AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 12, 2018

UPON ADJOURNMENT OF ASSEMBLY SESSION - STATE CAPITOL ROOM 444

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LIST OF PANELISTS IN ORDER OF PRESENTATION

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: CENTER FOR HEALTH STATISTICS AND INFORMATICS OVERVIEW

PANELISTS

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Alex Haq**, Chief, Fiscal Services Section, Center for Health Statistics and Informatics, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 2: BIRTH CERTIFICATE PROCESSING INCREASE FOR REAL ID ACT COMPLIANCE BUDGET CHANGE PROPOSAL

PANELISTS

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Alex Haq**, Chief, Fiscal Services Section, Center for Health Statistics and Informatics, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 3: CENTER FOR FAMILY HEALTH OVERVIEW AND PROGRAM UPDATES

PANELISTS

- **Connie Mitchell, MD, MPH**, Deputy Director, Center For Family Health, DPH
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 4: WOMEN INFANTS & CHILDREN (WIC) PROGRAM ESTIMATE

PANELISTS

- **Connie Mitchell, MD, MPH**, Deputy Director, Center For Family Health, Department of Public Health
- **Christine Nelson**, Chief, Women Infants & Children Division, Center For Family Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 5: INFANT AND EARLY CHILDHOOD HOME VISITING PROGRAM BUDGET CHANGE PROPOSAL

PANELISTS

- **Connie Mitchell, MD, MPH**, Deputy Director, Center for Family Health, Department of Public Health
- **Leslie Kowalewski,** Chief, Maternal, Child and Adolescent Health Division, Center for Family Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 6: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

PANELISTS

- **Connie Mitchell, MD, MPH**, Deputy Director, Center For Family Health, Department of Public Health
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, Department of Public Health
- **Richard Olney, MD, MPH**, Chief, Genetic Disease Screening Program, Center For Family Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 7: NEW GENETIC DISORDERS (SB 1095) AND SECOND TIER TESTING BUDGET CHANGE PROPOSAL

PANELISTS

- **Connie Mitchell, MD, MPH**, Deputy Director, Center For Family Health, Department of Public Health
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, Department of Public Health
- **Richard Olney, MD, MPH**, Chief, Genetic Disease Screening Program, Center For Family Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 8: CENTER FOR INFECTIOUS DISEASES OVERVIEW AND PROGRAM UPDATES

PANELISTS

- **Gil Chavez, MD, MPH,** Deputy Director, Center for Infectious Diseases, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 9: RICHMOND VIRAL RICKETTSIAL DISEASE LABORATORY CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

PANELISTS

- **Tim Bow**, Administration Division, Department of Public Health
- **Brian Fuller,** Finance Budget Analyst, Department of Finance
- **Koreen van Ravenhorst**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 10: VALLEY FEVER OUTREACH AND AWARENESS CAMPAIGN MEMBERS' PROPOSAL

PANELISTS

- **Assemblymember Rudy Salas**

Public Comment

ISSUE 11: VALLEY FEVER RESEARCH MEMBERS' PROPOSAL

PANELISTS

- **Assemblymember Vince Fong**

Public Comment

ISSUE 12: SEXUALLY TRANSMITTED DISEASE PREVENTION ADVOCATES' PROPOSALS

PANELISTS

- **Rand Martin,** AIDS Healthcare Foundation
- **Sylvia Castillo**, Essential Access Health

Public Comment

ISSUE 13: HEPATITIS PREVENTION ADVOCATES' PROPOSALS

PANELISTS

- **Andrew Reynolds,** Hepatitis C Education Manager, Project Inform

Public Comment

ISSUE 14: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE AND PROGRAM UPDATES

PANELISTS

- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 15: ADAP ELIGIBILITY AND ENROLLMENT BUDGET CHANGE PROPOSAL

PANELISTS

- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 16: HIV/AIDS PREVENTION ADVOCATES' (CA HIV ALLIANCE) PROPOSALS

PANELISTS

- **Anne Donnelly**, Director of Health Care Policy, Project Inform
- **Craig Pulsipher, MPP, MSW,** State Affairs Specialist, Government Affairs, APLA Health

Public Comment

ISSUE 17: HIV/AIDS PREVENTION ADVOCATES' (INLAND COALITION) PROPOSAL

PANELISTS

- **Gabriel Maldonado**, Executive Director / CEO, TruEvolution Inc.

Public Comment

ITEMS TO BE HEARD

4265 DEPARTMENT OF PUBLIC HEALTH

CENTER FOR HEALTH STATISTICS AND INFORMATICS

ISSUE 1: CENTER FOR HEALTH STATISTICS AND INFORMATICS OVERVIEW

PANELISTS

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Alex Haq**, Chief, Fiscal Services Section, Center for Health Statistics and Informatics, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

This is an informational item and the Subcommittee requests the Department of Public Health (CDPH) to provide an overview of the Center for Health Statistics and Informatics and its major programs. The January budget proposes approximately $30.1 million for this Center, about 0.9 percent of the total budget of the Department of Public Health.

BACKGROUND

The Center for Health Statistics and Informatics (CHSI) is responsible for department-wide initiatives to improve the effectiveness of CDPH's work through better health information systems, increased application of epidemiologic methods of analysis, strong liaisons with public health organizations and schools of public health, and effective partnerships with local health agencies and professionals. This Center is made up of the following five branches:

Vital Records Registration Branch. The Vital Records Registration Branch (VRRB) ensures the timely and accurate registration of all vital events occurring in California. Annually California registers:

- more than 540,000 Births
- more than 240,000 Deaths
- more than 210,000 Marriages
- more than 40,000 Amendments

- fetal deaths and stillbirths

VRRB works closely with Local Registrars, County Clerks, Recorders, Hospitals, Funeral Homes and Coroners. All amendments to vital records in California are processed by VRRB including preparing new birth records for all adoptions.

Vital Records Issuance and Preservation Branch. The Vital Records Issuance and Preservation Branch (VRIPB) ensures timely and accurate issuance of vital event records registered in California, in addition to the preservation of all records since 1905. VRIPB is charged with the responsibility of:

- Maintaining a permanent central registry of all birth, death, fetal death, still birth, marriage, and dissolution records for vital events which occur in California.
- Preserving over 45 million records dating back to 1905. Over 15 million of these records are digitally imaged. Over one million events are added annually.
- Issuing certified copies of registered vital events. Approximately 120,000 certified copies are issued annually.
- Protecting the integrity of California's vital records in compliance with state and federal laws.

