from CDPH given that this type of work is typically and historically public health work.

- How does DHCS plan to support innovation in the prevention and treatment of substance abuse, addiction, and overdose?

- How will DHCS measure progress and achievement with this funding? How will DHCS share this information with the public and Legislature?

Staff Recommendation: Hold open to allow for additional discussion and review.

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 11: INFORMATION TECHNOLOGY, DATA SCIENCE, AND INFORMATICS FRAMEWORK FOR A 21ST CENTURY PUBLIC HEALTH SYSTEM – APRIL 1 BCP

PANEL 11 – PRESENTERS

- **John Roussel**, Chief Technology Officer/(Acting) Chief Information Officer, California Department of Public Health
- **Dana Moore**, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health
- **Brian Metzker**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 11 – Q&A ONLY

- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Rob Trojan**, Oversight Manager, Department of Finance
- **Tulika Srivastava**, Branch Chief, California Department of Technology

PROPOSAL

The California Department of Public Health (CDPH), Information Technology Services Division (ITSD) and Center for Health Statistics and Informatics (CHSI), requests 33 positions and $20.1 million General Fund in 2022-23 for foundational enterprise and strategic planning activities to modernize public health IT infrastructure and systems and implement the Ecosystem of Data Sharing, consistent with 10 initiatives recommended by the Future of Public Health Workgroup. Provisional language is also requested that authorizes encumbrance or expenditure until June 30, 2024 and augmentation of up to $15.9 million General Fund one-time to complete planning efforts and for consulting services to begin implementation of the initiatives. In 2023-24 and ongoing, the request includes 33 positions and $18.1 million General Fund to implement and support the framework for modernization of public health IT infrastructure and systems, training and upskilling, and expanded workforce pipeline for the Information Technology, Data Science, and Informatics Framework for a 21st Century Health System.

The funding is comprised of three components:

1. *One-time planning resources*: $18.5 million for foundational enterprise and strategic planning to modernize public health IT infrastructure and systems and implement the ecosystem of data sharing ($9.3 million of which is contingent upon approval of enterprise planning and strategy documents for preceding planning activities by California Health and Human Services Agency and Department of Technology);

2. *One-time implementation resources*: $6.6 million for consulting to begin implementation of a flexible and scalable information technology backbone, focusing on cloud migration and technology, and public health data systems integration, contingent upon approval of related enterprise planning and strategy documents by California Health and Human Services Agency and Department of Technology; and,

3. *Ongoing staffing, training and expanded workforce pipeline resources*: $10.8 million in 2022-23 and $18.1 million ongoing for 33 permanent positions, staff training and upskilling, and implementation of a comprehensive internship program beginning in 2023-24.

	Yr 1 (BY) 22/23					Yr 2 (BY+1) 23/24			
Tasks	Staffing Count	Staffing Cost	Other Costs	Other Costs (Subject to BBL)	Total Costs BY 22/23	Staffing Count	Staffing Cost	Other Costs	Total Costs BY 23/24
BCP REQUEST TOTALS	33	$ 10,822,350	$ 9,286,400	$ 15,882,300	$ 35,991,050	33	$ 10,822,900	$ 7,323,104	$ 18,146,004

These resources are requested to plan for, and begin implementing, ten public health strategic initiatives, consistent with the recommendations of the Future of Public Health Workgroup, that deliver a comprehensive public health information technology and data systems transformation and address IT infrastructure upgrades like migration of solutions off premise to cloud, consolidating platforms and systems, bolstering data and analytics-as-a-service capabilities. To meet the rapidly growing demands of the technology infrastructure, CDPH proposes an organizational model focused on delivering enterprise platform transformations in accordance with Enterprise Architecture standards and rigorous project management capabilities, which will set CDPH up for successfully meeting future demands effectively and with agility. Enterprise class data management and data analytics capabilities are critical to informing public health administration.

The Future of Public Health Workgroup used the insights and data gleaned from its research to develop the following ten public health strategic initiatives, which CDPH proposes to implement to meet its information technology and data systems infrastructure needs:

1. Enterprise Planning and Strategy: Develop a continually evolving and responsive overarching digital transformation strategy and roadmap to govern, prioritize and align critical planning activities, initiatives, and projects to the Future of Public Health initiatives
2. Dynamic Public Health Structure: Build a flexible and scalable backbone for dynamic public health activities with an emphasis on cloud migration and technologies
3. Surveillance and Licensing Systems: Streamline transactional systems to create one-stop, enterprise-scale systems as core backbone for surveillance and licensing activities

4. Rapid Public Health Data Services: Enable more efficient public health business processes and reduce manual burden
5. Public Health Data Integration: Integrate additional data into systems to enable public health analyses
6. Public Health Information Asset Management: Enhance system-wide data governance and standards to improve data interoperability and access
7. Analytics Workspaces: Build analytics workspaces to query data, run, iterate, and share models on key public health use cases
8. Information Sharing and Interoperability: Enhance access to accurate and timely data for local health jurisdictions (LHJs) and stakeholders
9. Public Health Strategy and Innovation: Build IT, data, and informatics capacity, skillsets, and knowledge sharing to improve decision making
10. Enhancing the Public Health IT Operating Model: Build project management capacity to enhance the operating model and to successfully deliver each of the proposal's initiatives.

According to CDPH, this proposal aims to improve the CDPH public health technology infrastructure with investments in critical areas essential for addressing existing and emerging public health threats. CDPH seeks to strengthen support for the department's programs, local health departments, community organizations, and state level stakeholders, so that existing and emerging public health threats are addressed appropriately and rapidly. This request lays the foundation for enterprise-wide modernization and includes capabilities related to IT infrastructure, system interoperability, data domains addressing accessibility and usability, and cloud services. Key enabling activities such as comprehensive governance, product/project management, and talent development and acquisition are also addressed.

Ongoing funds will also support the establishment of the Office of Data Strategy and Innovation (ODSI) which would be housed in CHSI, whose staff will coordinate with the new Office of Technology Innovation and Strategy in ITSD on setting the strategic direction for public health data and public health information for all of CDPH. ODSI will also provide oversight to, and more fully develop, implement, and sustain actionable plans for establishing a next generation public health data and information infrastructure that supports much needed Data as a Service and Analytics as a Service functions. These functions will provide for a shared CDPH data infrastructure that begins to bridge the many data siloes that exist today across the multitude of CDPH programs.

CDPH also proposes to expand access to the Ecosystem of Data Sharing, the technology infrastructure and data services used by organizations to share data and insights. It includes source systems as well as the applications used for capturing and analyzing data and serves as a governance structure that is focused on internal data and information sharing policies and procedures that intentionally and strategically break down siloed processes across multiple data systems department wide. Implementation of the

Ecosystem of Data Sharing will allow data to be standardized and therefore integrated providing more meaningful insight to public health problems, both current and emerging. As a cloud based technological platform, Ecosystem of Data Sharing has the capability of powerful analytics that can be used for modeling and predictive analytics and causal inference. Predictive analytics is the use of data, statistical algorithms and machine learning techniques to identify the likelihood of future outcomes based on historical data. The goal is to go beyond knowing what has happened, to providing a best assessment of what will happen in the future. Causal inference refers to the process of drawing a conclusion that a specific intervention was the "cause" of the effect (or outcome) that was observed. Inference for causal effects in education might include, for instance, aiming to select programs that improve educational outcomes or identifying events in childhood that explain developments in later life.

Through enhancements to the Ecosystem of Data Sharing, improvements in technology infrastructure, and investing in staffing resources, CDPH will increase outreach and engagement with local health departments, community organizations, and state level stakeholders to improve quality, timeliness, and access to critical public health data.

The critical strategic planning funds requested for each of the initiatives, as well as the establishment of ODSI and the Ecosystem of Data Sharing, are considered vital to CDPH's enterprise-wide modernization needs and will allow CDPH to engage with the California Department of Technology on the next phases of implementation.

BACKGROUND

CDPH advances the health and well-being of California's diverse people and communities. CDPH's functions include protecting people from the threat of preventable infectious diseases like Zika virus, Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS), tuberculosis, and viral hepatitis, and providing reliable and accurate public health laboratory services and information about health threats. CDPH also provides nutritional support to low-income women, infants, and children, and screens newborns and pregnant women for genetic diseases. CDPH monitors the safety of food and bottled water, helps reduce smoking and its impacts, and works to prevent chronic diseases and conditions such as diabetes, cardiovascular disease, cancer, asthma, and obesity. The Department also protects patient safety in hospitals and skilled nursing facilities, and it maintains vital records.

In addition to these functions, the Department is also responsible for public health emergency response. CDPH responded to the Coronavirus Disease 2019 (COVID-19) pandemic with emergency response at a level never experienced before. CDPH rapidly augmented staff resources with contract staff and implemented multiple complex technology solutions to meet the unprecedented need in record time.

The COVID-19 pandemic emphasized the need for adequate investment in public health and exposed significant gaps in the ability of CDPH and LHJs to respond to the needs of Californians rapidly and sustainably. In response to evident gaps in the existing public health infrastructure, the 2021 Budget Act signaled a commitment from the Administration and Legislature to invest in its fortification by including $3 million General Fund to support a public health infrastructure study to assess essential public health infrastructure needs. This culminated in the rapid formation of a Future of Public Health workgroup comprised of stakeholders, local partners, and leadership from CPDH and California Health and Human Services Agency who worked collaboratively to identify key investments in a set of core public health functions that are cross-cutting and underpin the work of state and local public health departments, that if successful, could help make significant strides in achieving the overarching vision of population health improvement.

This proposal is based on the work of the Future of Public Health Workgroup that conducted more than 60 analyses, discussions with stakeholders, jurisdictions, city, county and state surveys, and expert interviews across a broad range of topics to create the ten public health strategic initiatives outlined in this proposal.

CDPH states that the future of CDPH is one where the Department is prepared to respond to public health emergencies and accomplish essential functions critical to reducing health disparities among vulnerable and underserved communities in California. Within CDPH, CHSI and ITSD provide critical support to CDPH's mission and will play a key part in realizing this vision.

CHSI

CHSI is currently responsible for:

- Registering birth, death, fetal death, and marriage certificates, and amendments
- Issuing Certified Copies of birth, death, fetal death, and marriage certificates
- Maintaining Vital Records Data
- Processing Vital Records Data applications
- Developing Statistical reports
- Overseeing the Medical Marijuana Identification Card Program and End of Life Option Act

CHSI has three main lines of business: 1) Vital Records Registration (which provides the basis upon which public health insights can be garnered) and Issuance; 2) Vital Statistics (which transforms vital records data into meaningful descriptive statistics to allow public health insights); and 3) the relatively new team of Informatics. All these functions are currently funded by fees collected for vital records. These fees are deposited in the Health Statistics Special Fund (HSSF).

Vital Statistics is the field of statistics relating to births, deaths, marriages, health, and disease, which has a focus on basic descriptive statistics (e.g., procedures for depicting the main aspects of sample data, without necessarily inferring to a larger population), as

well as data quality activities. Public Health Informatics is the process by which raw data is turned into digestible information and subsequently knowledge. Informaticians often act as knowledge architects—they develop blueprints for the information systems that store and transmit health data. Like architects, informaticians consider user needs and legal mandates when planning construction, embracing efficiency, timeliness, and privacy. Informaticians collect data and translate them into a language practitioners can understand so that they can make data-driven decisions to improve public health. The ODSI builds on the foundational public health services that CHSI provides and, which includes hiring staff that have the skills to implement informatics. CDPH lacks this capacity as illuminated by the COVID-19 response efforts.

Historically, Vital Records and Vital Statistics and Informatics have been reliant on multiple disparate legacy systems. The design and use of disparate legacy systems evolved over time as the need arose, with development by a variety of sources: in-house CHSI teams, in-house ITSD teams, contracted vendors, UC Davis, UC Santa Barbara, etc. As a result, each of the systems was developed in silos with different programming languages and limited or no interoperability. These systems include birth registration, death registration, marriage registration, FileNet to access stored vital records images, Vital Records Business Intelligence System (VRBIS), Center Request Tracking System (CRTS) used for tracking public vital records requests, County Transmittal Automated System (CTAS) which houses county vital record fees, and Vital Records Image Redaction Statewide Access (VRIRSA) used by county health departments. The lack of flexibility and challenges extracting data for reporting, necessitates a lot of time and effort by staff requiring that new reports be created every time a new metric is needed. Reports can often take months to complete, depending on the complexity and other projects in progress. More substantive change requests for CRTS take longer yet. Even the newest system, Cal-IVRS (part of the Ecosystem of Data Sharing) has no interoperability with mission critical systems, such as CRTS.

The COVID-19 pandemic emphasized the need for efficient workflow automation and rapid access to intelligent data. To meet these needs CDPH needs a fully interoperable vital record system based on a common architecture with a robust API to facilitate sharing data.

ITSD

ITSD has three subdivisions: Information Security Office (ISO), Security Operations Center (SOC), and Application Development and Support Branch (ADSB). The ISO is responsible for the protection of confidentiality, integrity, and availability of CDPH's electronic and physical information resources. The SOC addresses immediate operational needs in the areas of threat analytics, cloud security, and network intrusion detection. The ADSB provides support for new business applications and information technology systems, as well as ongoing development and operational support for existing business applications and systems.

The CDPH technology landscape has experienced unprecedented growth year over year. This growth was addressed by the department's rapid implementation of new systems and services in response to the COVID pandemic. In just three years, the department has seen a 400 percent growth in the number of systems that are managed on low code cloud-based platforms as well as the number of CDPH IT projects it manages, nearly doubled the number of CDPH remote access user accounts, and increased its adoption of cloud hosting from 20 percent to 70 percent.

The State's response to the COVID-19 pandemic strained CDPH technology operations; CDPHs' IT systems faced barriers to efficiently scaling up to meet demands, new applications were needed and had to be developed rapidly, and fundamental public health questions (e.g., cases, testing results, vaccination rates, equity measures, waste, etc.) were initially difficult to answer. CDPH responded in part by partnering with CDT to build and host pandemic-related applications. Solutions were stood up rapidly and existing systems were enhanced, reporting and analytics functions were quickly stood up, and dashboards, with limited data, were created and made available for public reporting and for LHJs. Going forward, responsibility of these systems will shift from CDT to CDPH to house and maintain these applications.