Public Health Policy and Research Branch. The Public Health Policy and Research Branch (PHPRB) develops and evaluates policy to support Public Health programs, support State Registrar data management and reporting requirements and administers CHSI local service programs.

Public Health Informatics Branch. The Public Health Informatics Branch (PHIB) supports CDPH informatics requirements and the State Registrar systems and functions. Informatics requirements include:

- eHealth program, policy and planning
- Public Health Informatics Workforce Development
- Geographic Information Systems (GIS)
- CDPH web services coordination and administration of CDPH Internet/Intranet web sites

State Registrar systems include business applications and data systems to support core functions of the Vital Records Registration and Vital Records Issuance Branch and the data management needs of the Public Health Policy and Research Branch.

Operations Branch. The Operations Branch (OB) meets and supports all CHSI business functions through the provision of accurate and timely administrative services. OB is composed of the Fiscal Services Section (FSS), the Employee Services Section (ESS) and the Contracts and Procurement Section (CPS).

- The FSS is responsible for recording and monitoring revenue and expenditures from all CHSI fund sources. FSS also creates and updates the Vital Records Fee Schedule.

- The ESS is responsible for providing a wide array of employee services to CHSI, such as telecommunications, inventory and supplies, and space management.

- The CPS is responsible for the timely processing of all CHSI procurements and contracts in compliance with Department of General Services' requirements, guidelines and opportunities.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to provide an overview of this Center.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 2: BIRTH CERTIFICATE PROCESSING INCREASE FOR REAL ID ACT COMPLIANCE BUDGET CHANGE PROPOSAL

PANELISTS

- **Jim Greene, MS, MD**, Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Alex Haq**, Chief, Fiscal Services Section, Center for Health Statistics and Informatics, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH, Center for Health Statistics and Informatics (CHSI) requests expenditure authority of $796,000 in Fiscal Years (FYs) 2018-19, 2019-20, and 2020-21 from the Health Statistics Special Fund (Fund 0099) to meet the demand for an increased number of birth certificate requests due to the Real ID Act (federally compliant driver's license/identification card). CDPH proposes to redirect four positions for this workload.

CDPH also requests Budget Bill Language (BBL) to authorize up to $1.59 million from the Health Statistics Special Fund if necessary to support possible additional workload to implement the Act.

BACKGROUND

CDPH/CHSI is responsible for the registration of vital events, the issuance of legal vital records documents and the collection and management of public health and vital statistics data. CDPH/CHSI annually compiles vital statistics data from birth, death, and fetal death certificates for more than 750,000 Californians annually. This data is foundational to the federal government, state agencies, local government agencies, policy makers, and researchers for measuring population health, research on health outcomes, and state and local public health reporting and surveillance.

By statute, the State Registrar operates under the authority of Division 102 of the Health and Safety Code (HSC). Division 102 makes the State Registrar responsible for registering each live birth, fetal death, death, and marriage that occurs in California, and for providing certified copies of vital records to the public. HSC Section 102230 requires the State Registrar to permanently preserve vital records in a systematic manner and to prepare and maintain a comprehensive and continuous index of all registered certificates.

State law requires every applicant for a California driver's license or identification card (DL/ID) to provide verification of birth date and legal presence in the United States. A certified copy of a birth certificate provides a vital record that documents the facts of birth of an individual and establishes proof of identity and citizenship.

On May 11, 2005, Congress passed the Act as part of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and the Tsunami Relief Act (H.R. 1268, Public Law 109-13), establishing minimum security standards for state-issued DL/ID cards. Additionally, the Act prohibits federal agencies from accepting non-compliant DL/ID cards for official purposes, including domestic air travel. On December 20, 2013, the Department of Homeland Security announced a phased enforcement plan for the Act. Presently, California has an extension for enforcement of the Act, allowing access to Federal facilities and nuclear power plants until October 10, 2017. Starting October 1, 2020, every air traveler will need a Real ID compliant license, or another acceptable form of identification to fly domestically.

To meet the requirements of the Act, Californians must have an updated, federally compliant DL/ID card to board an aircraft, access Federal facilities, and nuclear power plants. Since July 1, 2016, the California Department of Motor Vehicles (DMV) has required proof of legal presence in the United States for all new, federally compliant DL/ID applications in accordance with federal law, and AB 1465 (Gordon, Chapter 708, Statutes of 2016), which established the statutory implementation of the Act. To obtain a federally compliant DL/ID, applicants will need to provide documents that support they are legally present in the United States. Certified copies of birth certificates will be the primary document for establishing a legal presence. Other documents, such as permanent or temporary work visas, naturalization certificates, or passports, will also be suitable for establishing a legal presence.

DMV estimates a total of 18.5 million of the 29.5 million current DL/ID card holders over a five-year period (2018-2022) will choose to have a federally compliant card. DMV based this estimate on the current five-year DL/ID renewal cycle and on numbers reported by states that have already implemented Real ID.

Beginning on January 1, 2018, the DMV will begin offering two options for DL/ID renewals. People will have their choice of a federally compliant DL/ID, or a California compliant DL/ID. Based on other states' data, DMV has calculated 18.5 million people will request a federally compliant DL/ID, as opposed to an existing California compliant DL/ID. CDPH/CHSI estimates that these 18.5 million Californians who choose the federally compliant DL/ID will do so prior to October 2020 in order to prevent any restrictions on air travel. Thus, CDPH/CHSI reduced the time available for compliance from a five-year period to three years. CDPH estimates that this will result in an average of 6.2 million people who will request federally compliant DL/ID cards per year for FY 2018-19, FY 2019-20, and FY 2020-21.

Federally Compliant Real ID/DL Cards Processing FY 2018-19, FY 2019-20, FY 2020-21	Estimates
Federally Compliant Real ID/DL Requests per Year	6,166,667
% of People Needing Birth Certificates	10
% of Birth Certificates Done by State	6
State Birth Certificate Requests Increase per Year	37,000
State Birth Certificate Requests Increase per Day	151
Production Rate per Employee per Day	33
Temporary Production Employees Needed	4

* The State Registrar produces 5.97% of the birth certificate copies requested by California citizens, based on FY 2015-16 data.

The federally compliant DL/ID option will meet the requirements of the Act and will allow access to air travel and federal buildings after October 1, 2020. To obtain a federally compliant DL/ID, applicants will need to provide documents that support they are legally present in the United States. Certified copies of birth certificates will be the primary document to establish a legal presence.

The California compliant DL/ID option will not meet the requirements of the Act and will not allow people access to air travel or federal buildings after October 1, 2020, unless they present other federally compliant identification, e.g., a valid passport. Renewing a current California DL/ID to the California compliant DL/ID will not require any additional documentation, other than an existing California DL/ID.

Beginning on July 1, 2016, AB 1465, the statutory basis for the Act, requires all new applicants for DL/IDs to provide proof that the applicant's presence in the United States is authorized under federal law. AB 1465 is specific to new applications and does not apply to renewals. The federally compliant option for DL/ID renewals falls under the scope of AB 1465, which requires proof of legal presence in the United States.

On July 1, 2016, DMV began implementing AB 1465, requiring new DL/ID applicants to provide a proof of legal presence, e.g., a birth certificate. Compared to the number of potential new applicants provided by DMV, CDPH/CHSI calculated 10 percent of applicants did not have access to a birth certificate or passport and needed to request birth certificates. Assuming that 10 percent of applicants will need a birth certificate for DMV, and that approximately 6 percent of those requests will be made to CDPH, CDPH/CHSI will process 37,000 copies annually in addition to the existing workload (3,083 copies per month over FY 2018-19, FY 2019-20, and FY 2020-21). After FY 2020-21, CDPH/CHSI estimates the demand for birth certificates will return to normal.

CDPH/CHSI requests expenditure authority of $796,000 for FYs 2018-19, 2019-20, and 2020-21 from the Health Statistics Special Fund and to redirect four positions to meet the demand for an increased number of birth certificate requests due to the Act. The increased number of birth certificate requests is projected to increase the revenue of the Health Statistics Special Fund by $3.3 million annually in FY 2018-19, FY 2019-20 and FY 2020-21.

Proposed BBL

The request for BBL will enable CDPH to increase the Health Statistics Special Fund up to $1.59 million if there is an unanticipated increase in workload to meet the demand for an increased number of birth certificate requests due to the Act.

Add Provision 1 to Item 4265-001-0099

> 1. The Director of Finance may augment this item by an amount not to exceed $1,592,000 from the Health Statistics Special Fund, after review of a request submitted by the Department of Public Health that demonstrates a need for additional temporary resources and data reflecting an increase in workload related to implementation of the Real ID Act. Any augmentation shall be authorized not sooner than 30 days after notification in writing to the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may determine. The written notification to the Chairperson of the Joint Legislative Budget Committee for funds for the purposes described above shall include: (1) a description of why additional resources are needed, and (2) the risks associated with not having the additional resources

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

CENTER FOR FAMILY HEALTH

ISSUE 3: CENTER FOR FAMILY HEALTH OVERVIEW AND PROGRAM UPDATES

PANELISTS

- **Connie Mitchell, MD, MPH**, Deputy Director, Center For Family Health, DPH
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

This is an informational item in order for the Subcommittee to:1) learn more about the Center for Family Health; and 2) receive updates on Center for Family Health programs of interest to the Subcommittee.

BACKGROUND

The Center for Family Health is organized into three major program areas:

1. WIC Program – discussed in detail in issue 4 of this agenda;
2. Genetic Disease Screening Program – discussed in detail in issue 6 in this agenda; and
3. Maternal, Child and Adolescent Health (MCAH) Programs, described in more detail here (below):

The January budget proposes $1.5 billion for this Center (46.5% of the total CDPH budget), of which $1.2 billion is for the WIC program. MCAH includes the following programs:

1. Adolescent Family Life Program, AFLP
2. Adolescent Sexual Health Work Group, ASHWG
3. Black Infant Health Program, BIH
4. Breastfeeding Program, BFP
5. California Birth Defects Monitoring Program, CBDMP
6. California Diabetes and Pregnancy Program, CDAPP
7. California Early Childhood Comprehensive Systems, CA-ECCS
8. California Home Visiting Program (CHVP)
9. California Personal Responsibility Education Program (CA PREP)
10. Comprehensive Perinatal Services Program, CPSP
11. Fetal and Infant Mortality Review Program, FIMR
12. Human Stem Cell Research Program, HSCR
13. Infant Health
14. Information & Education (I&E) Program
15. Intimate Partner Violence, IPV

16. Local Health Jurisdiction Maternal, Child and Adolescent Health Program, Local MCAH
17. Maternal Health
18. Sudden Infant Death Syndrome Program, SIDS
19. Nutrition and Physical Activity Initiative, NUPA
20. Oral Health Program, OHP
21. Perinatal Substance Use Prevention, PSUP
22. Preconception Health
23. Regional Perinatal Programs of California, RPPC
24. Children and Youth with Special Health Care Needs (CYSHCN)
25. Text4baby Program

The Black Infant Health (BIH) and Adolescent Family Life (AFL) Programs have been of particular interest to the Legislature in recent years. Both programs received substantial funding reductions during the recent recession; funding has been restored to only the BIH.

BIH

The BIH seeks to improve African-American infant and maternal health, as well as decrease Black-White health inequities and social inequities for women and infants. The program serves African-American women who are 18 years or older and up to 26 weeks pregnant at the time of enrollment. Services are provided by Family Health Advocates, Group Facilitators, Public Health Nurses and Social Workers. Services are provided in communities where over 90% of African-American births occur, including:

Counties:

- Alameda
- Contra Costa
- Fresno
- Kern
- Los Angeles
- Riverside
- Sacramento
- San Bernardino
- San Diego
- San Francisco
- San Joaquin
- Santa Clara
- Solano

Cities:

- Long Beach
- Pasadena

In 2009, $3.9 million was cut from the BIH, and this funding was restored in 2014.

BIH

The BIH Program receives funding from General Fund in the amount of $4.0 million and from Title V Federal Funds in the amount of $4.2 million (with a one-time increase to $4.8 million in FY 2016-17). The chart below displays funding for BIH from FY 2009-10 through budget year 2017-18.

	General Fund (Fund 0001)	Federal Trust Fund Title V (Fund 0890)	Total
FY 2009-10*	$0	$4,315,000	**$4,315,000**
FY 2010-11	$0	$4,315,000	**$4,315,000**
FY 2011-12	$0	$4,175,669	**$4,175,669**
FY 2012-13	$0	$4,175,669	**$4,175,669**
FY 2013-14	$0	$4,175,669	**$4,175,669**
FY 2014-15	$4,000,000	$4,175,669	**$8,175,669**
FY 2015-16	$4,000,000	$4,175,668	**$8,175,668**
Current Year FY 2016-17**	$4,000,000	$4,775,668	**$8,775,668**
Budget Year FY 2017-18	$4,000,000	$4,175,668	**$8,175,668**

Notes: *State General fund was eliminated from the program in FY 2009-10.
**One time increase in Title V Federal Funding in FY 2016-17.