Following advances made in response to the COVID-19 pandemic, such as enhancements to existing systems, CDPH determined that a digital transformation is necessary to meet future public health needs as part of the "Future of Public Health", a state and local strategic roadmap that defines a vision with a fundamental theme of public health information. Achieving this vision allows state and local public health departments and public health stakeholders to identify and address new public health questions to be answered, to rapidly identify and respond to future pandemics and other public health events, and to develop a robust ability to explore subtle correlations to uncover new public health insight. Implementing this plan and roadmap requires transformation of the information technology and data ecosystem, implementation of data governance and policies, and implementation of data analytics tools that enable the types of processing, analysis, and modeling needed to make information actionable.

CDPH explains that it must increase its technology operational efficiency if it is to achieve this digital transformation vision. A flexible, scalable IT ecosystem will provide the opportunity to consolidate timely data and leverage information to deliver public health services and policies more rapidly as they are needed. The current lack of interoperability, disparate datasets, legacy on-premises systems, and public health services scattered across several systems impede CDPH's ability to effectively meet objectives and necessitate digital transformation. The partnership between CHSI and ITSD is central and pivotal to fully implementing and sustaining the vision laid out in the Future of Public Health roadmap. It serves as a data integration hub, linking data across 220+ CDPH programs, local public health departments, and community organizations.

Future of Public Health

The Future of Public Health Workgroup emphasized that to reduce harm and improve the resiliency and health of Californians, it is necessary to strengthen California's public health information technology and data systems infrastructure. The Future of Public Health IT Workgroup's recommendations emphasize three key domains: Infrastructure, systems, and data, which coupled with transformation enablers such as planning, talent acquisition and product/project management, inform the ten initiatives proposed in this request.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal, and respond to the following:

- How does this proposal fit into the overall context of the proposal in the Governor's January budget to provide CDPH with significant new, ongoing resources?

- Please provide some real-world examples of how this type of IT infrastructure may reduce the burden of morbidity and mortality in California.

- If CDPH had had this infrastructure in place before the pandemic, how might the state's response to the pandemic have been more effective?

Staff Recommendation: Hold open to allow for additional discussion and review.

NON-PRESENTATION ITEMS

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 12: CALIFORNIA EMERGENCY MEDICAL SERVICES DATA RESOURCE SYSTEM FUNDING RE-APPROPRIATION – APRIL 1 BCP

PROPOSAL

EMSA requests the re-appropriation of $10 million General Fund, and provisional language authorizing encumbrance or expenditure until June 30, 2024, to continue and complete the project planning process for the California Emergency Medical Services (EMS) Data Resource System (CEDRS), and increase data interoperability between hospitals, EMS agencies, and other healthcare organizations, providing continuity of care to currently uncovered areas of the state.

BACKGROUND

SB 128 (Skinner, Chapter 21, Statutes of 2021) included one-time funding of $2.4 million General Fund to support project planning efforts and approval of CEDRS through the Project Approval Lifecycle (PAL) process and $7.6 million General Fund to onboard additional Local Emergency Medical Services Agencies (LEMSAs) to the existing +EMS Capabilities via existing State Electronic Patient Care record (ePCR) System software and connect all Health Information Entities and Health Information Organizations (HIOs) to EMS data. Re-appropriating these funds through June 30, 2024 will further the development of EMS data connections and policies increasing the flow of real time patient information between EMS providers and hospitals in pre- and post-hospital care. The re-appropriated funds would also increase retrospective analysis of data to boost quality of patient care and increase the number of LEMSAs with full +EMS capabilities.

EMSA will award funding to approximately nine counties that have not already implemented +EMS and have an established HIO in their county or to multicounty LEMSAs that have not connected +EMS or have additional counties in their region to connect. EMSA estimates that these priority counties and LEMSAs will add up to 47 additional connections with 25 of these EMS providers and 22 connections to hospitals. The extension of Health Information Exchange (HIE) to these nine counties or multicounty LEMSAs will have the additional benefit of allowing these agencies to access federal funding provided by Centers for Medicare and Medicaid Services for ongoing maintenance and operations at a 75 percent match rate.

This request is for the re-appropriation of $10 million General Fund, available for encumbrance or expenditure until June 30, 2024. The re-appropriation is necessary due to project delays, staffing recruitment issues, emergency response efforts, and effects of

the COVID-19 pandemic during the 2021-22 fiscal year. The PAL process and onboarding of LEMSAs to the +EMS system is expected to be completed by June 30, 2024.

AB 133 (Budget Committee, Chapter 143, Statutes of 2021) requires EMSA to implement CEDRS in conjunction with the Physician Orders for Life Sustaining Treatment (POLST) Registry, as the registry is dependent upon CEDRS IT infrastructure. AB 133 appropriated funding for the registry through June 30, 2024, and this proposal would align the timing of both IT projects.

Staff Recommendation: Hold open.

ISSUE 13: INCREASED RESOURCES FOR INFORMATION TECHNOLOGY MISSION EFFICIENCY – APRIL 1 BCP

PROPOSAL

EMSA requests 2 positions and $443,000 General Fund in 2022-23 and ongoing. The requested staffing resources will allow EMSA to manage growth in information technology (IT) staffing, allow for more health informatics strategic planning, and enhance the Office of Information Technology (OIT) to be an efficient, business-enabling organization and address security deficiencies to meet EMSA's current and long-term IT infrastructure needs.

BACKGROUND

Before the COVID-19 pandemic, EMSA had 65 permanent staff and a small IT Unit that served as a Help Desk. The IT Unit was staffed with a Chief Information Officer (CIO), an Information Security Officer, a Help Desk specialist, and an IT Network and Server Specialist. Three additional IT Specialists report directly to the EMSA programs responsible for the Paramedic My License Office (MLO) System and Emergency Response communications. The IT Unit was renamed OIT in 2019 to reflect the increasing reliance on information technology and cybersecurity.

Currently, EMSA is comprised of approximately 160 staff (permanent and temporary positions). The OIT is currently staffed with 12 permanent positions and 5 of these positions are vacant. Of these 12 positions, 1 position is allocated to CIO, oversight, and supervision duties; 4 positions are dedicated to supporting IT infrastructure Operations (Information Security Officer (ISO), Network/Server, Endpoint Engineering and Help Desk), and 7 positions are dedicated to IT system support for the Disaster Healthcare Volunteer (DHV) System, My License Office (MLO) System (paramedic licensing), Community Paramedicine (CP) Program, and the California EMS Data Repository System (CEDRS). Additionally, the OIT also utilizes 4 student assistants and 2 retired annuitants on a part-time basis to augment IT Infrastructure Operations.

EMSA's only ISO position is responsible for security policies, state security policy compliance, risk management, and Technology Recovery. When there are requests for security investigations or security forensics, completion of the requests may be significantly delayed or are completed at the cost of not performing primary tasks such as security compliance and remediation work. In addition, the Independent Security Assessment in 2020 and the Security Audit in 2021 identified many vulnerabilities and remediation requirements that have not yet been addressed. EMSA states that not addressing known vulnerabilities or remediation requirements, and not having the proper security tools, will result in EMSA's computing infrastructure being compromised and EMSA operations affected as a result.

As EMSA missions increase, OIT grows as a result, yet the OIT has only one manager, the CIO. Growing from the Help Desk to a full-service enterprise-level IT organization, the OIT needs to be realigned to three entities: IT Infrastructure Operations, IT Program Support, and the Information Security Office. Additional leadership is necessary to help oversee IT Infrastructure Operations, relieving the CIO from day-to-day IT operations to focus on health informatics strategic planning and initiatives to maximize OIT effectiveness as a business-enabling organization.