AFLP

The Adolescent Family Life Program (AFLP) addresses the social, health, educational, and economic consequences of adolescent pregnancy by providing comprehensive case management services to pregnant and parenting teens and their children. The AFLP emphasizes promotion of positive youth development, focusing on and building upon the adolescents' strengths and resources to work toward:

- Improving the health of the pregnant and parenting teen, thus supporting the health of the baby;
- Improving graduation rates;
- Reducing repeat pregnancies; and
- Improving linkages and creating networks for pregnant and parenting teens

The AFLP was established in 1985 and since then has provided support services to over 150,000 teen parents and their children. In 2009, the budget eliminated the program's General Fund appropriation of $10.7 million, which resulted in the additional reduction of $5.4 million in federal matching funds. Since 2009, the program also experienced an additional $2.8 million reduction in federal funds, for a total loss of $18 million in funding. The AFLP had sufficient funding in 2008-09 to serve a high of 18,000 adolescent families and dropped to serving 3,956 teens in fiscal year 2014-15.

AFLP only receives funding from Title V Federal Funding. The program's General Fund was eliminated in FY 2009-10. The chart below displays funding for AFLP from FY 2009-10 through budget year 2017-18.

	Federal Trust Fund Title V (Fund 0890)	Total
FY 2009-10	$8,460,418	$8,460,418
FY 2010-11*	$7,516,469	$7,516,469
FY 2011-12	$7,266,470	$7,266,470
FY 2012-13	$5,365,219	$5,365,219
FY 2013-14	$4,313,079	$4,313,079
FY 2014-15	$4,781,367	$4,781,367
FY 2015-16	$5,631,367	$5,631,367
Current Year FY 2016-17	$5,631,364	$5,631,364
Budget Year FY 2017-18	$5,631,364	$5,631,364

Notes: *Starting in FY 2010-11 there was an incremental decrease in AFLP Title V Federal Funding due to an overall reduction in Title V Federal Funds.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to provide an overview and updates on the Center for Family Health and respond to the following:

How much more federal funding is available to be matched with additional state funding for the AFLP?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 4: WOMEN INFANTS & CHILDREN (WIC) PROGRAM ESTIMATE

PANELISTS

- **Connie Mitchell, MD, MPH**, Deputy Director, Center For Family Health, Department of Public Health
- **Christine Nelson**, Chief, Women Infants & Children Division, Center For Family Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

WIC BUDGET

The WIC program is funded almost entirely with federal funds, including a Food Grant from the United States Department of Agriculture (USDA) as well as Nutrition Services and Administration (NSA) grant. The state also contracts for rebates from infant formula providers, which amounts to approximately 15 percent of the program funding.

As shown in the table below, the WIC estimate proposes total expenditures of $1.2 billion in 2018-19, a $2.3 million (0.2%) decrease over the revised estimate for 2017-18.

WIC Expenditures

	2017 Budget Act	2017-18 Estimate	2018-19 Proposed	CYE to BY Change	% Change
Local Assistance	1,175,135,000	1,132,459,000	1,129,983	($2,476,000)	-0.22%
State Operations	$63,463,000	$63,463,000	$63,684,000	$221,000	0.35%
Total Expenditures	**$1,238,598,000**	**$1,195,922,000**	**$1,193,667,000**	**($2,255,000)**	**-0.2%**

Current Year Adjustments:
The November 2017 Estimate anticipates a decrease in food expenditures in 2017-18 from $874.3 million to $831.6 million, a decrease of $42.7 million (4.9%) compared to the 2017 Budget Act. The most recent Consumer Price Index rate projects an increase in food costs of 2.5% for 2017-18, however the drop in projected participation levels still results in an overall decrease in food expenditures.

Budget Year Adjustments:
For 2018-19, the food expenditure estimate is $819.1 million, a decrease of $55.2 million (6.3%) compared to the 2017 Budget Act and a decrease of $12.5 million (1.5%) from the revised 2017-18 estimate. Although the manufacturer rebate contract

increased in rebate per can of infant formula, the projected rebate amount decreased due to the drop in participation.

BACKGROUND

WIC provides supplemental food and nutrition for low-income families (185 percent of poverty or below) with pregnant women, breastfeeding and early postpartum mothers, infants, and children up to age five. WIC services include nutrition education, breastfeeding support, help finding health care and other community services, and checks for specific nutritious foods that are redeemable at retail food outlets throughout the state. WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

DPH administers contracts with 84 local agencies (half are local government and half private, non-profit community organizations) that provide 650 locations statewide. Approximately 3,000 local WIC staff assess and document program eligibility based on residency, income, and health or nutrition risk, and issue 4.8 million food checks each month. Local WIC agencies issue WIC participants paper vouchers to purchase approved foods at authorized stores. Examples of WIC foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter, and iron-fortified infant formula.

The goal of WIC is to decrease the risk of poor birth outcomes and improve the health of participants during critical times of growth and development. The amounts and types of food WIC provides are designed to meet the participant's enhanced dietary needs for specific nutrients during short but critical periods of physiological development.

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support, and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged as being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

WIC Funding

DPH states that California's share of the national federal grant appropriation has remained at about 17 percent over the last 5 years. Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:

- **Food**. Food funds reimburse WIC authorized grocers for foods purchased by WIC participants. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.

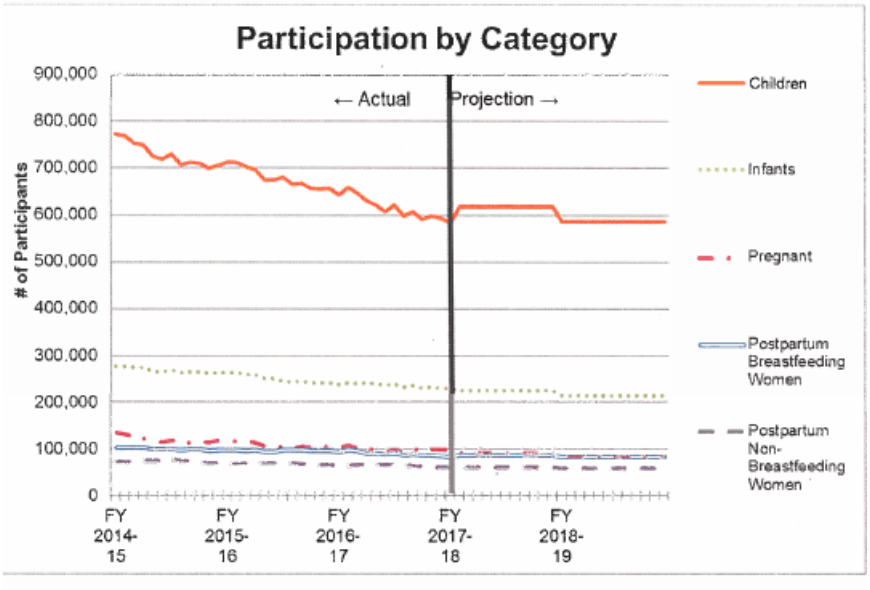
- **Nutrition Services and Administration.** Nutrition Services and Administration (NSA) Funds that reimburse local WIC agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition education, breastfeeding support, and referrals to health and social services, as well as support costs. States manage the grant, provide client services and nutrition education, and promote and support breastfeeding with

NSA Funds. Performance targets are to be met or the federal USDA can reduce funds.

- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with infant formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down Federal WIC food funds.

WIC Participation

Caseload (participation) in WIC has been decreasing since 2013, consistent with national trends, as can be seen in the chart below:



WIC Program staff note that although participation is decreasing in California and nationally, California's WIC program serves 76 percent of the eligible population, while the national average is 60 percent.

Electronic Benefit Transfer (EBT)

DPH is in the process of replacing the program's information technology system in order to be able to transition the program from paper vouchers to EBT cards. DPH anticipates issuing EBT cards during the summer of 2019, with full implementation by April 2020.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the WIC estimate and describe significant changes to, and challenges and trends in, the program, and to respond to the following:

1. What is known at this point about decreasing participation?

2. Please provide an update on the EBT project.

3. Please describe the WIC program's efforts to modernize its communications with WIC families and the public.

4. How many and which languages are utilized in WIC outreach and communications efforts?

5. Please describe any efforts underway to improve the WIC food package, and specifically ways to incentivize the purchasing of California-grown produce.

6. Could streamlining the WIC application help with participation rates?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 5: INFANT AND EARLY CHILDHOOD HOME VISITING PROGRAM BUDGET CHANGE PROPOSAL

PANELISTS

- **Connie Mitchell, MD, MPH**, Deputy Director, Center for Family Health, Department of Public Health
- **Leslie Kowalewski,** Chief, Maternal, Child and Adolescent Health Division, Center for Family Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH, Maternal Child and Adolescent Health (MCAH) Division, requests to convert 11 limited-term positions to permanent positions and expenditure authority of $903,000 in fiscal year (FY) 2018-19, and convert an additional 16 limited-term positions to permanent positions and expenditure authority of $21.8 million ($4.0 million in State Operations and $17.8 million in Local Assistance) in FY 2019-20 and ongoing from the Federal Trust Fund (Fund 0890).

BACKGROUND

The CDPH California Home Visiting Program (CHVP) was initially created through an amendment to the Title V Social Security Act within the Patient Protection and Affordable Care Act (ACA) of 2010, Section 2951, which established the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program grant. In addition. Health and Safety Code Section 123491 states that a voluntary home visiting (HV) program for expectant first-time mothers and for their children and families be administered by CDPH. CHVP funding has been consistent since the program was enacted in 2010 and was authorized for five years from 2010-2014 for $1.5 billion. The Protecting Access to Medicare Act of 2014 funded the program at $400 million for FY 2015 and also detached the MIECHV from the ACA. The Medicare and CHIP Reauthorization Act (MACRA) extended funding through September 2017 at $372 million. California funding levels for the past seven federal fiscal years (FFY) were: FFY 2010 $8.2 million; FFY 2011 $20.9 million; FFY 2012 $ 20.9 million; FFY 2013 $20.2 million; FFY 2014 $20.6 million; FFY 2015 $22.6 million; and in FFY 2016 $22.2 million. The California MIECHV grant application has been submitted for the projected award in the amount of $22 million and was approved on September 15, 2017.

CHVP's focus is to provide comprehensive, coordinated in-home services to support positive parenting, and to improve outcomes for families residing in identified at-risk communities. CHVP is an evidence-based, voluntary program offered to pregnant women and their children from birth to age three. CHVP has 23 sites in 24 Local Health

Jurisdictions (LHJs), which provide services using one of two evidence-based, nationally recognized home visiting models: Healthy Families America and Nurse Family Partnership. Program goals include: (1) improved maternal and child health; (2) prevention of child injuries; (3) child abuse/maltreatment and reduction of emergency department visits; (4) improvement in school readiness and achievement; (5) reduction in crime or domestic violence; (6) improvements in family economic self-sufficiency; and (7) improvements in the coordination and referrals for other community resources and supports. As of October 26, 2017, the California Home Visiting Program (CHVP) has completed 141,091 home visits and served over 7,554 families at 23 local sites.

In FY 2015-16 CDPH received approval to extend 27 limited-term positions, and associated funding, and Local Assistance expenditure authority of $24 million for CHVP. Of these 27 positions, funded from the Title V Health Resources and Services Administration (HRSA), MIECHV Program grant, 11 positions expire January 31, 2019, and the remaining 16 expire June 30, 2019, along with the Local Assistance expenditure authority.

Home visiting has been shown to lower rates of the following: childhood injuries; child abuse and neglect; infant mortality; preterm birth; low birth weight; and smoking during pregnancy. Home visiting has been shown to increase the following: immunizations; breastfeeding rates; and language development. By focusing on pregnancy and a child's first few years of life, home visiting is poised to assist parents in learning how to provide their children with a strong start through safe, stable and nurturing environments.

The LHJs administer the home visiting program through their County Department of Public Health, where they provide primary oversight of all home visiting activities. The $17.8 million in Local Assistance funding to the LHJs provides the needed funding to employ four to five home visitors and one supervisor per site. This funding supports the infrastructure needed to successfully administer a CHVP within the county.

CDPH is requesting to convert a total of 27 limited-term positions, 11 in FY 2018-19 and an additional 16 in FY 2019-20, to permanent positions to ensure continued support of the CHVP. Given the success of home visiting programs nationally and bipartisan support at the federal level, CDPH is confident that funding for MEICHV will continue, and therefore permanent positions are necessary to ensure sites comply with the requirements of the MIECHV federal grant to secure continued funding without adversely impacting other critical MCAH program functions. Grant requirements include the collection and analysis of data on the six federally-mandated benchmarks, and each of the 19 sub-measures referred to as Constructs.