EMSA's prior IT infrastructure grew as a patchwork of software and hardware solutions to meet immediate business needs and to respond to urgent programmatic requirements as they arose. The development of IT staffing was similarly task-specific. EMSA's current OIT was established in July 2019, only a few months prior to the onset of the COVID-19 pandemic. EMSA missions and staff expanded quickly during the pandemic, and immediate needs pre-empted the development of a comprehensive vision for an enterprise-level function-specific IT staffing model. The current IT task-specific staffing model is both ineffective and wasteful. The assistance of 4 student assistants and 2 retired annuitants has augmented the task-specific IT resource model while OIT has been serving the demands of a full-service IT organization. EMSA explains that this assistance is intended to be temporary and is unsustainable from the perspective of the needed skill sets. The use of Retired Annuitants and/or Student Assistants is not meant to replace permanent position needs.

The transformation of OIT from a small Help Desk with a task-specific staffing model to an enterprise-level function-specific IT organization that can handle statewide EMS diverse data bases, Security Operations and complex Infrastructure Operations will require broad IT skillsets and extensive IT management experience, including executive level IT leadership.

Finally, EMSA's current IT staffing model does not account for areas critical to modern infrastructure such as cloud computing and software-as-a-service, nor was it prepared for the rapid explosion of cybersecurity risks.

Staff Recommendation: Hold open.

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

ISSUE 14: SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM INCREASE IN EXPENDITURE AUTHORITY – APRIL 1 BCP

PROPOSAL

HCAI requests an increase in expenditure authority of $56,000 in 2022-23 and ongoing from the Federal Trust Fund to continue support for the Small Rural Hospital Improvement Program (SHIP).

BACKGROUND

In 2021-22, the Office of Statewide Health Planning and Development was recast as HCAI. This recast included consolidation of the State Office of Rural Health (SORH) and its associated federal grants from DHCS, with HCAI's Primary Care Office (PCO). HCAI currently receives federal grant funds from the Health Resources and Services Administration (HRSA) to serve as the state PCO and SORH. Within the SORH program, HCAI received HRSA grants for SHIP and the Medicare Rural Hospital Flexibility grant. The objectives for SORH are to strengthen the rural health infrastructure through research and policy initiatives, coordinate rural health access issues within the state, and assess the rural health workforce needs, including a focus on recruitment and retention.

The SHIP grant allows HCAI to provide federal funds to California's 49 qualifying small rural hospitals. The SHIP grant provides awards of up to $12,000 annually to support hospitals in meeting value-based payment and care goals, becoming accountable care organizations, participating in shared savings programs, purchasing health information technology, and training to comply with quality improvement activities.

In the current and ongoing federal SHIP grant project period, HRSA increased funding to the SORHs to account for additional small rural hospitals and allow states to maximize award amounts to the hospitals. HCAI is requesting an increase in expenditure authority that corresponds with the increase in federal funding available for SHIP.

Staff Recommendation: Hold open.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 15: ADMINISTRATIVE SUPPORT SERVICES – APRIL 1 BCP

PROPOSAL

The Department of Managed Health Care (DMHC) requests 8.0 positions and $1,301,000 in 2022-23 and $1,237,000 in 2023-24 and annually thereafter from the Managed Care Fund to support business management services, fiscal services, human resource administrative services, information technology, and to bring analytical and professional staffing in line with the department's growth. Specifically, HCAI is requesting 4.0 positions for its Office of Administrative Services and 4.0 positions for its Office of Technology and Innovation.

BACKGROUND

The DMHC has grown more than 30 percent in expenditure authority and 14 percent in position authority over the last five years. The DMHC's expenditure authority has increased from $80 million in 2017-18 to approximately $104 million in 2021-22. Consistent with this growth, the total number of authorized positions has increased from 451 employees in 2017-18 to 516 employees in 2021-22.

Additionally, the department has seen an increase in workload volume over the past five years. To address the DMHC's workload needs, the department submitted three (3) workload Budget Change Proposals (BCPs) as part of the Governor's Budget for 2022-23. While pending legislative approval, these BCPs will grant the DMHC 44.0 new positions beginning in 2022-23 as follows: 21.0 positions authorized for the Help Center Workload BCP, 11.0 positions authorized for the Office of Plan Monitoring Workload BCP and 12.0 positions authorized for the Administrative Workload BCP. DMHC states that these workload BCPs did not include the ongoing administrative support needed to support critical administrative functions for the department. Historically, the DMHC received 1.0 administrative support position for the Office of Administrative Services (OAS) and 1.0 administration support position for the Office of Technology and Innovation (OTI) for every ten new program positions.

The OAS encompasses all departmental support services functions except for Information Technology (IT). These functions include accounting, budgeting, requests for personnel actions (RPAs), developing supporting documents for recruitments, training and organizational effectiveness, procurements and contracting, and providing consultation to all the DMHC programs on a variety of administrative issues. DMHC explains that when the department program areas expand, resources to support the programs must increase at a similar rate.

The OTI is responsible for supporting the DMHC's information Technology (IT) systems so that they are sufficient and secure for employees and the public. The OTI handles application/system development and support, procurement and management of IT assets, data security and supporting staff members' IT needs. Similar to OAS, as program areas expand resources to support the programs, OTI resources must increase at a similar rate. For OTI, program expansion translates to an increase in new employee setup, service requests, change requests, collection of data analytics, security log analysis and ongoing maintenance of each new staff's devices.

DMHC states that the current staffing is not sufficient to provide the critical administrative and information technology services in a timely fashion or to meet state mandated requirements. This proposal is expected to provide the resources needed to support and address the increased workload resulting from procurements and contracting, accounting, budgeting, requests for personnel actions (RPAs), developing supporting documents for recruitments, processing payroll transactions, training and organizational effectiveness, improving critical business processes, providing desktop support, and providing assistance to all the DMHC programs on a variety of administrative issues.

Staff Recommendation: Hold open.

ISSUE 16: HEALTH PLANS AND HEALTH INSURANCE: THIRD-PARTY PAYMENT ASSEMBLY BILL 290 LIMITED-TERM WORKLOAD EXTENSION – APRIL 1 BCP

PROPOSAL

The DMHC requests a two-year limited-term extension of expenditure authority of $782,000 in 2022-23 and $750,000 in 2023-24 from the Managed Care Fund to address the workload and meet the requirements pursuant to AB 290 (Wood, Chapter 862, Statutes of 2019).

This request includes clinical consultant funding of $31,000 in 2022-23 and 2023-24 to assist with reviewing the cost saving schedules submitted with rate filings.

This request also includes limited-term resources (equivalent to 4.0 positions) of $751,000 in 2022-23 and $719,000 in 2023-24 to address the workload resulting from AB 290 implementation. Specifically, DMHC requests the following positions:

- Help Center – 2.0
- Office of Financial Review – 1.0
- Office of Technology and Innovation – 1.0

Given the uncertainty regarding workload required to implement AB 290 beyond 2024-25, resources for 2024-25 and ongoing are not requested in this BCP.

BACKGROUND

AB 290 required the DMHC to establish an Independent Dispute Resolution Process (IDRP) through which providers and health plans can seek rates above the Medicare rates, receive plan data regarding cost savings and recoupments and review health plan Evidence of Coverage (EOC) documents and other health plan documents to verify plan compliance with the bill's provisions.