DPH states that the CHVP is a high-yield investment that strengthens parent-child relationships, increases language and literacy skills, and reduces child abuse and neglect, poor health, academic failure and crime. Research on the return on investment of Nurse Family Partnership (NFP) programs (one model of providing home visiting) in California shows a 15% reduction in preterm births. In addition, the savings, net program costs, are $39,129 per NFP family in California. Studies have shown that for

every dollar spent on home visiting services, there is up to a $5.70 return on investment yield. Studies have also shown that exposure to adverse childhood experiences (ACEs) is associated with increased morbidity and mortality from multiple diseases and life challenges across the life span. Home Visiting aims to reduce the occurrence of ACEs, which could minimize exposure to the causal events, help prevent these diseases and challenges from manifesting, and prevent incurring the associated treatment costs.

STAFF COMMENTS/QUESTIONS

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

1. Please explain the differences between this program and the proposed new home visiting program included in the Governor's January Budget.

2. Please explain how this program helps to reduce ACEs.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 6: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

PANELISTS

- **Connie Mitchell, MD, MPH**, Deputy Director, Center For Family Health, Department of Public Health
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, Department of Public Health
- **Richard Olney, MD, MPH**, Chief, Genetic Disease Screening Program, Center For Family Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

GDSP BUDGET

The total GDSP proposed 2018-19 budget is $132.9 million, a $542,000 increase (0.4%) over the current year (2017-18) budget of $132.4 million. Of the proposed $132.9 million, $29.5 million is for state operations while $103.5 million is proposed for local assistance.

	Genetic Disease Screening Program Expenditures				
	2017 Budget Act	**2017-18 Estimate**	**2018-19 Proposed**	**CY to BY $ Change**	**CY to BY % Change**
NBS Local Assistance	$41,259,000	40,097,000	40,984,000	($275,000)	-0.7%
PNS Local Assistance	34,224,000	35,184,000	35,016,000	$792,000	2.3%
Operational Support	29,249,000	29,451,000	27,473,000	(1,776,000)	-6.1%
State Operations	26,854,000	27,650,000	29,451,000	2,597,000	9.7%
TOTAL	**$131,586,000**	**$132,382,000**	**$132,924,000**	**$542,000**	**0.41%**

BACKGROUND

The mission of the GDSP is "To serve the people of California by reducing the emotional and financial burden of disability and death caused by genetic and congenital disorders." California Health and Safety (H&S) Code sections 125000-125002, 125050-125119, and 124975-124996 require CDPH to administer a statewide genetic disorder screening program for pregnant women and newborn babies that is to be fully supported by fees.

The Genetic Disease Screening Program (GDSP) consists of two programs - the Prenatal Screening Program and the Newborn Screening Program. Both screening

programs provide public education, and laboratory and diagnostic clinical services through contracts with private vendors meeting state standards. Authorized follow-up services are also provided to patients. The programs are self-supporting on fees collected from screening participants through the hospital of birth, third party payers, or private parties using a special fund - Genetic Disease Testing Fund.

Prenatal Screening Program (PNS). This program screens pregnant women who consent to screening for serious birth defects. Since July 1, 2016, the fee for this screening has been $221.60; $211.60 is deposited into the Genetic Disease Testing Fund and $10 is deposited into the California Birth Defects Monitoring Program Fund. Beginning July 1, 2018, this fee will be increased by $4 which will increase the amount deposited into the Birth Defects Monitoring Program Fund to $14. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. There are three types of screening tests for pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester. Women who are at high risk based on the screening test results are referred for follow-up services at state-approved "Prenatal Diagnosis Centers." Services offered at these Centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

Newborn Screening Program (NBS). This program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee for this screening is $130.25, and it will increase by $12 on July 1, 2018. Where applicable, this fee is paid by prepaid health plans and insurance companies. Medi-Cal also covers the fee for its enrollees. The NBS screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment that mitigates more severe health problems. Informational materials are provided to parents, hospitals and other health care entities regarding the program and the relevant conditions, and referral information is provided where applicable.

When the NBS Program began in October 1980, each newborn was screened for only three disorders; today, with the advent of new scientific findings, the NBS Program screens for more than 80 disorders in over 500,000 newborns and diagnoses more than 850 babies each year. California leads the nation in the number of disorders screened and provides the most comprehensive program in terms of quality control, follow-up services, genetic counseling, confirmatory testing, and diagnostic services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the GDSP estimate.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 7: NEW GENETIC DISORDERS (SB 1095) AND SECOND TIER TESTING BUDGET CHANGE PROPOSAL

PANELISTS

- **Connie Mitchell, MD, MPH**, Deputy Director, Center For Family Health, Department of Public Health
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, Department of Public Health
- **Richard Olney, MD, MPH**, Chief, Genetic Disease Screening Program, Center For Family Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH requests 18 positions and $2.69 million in ongoing expenditure authority from the Genetic Disease Testing Fund (Fund 0203) beginning Fiscal Year (FY) 2018-19. This request includes 15 positions and $2.23 million in State Operations expenditure authority to comply with Health and Safety (H&S) Code Section 125001(d) and 3 positions and $460,000 in State Operations expenditure authority to perform Second-Tier testing for metabolic disorders. This increase will be offset by a $460,000 decrease in Local Assistance funding as displayed
in the Estimate.

BACKGROUND

SB 1095 (Pan, Chapter 393, Statutes of 2016) established Health and Safety Code section 125001(d) and required the CDPH NBS Program to expand statewide screening of newborns by adding new tests within two years of the disease screen being adopted by the federal Recommended Uniform Screening Panel (RUSP). At the time the bill was chaptered, there were two disorders on the RUSP that were not on the California Newborn Screening panel, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, which were added to the RUSP in 2016 and 2015, respectively. Therefore, as specified in state statutes, CDPH is required to add these disorders to the California NBS panel by August 30, 2018.

To begin screening for Pompe disease and MPS-I, a test method for each disorder must be developed by CDPH. The 2017 Budget Act included $2.25 million in one-time Local Assistance funding and $139,000 in State Operations funding to incorporate MPS-I and Pompe disease into the Screening Information System and support one Research Scientist II to start-up test method development activities.

In addition, the CDPH/GDSP works to improve the quality of testing by preventing false negative tests and keeping false positive test rates as low as possible. Incorporating new testing strategies to reduce false positive test rates to prevent unnecessary stress and anxiety for parents is vital. By coupling the primary screening method with a second linked test that is more specific than the original method, CDPH can improve diagnostic specificity (fewer false positives) without reducing sensitivity (the rate of false negatives). A second-tier test uses the same blood specimen from the original test, eliminating that additional burden to families or hospital personnel, and measures additional metabolites that either strongly supports the presumption of a true positive case or shows that the patient does not have the disorder

Using second-tier testing to increase positive predictive values of screening assays is a common standard of practice in most newborn screening laboratories. The effectiveness of second-tier testing on decreasing overall costs for the NBS Program has been tested and validated, and the results have been published by many researchers. The estimated cost savings would be approximately $380,000 annually.