In 2020-21, the DMHC submitted a BCP and received approval for a two-year limited expenditure authority to implement the requirements of AB 290. Given the uncertainty regarding workload required to implement AB 290 beyond 2022-23, limited resources were granted for 2020-21 and 2021-22 only. The resources beyond 2021-22 were denied because it was uncertain if the DMHC's estimated workload would materialize due to a potential decrease in third-party payment activity.

This proposal provides the limited-term resources necessary to enable the DMHC to address the workload in 2022-23 and 2023-24 resulting from the AB 290 implementation. The limited-term resources (equivalent to 4.0 positions) requested in this proposal will remain unfilled pending the outcome of the litigation. AB 290 did not become operative

for the AKF and related financially interested parties on July 1, 2020, due to a request for an updated opinion from the U.S. Department of Health and Human Services Office of the Inspector General. The approval of the limited-term resources requested in this proposal allows for time to review and address the required DMHC workload as a result of AB 290 implementation.

Staff Recommendation: Hold open.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 17: DATA ANALYTICS AND MANAGEMENT SUPPORT – APRIL 1 BCP

PROPOSAL

DHCS requests 13.0 permanent positions, funding for 5.0 existing permanent positions, three-year limited-term (LT) resources equivalent to 4.0 positions, conversion of 2.0 LT resource to permanent, LT contract resources, and expenditure authority of $7,587,000 ($3,794,000 General Fund (GF); $3,793,000 Federal Fund (FF)) in fiscal year (FY) 2022-23, $8,970,000 ($4,485,000 GF; $4,485,000 FF) in FY 2023-24, $8,470,000 ($4,235,000 GF; $4,235,000 FF) in FY 2024-25, and $5,396,000 ($2,698,000 GF; $2,698,000 FF) in FY 2025-26 and ongoing to address increased workload related to departmental data analytic, data provisioning, and data reporting functions to improve data management and transparency.

This workload is supported by Enterprise Data and Information Management (EDIM), which, in close coordination and collaboration with Enterprise Technology Services (ETS) and the Office of Legal Services (OLS), and in partnership with DHCS programs, supports robust data analytics, reporting, and management for DHCS.

The following charts detail the resources being requested:

Position Summary

Division- Positions effective 7/1/22	Activity
EDIM Program Data Reporting Division (PDRD, or similar): 2.0 Permanent Positions 1.0 Career Executive Assignment (CEA B) 1.0 Research Data Specialist III (RDS III) Convert 1.0 LT resource to Permanent 1.0 Research Data Specialist II (RDS II)	• Support data reporting needs of ongoing Medi-Cal managed care programs • Support data reporting needs of departmental administrative functions and other programs throughout the Department
EDIM Data Management and Analytics Division (DMAD): 5.0 Permanent Positions 1.0 Research Data Supervisor I (RD Sup I) 2.0 RDS II 1.0 Research Scientist II (RS II) 1.0 Research Scientist I (RS I) Permanent Funding Equivalent to 5.0 Positions 1.0 Staff Services Manager I (SSM I) 4.0 Associate Governmental Program Analyst (AGPA)	• Perform data transparency, coordination, data mining and advanced statistical analyses and reporting. • Conduct departmental data release activities, including managing data release agreements. Support programmatic work throughout the Department
EDIM Health Information Management Division (HIMD): 3.0 Permanent Positions 1.0 Information Technology Manager II (ITM II) 1.0 Information Technology Supervisor II (ITS Sup II) 1.0 Information Technology Specialist I (ITS I) Convert 1.0 LT resource to Permanent 1.0 RDS II Extending 4.0 LT resources for three-years 4.0 RDS I	• Monitor data quality and management support for software platforms and other analytic tools and resources. • Manage data standards, exchange, and integration • Conduct the data analysis, data validation, data issue resolution, and data support functions for the planning and design, development, and implementation phases of the 274 expansion to MHPs and DMC-ODS, as well as to provide the ongoing data quality monitoring and

Division- Positions effective 7/1/22	Activity
	analysis support to plans and DHCS staff related to the resulting data.
ETS Business Operation Technology Services Division (BOTSD) 2.0 permanent positions 1.0 Information Technology Manager I (ITM I) 1.0 Information Technology Specialist II (ITS II)	Perform data documentation, visualization, reporting, and analytical support to DHCS programs.
OLS Privacy Office (PO) 1.0 permanent position 1.0 Attorney III	Provide expert legal advice to support legally compliant data use and protection.

Contract Summary

Product/Effort	Duration	2022-23	2023-24	2024-25
Training and staff development in data analytics	3-year LT	$250,000	$500,000	$250,000
Analytic coding curation	3-year LT	$125,000	$250,000	$125,000
SharePoint/Teams Architect and SharePoint/Teams Developer	3-year LT	$125,000	$250,000	$125,000
Architecture and Infrastructure Support	3-year LT	$1,000,000	$2,000,000	$2,000,000
Reference Data Procurement	Ongoing	$2,000,000	$2,000,000	$2,000,000
Total		**$3,500,000**	**$5,000,000**	**$4,500,000**

BACKGROUND

Driving improvements in quality in the Medi-Cal program is a critical foundation for the state's efforts to eliminate health care disparities. Data analytics and reporting are a core component of this quality improvement and play an essential role in the monitoring and oversight functions of DHCS for all of its programs.

EDIM was established to consolidate data analytics, management, provisioning, and reporting in 2020. EDIM is responsible for a variety of data functions, such as program performance and outcomes reporting, such as the Centers for Medicare & Medicaid Services (CMS) Core Set Quality Measures reporting; program utilization and monitoring including dashboards; data quality monitoring and management; data releases and data provisioning to support various research efforts external to DHCS; and data de-identification for public release of publications, reports, and products. In 2021-22, DHCS has further aligned data functions within EDIM in order to improve data literacy and data-driven decision making which is necessary to support business programs and initiatives. This focus on data aligns with state and federal priorities related to data and transparency and expands EDIM's workload and scope of responsibility.

EDIM is reorganizing further, from two divisions to three divisions. EDIM currently consists of the Deputy Director's Office and the Data Management and Analytics Division (DMAD) and Health Information Management Division (HIMD). Under the restructure, DHCS will create a new division, tentatively titled the Program Data Reporting Division (PDRD, or similar), utilizing redirected staff from within EDIM, redirected staff from other DHCS programs, and new 2022-23 resources.

In recent years, various changes in state and federal law, development of data provision policies and processes, stakeholder requests, and increased focus on health disparities have resulted in new expectations and workload for DHCS without corresponding increases in resources. DHCS claims to be unable to keep pace with the workload, resulting in a backlog of reports and data publications, data projects delayed or uninitiated, and other functions not being performed. DHCS submitted a proposal to address this workload in the Governor's Budget released in January 2020 (Data Transparency Workload - 4260-059-BCP-2020-GB). The proposal was subsequently withdrawn in response to the COVID-19 pandemic.

This proposal incorporates the request in the previous Data Transparency Workload proposal and is intended to address gaps in data analysis, reporting, and management that currently exist and will not be addressed by alignment of data functions in EDIM. Resources in this proposal will support various departmental programs that have known gaps in data literacy and analytics, including administrative activities in the Department. Functional categories of data analytics and data management addressed in this proposal include:

1. Data Transparency and Coordination
2. Data Visualization, Reporting, and Analytical Support to DHCS Programs
3. Data and Data Analytic Management

Conducting these functions requires close coordination and collaboration with ETS and OLS. Therefore as EDIM's workload increases so does that of ETS and OLS. ETS manages the department-wide information technology (IT) including IT strategic direction, enterprise architecture, IT governance, portfolio and project management, IT application and infrastructure operations, and modernization of DHCS' Medi-Cal Enterprise System. BOTSD, the Medi-Cal Enterprise System Modernization Division (MESMD) and the Information Security Office (ISO) reside within ETS and support critical infrastructure and systems necessary for EDIM to perform its functions. Similarly, OLS is an integral part of the reviews of data provisioning and transparency processes, providing expert, legal consultation and guidance to EDIM staff to support the use and protection of sensitive data in legally compliant ways. As the volume of data requests and analytic and reporting activities has increased, so has the workload related to these efforts for ETS and OLS.

DHCS receives many requests for data and information about the programs it administers, ranging from legislative requirements to a wide range of stakeholder requests. DHCS also performs extensive analysis for programs to monitor, oversee, and evaluate the programs it administers. The proposed staffing resources requested are expected to facilitate consistency and timeliness of reporting by DHCS programs by streamlining processes related to data analysis and data management; increasing capacity to meet the steadily increasing demand for DHCS data; and establishing infrastructure and organizational support critical to conducting the various data and administrative functions EDIM is responsible for, and for the support provided for these functions by ETS and OLS.

DHCS explains that, given the complexity and diversity of programs that impact Medi-Cal members and DHCS clients, the need to integrate and align data with other federal, state, and local programs is essential to understanding the full scope of opportunities to improve outcomes. EDIM's role supporting data management and data reporting for the Department continues to expand with the ever-increasing volumes of data and the complexity of the data received through the various departmental programs. Additionally, DHCS is experiencing increasing demands to provide data and information routinely and in response to a wide range of stakeholders.

Staff Recommendation: Hold open.

ISSUE 18: INTEROPERABILITY FEDERAL RULE IMPLEMENTATION – APRIL 1 BCP

PROPOSAL

DHCS requests funding for 6.0 existing permanent positions, three-year limited term (LT) resources equivalent to 12.0 positions, one-year LT resources equivalent to 8.0 positions, the extension of 1.0 LT resource for one-year, re-appropriation of contract funding, and expenditure authority of $4,520,000 ($2,260,000 General Fund (GF); $2,260,000 Federal Fund (FF)) in fiscal year (FY) 2022-23, $2,896,000 ($1,448,000 GF; $1,448,000 FF) in FY 2023-24 and FY 2024-25, and $1,110,000 ($555,000 GF; $555,000 FF) in FY 2025-26 and ongoing. The resources are being requested to implement and plan for the new interoperability rules required by the federal Centers for Medicare and Medicaid Services (CMS).

BACKGROUND

DHCS has been responsible for implementing interoperability programs such as the Promoting Interoperability Program. The Promoting Interoperability Program, formerly the Medi-Cal Electronic Health Record (EHR) Incentive Program, was authorized under the federal Health Information Technology for Economic and Clinical Health Act (HITECH) in 2009. The Promoting Interoperability Program incentivized providers and hospitals to adopt and "meaningfully use" EHRs. One of the main focus points of "meaningful use" was to improve interoperability—the ability of different entities to exchange health information with each other—by requiring participants to electronically share specific patient data. The HITECH Programs, including the Promoting Interoperability Program, ended in fall 2021.

However, CMS continues to advance interoperability requirements through new regulations. In May 2020, CMS passed the Interoperability and Patient Access Final Rule (CMS-9115-F). This rule places specific requirements on state Medicaid agencies, Medicaid managed care plans, Children's Health Insurance Program (CHIP) agencies, and CHIP managed care entities.

While the Interoperability and Patient Access Rule was published in the Federal Register May 1, 2020, due to the COVID-19 response efforts, DHCS did not have the resources to meet all enforcement deadlines required by the rule. CMS has indicated that it will work with states through the process of Advanced Planning Documents (APDs) and Corrective Action Plans to address compliance requirements. While financial consequences have not yet been formalized, CMS has stated that reductions to enhanced funding could be possible if states do not present clear approaches with acceptable timelines.

In order to develop a departmental plan for the CMS Interoperability and Patient Access Rule, DHCS submitted BCP (4260-168-BCP-2021-A1) for FY 2021-22. The BCP included

permanent funding for five existing positions and one-year LT funding for ten contract positions. With these resources, DHCS has implemented education and coordination for cross-cutting teams to develop implementation requirements and plans for the different components of the Interoperability and Patient Access Rule. This work can be grouped into the following focus areas:

- Managed care plan technical assistance and oversight activities;
- Interoperability expertise and coordination for planning and implementation; and
- Technical implementation to meet requirements specific to DHCS.

As DHCS has moved through planning and begun implementation of the interoperability rules, the Department has identified additional resources that are needed to fully implement the plan and help DHCS achieve compliance with the rule. In addition, DHCS requests a one-year extension of planning contract resources approved for FY 2021-22. This BCP for FY 2022-23 requests resources to achieve compliance with Interoperability and Patient Access Rule, including through providing interoperability expertise and coordination for planning and associated managed care plan technical assistance and oversight activities. Part of the planning for DHCS and technical assistance support for the managed care plans involves mapping administrative data (Health Insurance Portability and Accountability Act of 1996 (HIPAA) claims transactions) to the United States Core Data for Interoperability (USCDI).

Doing so represents a significant change with respect how data is organized and coded. Associated training and communication with plans, counties, and health information organizations to support the use of the USCDI standard represents a significant component of both the planning and implementation work for managed care plans and for DHCS. A planning APD was approved on July 13, 2021 for the Interoperability and Patient Access Rule and an updated APD will be submitted to CMS in early 2022.

Staff Recommendation: Hold open.

ISSUE 19: MANAGED CARE PROGRAM ANNUAL REPORT – APRIL 1 BCP

PROPOSAL

DHCS requests 21.0 permanent positions and expenditure authority of $3,512,000 ($1,756,000 General Fund (GF); $1,756,000 Federal Fund (FF)) for fiscal year (FY) 2022-23, $3,073,000 ($1,537,000 GF; $1,536,000 FF) in FY 2023-24 and ongoing (including funding for limited-term (LT) contract resources).

This request will augment staff resources to comply with the new reporting requirements of the federal Centers for Medicare and Medicaid Services (CMS), as part of its monitoring system over all Medicaid managed care programs in accordance with 42 CFR § 438.66(e). Importantly, the failure to comply with Federal requirements may trigger CMS to withhold payments to the state, consistent with regulatory provisions set forth in 42 CFR § 430.35. The positions requested are needed to lead reporting and monitoring requirements for the Managed Care Program Annual Report (MCPAR), including providing technical assistance to all impacted contracted plans, performing monitoring and network certification activities specific to the MCPAR, and analyzing and reporting results to CMS.

BACKGROUND

On June 28, 2021, CMS announced new reporting requirements as part of its monitoring system over all Medicaid managed care programs, including the evaluation of managed care organizations (MCO), prepaid inpatient health programs (PIHP), prepaid ambulatory health plans (PAHP), and managed long-term services and supports (LTSS) plans.