The 2017 Budget Act also included $300,000 in one-time State Operations expenditure authority, supported by a one-time transfer of $330,000 in Local Assistance expenditure authority, for the purchase of mass spectrometry equipment and testing method development.

In August of 2018, CDPH/GDSP will incorporate testing for MPS-I and Pompe disease into the newborn screening panel. By incorporating these screenings into the newborn screening panel, California will meet the national standard of care as recommended by the federal Advisory Committee on Heritable Disorders in Newborns and Children and will bring the NBS Program into alignment with the most up-to-date research, technology, laboratory, public health standards, and practices, as well as Health and Safety Code section 125000.

Beginning FY 2018-19, $2.23 million of this proposal will support 15 positions to perform routine testing for two new disorders, Pompe and MPS-I at the Genetic Disease Laboratory (GDL), and fully evaluate, validate, and approve the new FDA kit for Pompe and MPS-I prior to rolling out to the regional laboratories within five years of the release of the FDA kit.

Until there is an FDA-approved test kit for these disorders, and testing can be rolled out to the regional laboratories, testing will need to be done in a central location, with a locally developed and maintained test methodology. The positions are essential to perform the following required duties:

Perform the routine screening at the GDL;

Fully evaluate, validate, and approve the new kit prior to rolling out to the regional laboratories; and,

Upon rollout to the regional laboratories, perform repeat testing on sample sizes to ensure accuracy, quality control review, and patient result reporting.

CDPH also requests $460,000 in State Operations expenditure authority and 3 positions in FY 2018-19 and ongoing to perform Second-Tier testing to reduce false positives in newborn screening for five metabolic disorders. This increase will be offset by a $460,000 decrease in Local Assistance funding, as displayed in the Estimate, resulting in a net zero request from the Genetic Disease Testing Fund. The CDPH administrative functions will be supported by 1 Associate Governmental Program Analyst and include activities such as budget building, human resources, contracting, purchasing, and conducting all other analytical administrative support needs.

Primary NBS methods are designed to identify as many abnormal infants as possible, with diagnostic sensitivity (true positive rate) favored over specificity (true negative rate) to identify the fewest number of newborns at risk of the disease. While this approach ensures that true positives are identified by casting a wider net, false positives are also caught in the net. Currently, any positive screens require the collection and testing of a second specimen, thus adding to the cost of operating NBS programs. A Second-tier test on the original blood specimen that is more specific than the original method eliminates the need for a second specimen, reducing costs and reducing unnecessary stress to families due to a false positive test.

Based on current cut-off levels, primary markers and screening algorithms, performing Second-Tier testing using mass spectrometry has the potential for significant savings of approximately $380,000 (Local Assistance) annually starting in FY 2018-19. The Genetic Disease Laboratory is a Clinical Laboratory Improvement Amendments (CLIA)-certified clinical laboratory and by law is responsible for the quality of all assays and performance of screening assays used in our newborn screening services.

Adding Second-Tier testing to the screening algorithm will help GDSP to meet and be in compliance with CLIA regulations and make sure the assays have the adequate performance for the population served.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

CENTER FOR INFECTIOUS DISEASES

ISSUE 8: CENTER FOR INFECTIOUS DISEASES OVERVIEW AND PROGRAM UPDATES

PANELISTS

- **Gil Chavez, MD, MPH,** Deputy Director, Center for Infectious Diseases, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

This is an informational item and the Subcommittee requests DPH to provide an overview of the Center for Infectious Diseases, its major programs, and how recent legislative augmentations specifically for infectious disease prevention have been used. The January budget proposes approximately $669 million for this Center, about 21 percent of the total budget of the Department of Public Health.

BACKGROUND

The Center for Infectious Diseases (CID) seeks to protect the people in California from the threat of preventable infectious diseases and assists those living with an infectious disease in securing prompt and appropriate access to healthcare, medications and associated support services. The CID is made up of the following Division and Offices which are described below:

- Division of Communicable Disease Control
- Office of AIDS
- Office of Binational Border Health
- Office of Refugee Health

Division of Communicable Disease Control (DCDC)
The DCDC works to promptly identify, prevent and control infectious diseases that pose a threat to public health, including emerging and re-emerging infectious diseases, vaccine-preventable agents, bacterial toxins, bioterrorism, and pandemics (e.g. avian influenza in humans). The DCDC branches also work closely with the Office of AIDS on comprehensive prevention, diagnosis and treatment services for sexually transmitted diseases, viral hepatitis, tuberculosis and HIV. The DCDC includes the following:

- ***Communicable Disease Emergency Response Program***
  The mission of the Communicable Disease Emergency Response Branch (CDER) is to: 1) monitor reportable infectious diseases, emerging pathogens and unusual outbreaks: and 2) prepare for infectious disease emergencies.

- ***Immunization Branch***
  The Immunization Branch provides leadership and support to public and private sector efforts to protect the population against vaccine-preventable diseases.

- ***Infant Botulism Treatment and Prevention Program (IBTPP)***
  The mission of the IBTPP is to provide and improve the treatment of infant botulism and to prevent infant botulism and related diseases. Infant Botulism is an orphan ("rare") disease that affects infants primarily between 1 and 52 weeks of age. First recognized in 1976 in California, infant botulism occurs globally and is the most common form of human botulism in the United States.

  Infant botulism is a novel form of human botulism in which ingested spores of Clostridium botulinum colonize and grow in the infant's large intestine and produce botulinum neurotoxin in it. The action of the toxin in the body produces constipation, weakness (notably of gag, cry, suck and swallow), loss of muscle tone, and ultimately, flaccid ("limp") paralysis. Affected infants have difficulty feeding and often, breathing. However, in the absence of complications, patients recover completely from the disease. After an approximate 15-year development period, in October 2003, the U.S. Food and Drug Administration licensed to the California Department of Public Health its public service orphan drug for the treatment of infant botulism, Human Botulism Immune Globulin, under the proprietary name BabyBIG(R).