In accordance with 42 CFR § 438.66(e), CMS requires each state to submit a report for each managed care program administered using standardized reporting measures and mechanisms. The new reporting requirements are part of a larger effort by the federal government to implement the 2016 Medicaid and CHIP Managed Care Final Rule (81 FR 27497). Under the regulation, each state must submit to CMS, no later than 180 days after each contract year (See 42 CFR §§ 438.66(e), 438.74(a), 438.207(d), (e)). For mental health plans, DMC-ODS providing substance use disorder and specialty mental health services, the MCPAR report is due by December 27, 2022, whereas, for dental managed care plans and Medi-Cal managed care plans, including non-specialty behavioral health, MCPAR reports are due by June 29, 2023.

As defined by the federal regulation, MCPAR collects information in the following health categories:

I. Program enrollment and service area expansions
II. Financial performance
III. Encounter data reporting

IV. Grievances, appeals, and state fair hearings
V. Availability, accessibility, and network adequacy
VI. Delegated entities
VII. Quality and performance measures
VIII. Sanctions and corrective action plans
IX. Beneficiary support system
X. Program integrity

MCPAR consists of dozens of health care measures and indicators to improve the reporting on managed care monitoring and oversight. MCPAR measures and indicators address plan enrollment statistics, provider standards, medical reviews, and audits. MCPAR, moreover, covers information that needs to be collected, compiled and presented from the state level, the plan level, and the program level.

According to DHCS, the reporting and monitoring requirements for the MCPAR will be critical mechanisms for holding the managed care delivery systems accountable for transparency, quality, and results. All impacted DHCS divisions have organizational responsibilities in this work and will require additional resources and staff in order to meet the requirements of MCPAR. These resources will ensure organizational effectiveness and lay the foundation for a more effective and more efficient Medi-Cal managed care program.

Staff Recommendation: Hold open.

ISSUE 20: OFFICE OF COMPLIANCE – APRIL 1 BCP

PROPOSAL

DHCS Office of Compliance (OOC) requests 12.0 permanent positions, limited-term contracts resources, and expenditure authority of $2,140,000 ($1,070,000 General Fund (GF); $1,070,000 Federal Fund (FF)) in fiscal year (FY) 2022-23, $2,032,000 ($1,016,000 GF; $1,016,000 FF) in FY 2023-24 and $1,782,000 ($891,000 GF; $891,000 FF) in FY 2024-25 and ongoing to enhance internal audit functions, federal compliance monitoring, and enterprise risk management activities.

BACKGROUND

To strengthen its compliance functions and outcomes, DHCS recently created the OOC, with the Chief Compliance Officer (CCO) reporting to the DHCS Directorate. This in turn resulted in two significant changes. The first change is that the internal audits group was redirected from its prior place within the Audits & Investigations Division to its current place within the OOC. The second change is that the federal compliance monitoring work within the Director's Office was moved to OOC, which serves as a liaison with federal partners such as the federal Centers for Medicare and Medicaid Services and the United States Department of Health and Human Services Office of Inspector General on matters that relate to California's Medicaid and Children's Health Insurance Program State Plan, waivers, and federal compliance.

Specifically, OOC, through its Internal Audits Group, conducts internal control reviews; coordinates external audits and tracks Corrective Action Plans; handles whistleblower complaints; provides assurance and consulting services for enterprise risk management; and tracks DHCS' numerous external reports. The Internal Audits Group administratively reports to the CCO to help facilitate the day-to-day operations of the internal audit function.

Additionally, OOC, through its federal Compliance Monitoring Group, leads the management of State Plan Amendments (SPAs); of reporting processes for various federal initiatives; and of tracking functions in support of various components of California's waiver programs; among a number of other federally-centered obligations.

While the existing resources performing these functions (15.0 positions in Internal Audits and 5.0 positions for SPAs/Waivers) were moved under the CCO, DHCS states that it requires additional resources to complete the establishment of the OOC and strengthen its compliance functions and outcomes.

In order to strengthen all of DHCS' compliance functions, OOC seeks the following 12.0 new, permanent positions:

Compliance Monitoring Group – 6.0 new positions will be responsible for all compliance aspects of SPAs, waivers, federal grants, federal managed care compliance reporting, quarterly reporting for the implementation of home and community based services spending plan, federal legislative/regulatory/sub-regulatory guidance, and related state and federal reporting obligations. Positions are needed to assist with OOC's overall operational needs, and enterprise governance. DHCS states that the total workload for compliance monitoring – tripled in scale – cannot be sustained by current staffing levels of only four line-level positions and one supervisor.

Internal Auditing Group – 6.0 new positions will handle all ongoing monitoring and training to DHCS programs to provide tools and techniques of programs' risk identification and risk controls, which will enable deeper and broader engagement with DHCS programs on corrective action plans, and the execution of regular internal control reviews. In addition, ongoing monitoring and training will produce guidance aids for DHCS programs related to corrective action plans, investigations, and internal audit reviews. DHCS states that the workload for internal auditing as projected – more than doubled in scale – cannot be sustained by current staffing levels of only 9.0 line-level positions and five supervisors/managers. Currently, internal control reviews and special reviews can only be fulfilled by reallocating current staff, which causes delays in ongoing, critical projects.

Staff Recommendation: Hold open.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 21: PHARMACY MODERNIZATION PROJECT – PHASE 3 – APRIL 1 BCP

PROPOSAL

The Department of State Hospitals (DSH) requests a re-appropriation of $2.7 million General Fund from fiscal year 2021-22 to 2022-23 to continue the implementation phase of the Pharmacy Modernization project. In addition, DSH requests $3.2 million General Fund in 2023-24, $3 million General Fund in 2024-25, $2.9 million General Fund in 2025-26 and $1.2 million General Fund in 2026-27.

This project includes the implementation of an inventory control system, unit dose repackaging equipment, automated drug dispensing system equipment and pharmacy data integration. DSH explains that a re-appropriation is needed due to delays in the Project Approval Lifecycle (PAL) process, attributable to the impacts of the COVID-19 Pandemic and an extended procurement phase. The re-appropriation will allow DSH to continue with the implementation in 2022-23. The additional funding in 2023-24 and 2024-25 will allow DSH to complete the implementation phase at all hospitals. The 2025-26 and 2026-27 funding will cover the initial ongoing support costs.

BACKGROUND

The Pharmacy Modernization project addresses the need to replace the current, manual processes used for inventory control, medication dispensing and security of controlled drugs. This will be accomplished with the implementation of automated, integrated systems, re-architecture of the pharmacy application environment, and equipment with standardized practices across the DSH system.

These improvements to DSH Pharmacy operations allow pharmacy staff to effectively manage medication inventory to minimize medication waste (drugs not used before their expiration date), support required medication dispensing guidelines (Title 22 controls for dispensing timeframe) and keep controlled medications secure. Standardized pharmacy operations provide the ability for DSH to measure improvements such as improved patient Medicare Part D claim reimbursements. The re-architecture of the Pharmacy application environment consolidates the five hospital systems and will provide a single connector for future use by the Department's proposed Electronic Health Records system.

According to DSH, the Pharmacy Modernization project will:

1. Replace manual processes for inventory management and drug tracking with automated workflow.
2. Reduce staff repackaging time with standardized repackaging equipment.

3. Improve the accuracy and security of all dispensed medication to patients with the use of Automated Drug Dispensing Systems (ADDS).
4. Implement a single IT solution that will be leveraged by clinical staff at all five state hospitals supported by standardized equipment implementations and business processes thereby also supporting Electronic Health Records (EHR).

The 2019 Budget Act included $2.2 million General Fund in 2019-20 for Phase 1 (planning) of Pharmacy Modernization during which DSH intended to complete the PAL stages 2 through 4.

The 2020 Budget Act included $928,000 General Fund in 2020-21, $5.6 million General Fund in 2021-22, $1.2 million General Fund in 2022-23 for Phase 2 (implementation) of Pharmacy Modernization. These costs were for all five hospitals based on the July 2019 Request for Information (RFI) which received two responses.

The Pharmacy Modernization project is intended to address inefficiencies and issues encountered by the DSH pharmacy operations and nursing staff, and to help improve patient care and safety. Replacing existing manual processes with integrated, automated systems provides DSH with the opportunity to recognize improved patient care and safety while implementing standardized business processes for staff. Furthermore, with these new systems, DSH will be able to significantly reduce revenue losses due to drug waste and refused billing claims from Medicare Part D due to erroneous National Drug Codes.

The request addresses resource needs across three areas, which are described below:

1. Re-appropriation of $2.7 million of 2021-22 funding to 2022-23 to continue the implementation of the pharmacy modernization project for two of the five hospitals.
2. Additional funding of $3.2 million in 2023-24 and $3 million in 2024-25 to address expense escalations as a result of increased costs since the project was originally estimated in 2019.
3. Request $2.9 million in 2025-26 and $1.2 million in 2026-27 for the initial maintenance and operations of the pharmacy equipment, which was not included in prior budget requests until the project began the implementation phase.

2021-22 to 2022-23 Re-appropriation

A re-appropriation of funds from 2021-22 to 2022-23 is requested due to the extended project planning and procurement timeline which caused a delay in the target implementation schedule. While hospital one will be implemented in the last half of 2021-22, the re-appropriation will allow DSH to complete implementation at another two of the five hospitals in 2022-23.

Planning was scheduled for completion in March 2021 however, over the 17 months, between June 2020 and November 2021 several events occurred which caused planning to be extended by eight months. These events included:

- Project priority changes for DSH and other partners due to COVID-19 response efforts that impacted resources.
- During Stage 4 of the PAL, a change in a vendor's "Best and Final Offer" initiated a second pass through the evaluation and contract negotiation processes. This resulted in higher costs than previously estimated through the request for information process conducted in 2019 and what was budgeted for in the event DSH was able to go with the first vendor.

Additional Funding for Implementation to all Hospitals

The combination of the above issues delayed the target start of implementation from spring 2021 to early 2022. These factors required extending planning activities which incurred additional expenses by $1.3 million. The Planning activities necessitated additional time from staff, inter-departmental consultants (California Department of Technology project oversight and technology procurement), external consultants for project management and technical analysts.

The request for additional funding for equipment costs is due to increased equipment lease costs including taxes, between the Stage 2 estimates (based on a 2019 Request for Information) and the final approved bid during Stage 4. This was identified and documented in the Stage 4 Cost Baseline information.

The procurement schedule was extended when the first selected vendor withdrew their Best & Final Offer and replaced it with a bid significantly higher in all costs. The Evaluation and Selection process was restarted to compare all vendors and all vendor bids were significantly higher in costs than estimates from the 2019 RFI. The additional funding is necessary to complete implementation in two hospitals by 2024-25. This would complete the implementation of Pharmacy Modernization at all five hospitals.

Maintenance and Operation Costs

Maintenance and Operation (M&O) costs cover regularly scheduled equipment maintenance including parts and equipment replacement, annual licensing and software updates. M&O funding was not included in prior funding requests as actual costs are needed before determining the ongoing need. However, during the recent contract negotiation period, the selected vendor provided DSH with a five-year schedule that includes implementation and initial M&O costs. At this time, DSH is requesting the M&O costs included in this five-year schedule since those are known.

Staff Recommendation: Hold open.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 22: MENTAL HEALTH STUDENT SERVICES ACT PARTNERSHIP GRANT PROGRAM POSITION AUTHORITY – APRIL 1 BCP

PROPOSAL

The Mental Health Services Oversight and Accountability Commission requests 5 positions in 2022-23 and ongoing to support the administration of a one-time 2021-22 Mental Health Services Fund (MHSF) augmentation to the Mental Health Student Services Act (MHSSA) Partnership Grant Program. Specifically, the 2021 Budget Act includes a $205 million one-time MHSF augmentation ($25 million state operations and $180 million local assistance), available over five years, to support the program. However, no corresponding position authority has been provided to the Commission for administration of one-time funds.

To support the implementation of the MHSSA Partnership Grant Program, the Commission requests position authority for 5 positions: 1 Health Program Specialist (HPS) II, 2 HPS I's, and 2 Associate Governmental Program Analysts (AGPAs). These positions will support grants to all 58 county mental health plans, regional collaboration meetings of grantees, information sharing, state reporting, evaluation of program effectiveness, and contract monitoring.

BACKGROUND

SB 75 (Committee on Budget and Fiscal Review, Chapter 51, Statutes of 2019) established the MHSSA to support partnerships between county behavioral health departments and educational entities for the purpose of increasing school-based mental health services. The 2019 Budget Act (Chapter 363, Statutes of 2019) included $50 million one-time MHSF in 2019-20 and $10 million MHSF in 2020-21 and ongoing to support the MHSSA. Of the $10 million MHSF ongoing, $1.2 million is for state operations and the remaining $8.8 million is for local assistance grants. The 2021 Budget Act (Chs. 21, 69, 43, 84, 240 Stats. 2021 and Chs. 2, 9 Stats, 2022) included a $205 million one-time MHSF augmentation to the program. Of the $205 million, $25 million is for state operations and $180 million is for local assistance. The funds are available for encumbrance or expenditure until June 30, 2026.

The MHSSA Partnership Grant Program provides competitive grants to counties for partnerships between county behavioral health departments and local education entities for the purpose of increasing access to mental health services in locations that are easily accessible to students and their families. These grants are intended to provide support services that include, at a minimum, services provided on school campuses, suicide

prevention services, drop-out prevention services, placement assistance and service plans for students in need of ongoing services, and outreach to high-risk youth, including foster youth, youth who identify as LGBTQ+, and youth who have been expelled or suspended from school. In addition to the Commission's responsibility to award school-county collaborative grants, the MHSSA requires the Commission to "… develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants" (Welfare and Institutions Code [WIC] section 5886(k)(1)).

The Commission will issue the MHSSA Partnership Grant program grants in five phases as funds are made available (See Table below). A total of 58 county programs will be funded for four years, with phase 1 grants having an optional fifth year of funding.

MHSSA Partnership Grant Award Phases - Totaling 58 Grant Programs to be Funded by 2022

Phase I (2020)	Phase II (Early 2021)	Phase III (Mid 2021)	Phase IV (Late 2021)	Phase V 2022
18 grants awarded totaling $75 million	6 grants awarded totaling $25 million	6 grants to be awarded totaling $25 million	8 grants to be awarded totaling $30 million	20 grants to be awarded totaling $95 million

Although the 2021 Budget Act MHSSA Partnership Grant Program augmentation included state operation resources, no position authority has been provided to the Commission to administer the five-year resources. Additional positions are needed to adequately administer and evaluate the increased MSHF-supported grants.

Staff Recommendation: Hold open.