- ***Infectious Diseases Branch***
  The Infectious Diseases Branch (IDB) conducts investigation, surveillance, prevention, and control of general communicable diseases of public health importance that are not covered by the specific programs of the Immunization Branch, the Tuberculosis Control Branch, the Sexually Transmitted Diseases Control Branch, and the Office of HIV/AIDS. IDB implements its program through its four Sections: Disease Investigations Section, Surveillance and Statistics Section, Vector-Borne Disease Section, and Veterinary Public Health Section. Diseases followed by IDB include foodborne, waterborne, vector-borne, zoonotic, and emerging infectious diseases. The IDB provides:

  - consultation and assistance to local health jurisdictions in the control and prevention of communicable diseases and outbreaks;
  - collection, coordination, and tabulation of surveillance data of over 60 infectious diseases;
  - investigations of local, regional, statewide, or multistate outbreaks;
  - information on infectious diseases to CDPH, local health jurisdictions, the medical community, and the public through emails, press releases by the Office of Public Affairs, postings of pamphlets and fact sheets on the IDB webpage, and publications in medical journals; and

- recommendations, guidelines, policies, and regulations on communicable disease prevention and control.

- ***Microbial Diseases Laboratory Program***
  The Microbial Diseases Laboratory (MDL) of CDPH provides reference, diagnostic and applied research activities for the detection, epidemiologic investigation, control and prevention of bacterial, mycobacterial, fungal and parasitic diseases in humans, food, water and other environmental sources.

- ***Sexually Transmitted Diseases (STD) Control Branch***
  The mission of the STD Control Branch is to reduce the transmission and impact of sexually transmitted diseases and viral hepatitis in California. The branch supports the prevention efforts through providing statewide leadership, guidance, training, technical assistance, surge capacity and safety net support for delivering services throughout the state.

- ***Tuberculosis Control Branch (TBCB)***
  TBCB provides leadership and resources to prevent and control tuberculosis (TB). The vision of TBCB is to speed the decline of TB morbidity and mortality.

- ***Viral and Rickettsial Disease Laboratory Program (VRDL)***
  VRDL provides laboratory support, technical assistance, and research required for the diagnosis, investigation, and control of viral diseases and for the development and maintenance of high quality local viral laboratory services in California. VRDL also provides consultation services to the staff of local public health laboratories, and state agencies. For counties not having available public health laboratory services, VRDL functions as the reference and local public health laboratory in its field of expertise. As part of the Department's laboratory science training program, VRDL trains local public health laboratory personnel in state-of-the-art standardized laboratory procedures.

Office of AIDS

As designated by California Health and Safety Code Section 131019, the Office of AIDS (OA) has lead responsibility for coordinating state programs, services, and activities relating to HIV/AIDS. OA's mission is to:

- Assess, prevent, and interrupt the transmission of HIV and provide for the needs of infected Californians by identifying the scope and extent of HIV infection and the needs which it creates, and by disseminating timely and complete information;
- Assure high-quality preventive, early intervention, and care services that are appropriate, accessible, and cost effective;
- Promote the effective use of available resources through research, planning, coordination, and evaluation; and
- Provide leadership through a collaborative process of policy and program development, implementation and evaluation.

The OA is comprised of the Division Office and five branches: Surveillance, Research & Evaluation, HIV Care, HIV Prevention, AIDS Drug Assistance Program, and the OA Support Branch, as follows:

- *Division Office*. The Division Office leads policy development, partnerships with statewide and national HIV/AIDS stakeholders, legislation, and the administration for OA. The Division Office coordinates all division activities.

- *Office of AIDS Support Branch*. The OA Support Branch is responsible for administrative functions which support OA program areas including: budgets, personnel, contracts, grants, clerical support, information technology, procurement, and business services. The OA Support Branch includes the Grants Management Section, Personnel Section, Contracts Unit, Operations Unit.

- *Surveillance, Research & Evaluation Branch*. The Surveillance, Research & Evaluation Branch conducts a variety of epidemiologic studies, evaluates the efficiency and effectiveness of publicly funded HIV/AIDS prevention and care programs, and maintains California's HIV/AIDS Case Registry.

- *HIV Care Branch*. The HIV Care Branch has responsibility for programs related to the delivery of care, treatment, and support services for people living with HIV/AIDS. Programs are designed to provide an effective and comprehensive continuum of care to underserved individuals.

- *HIV Prevention Branch*. The HIV Prevention Branch funds initiatives to assist local health departments and other HIV service providers to implement effective HIV detection and prevention programs.

- *AIDS Drug Assistance Program Branch*. The AIDS Drug Assistance Program (ADAP) helps ensure that people living with HIV and AIDS who are uninsured and under-insured have access to medication. OA works closely with the pharmacy benefits manager (PBM), to administer and manage ADAP for the clients served.

Office of Binational and Border Health (OBBH)

The mission of the OBBH is to facilitate communication, coordination, and collaboration between California and Mexico health officials, health professionals, and communities in order to optimize border and binational health. The goals of the OBBH include:

1. Assess, monitor, and report on border and binational public health issues.
2. Promote and optimize communication, coordination, and collaboration on border and binational health issues and policies.
3. Build capacity to effectively address border and binational public health issues.
4. Increase awareness about border and binational public health issues and the role of OBBH in addressing them.

Office of Refugee Health

The Federal Refugee Act of 1980 created the Office of Refugee Resettlement (ORR) to fund and coordinate post-arrival health assessments, time-limited medical services and cash assistance, and other benefits to newly arrived refugees, asylees, and other eligible entrants to help them achieve economic self-sufficiency as quickly as possible after their arrival to the United States. In California, the Office of Refugee Health (ORH) coordinates the following programs supported with ORR funds:

1. *Refugee Health Assessment Program (RHAP).* Impacted local health jurisdictions provide culturally and linguistically-appropriate comprehensive health assessments to newly arrived refugees, asylees, federally-certified victims of severe forms of trafficking, and other eligible entrants. The RHAP focuses on screening of and prevention of communicable diseases; early identification and diagnosis of chronic diseases and other important conditions; assessment of immunization status for children and adults; mental health screening; and referral to health providers for further medical evaluation, treatment, and follow-up.

2. *Refugee Medical Assistance Program (RMA).* In coordination with the Department of Health Care Services, Medi-Cal Eligibility Division, the RMA provides time-limited RMA-based Medi-Cal benefits to refugees, asylees, federally-certified victims of human trafficking, and other entrants who are not eligible to receive Title XIX Medi-Cal benefits. This benefit is available only for the first eight months from the date admitted to the U.S. or from the date of certification.

Recent Legislative Budget Augmentations

The following augmentations were spearheaded by the Legislature, and DPH provided the updates on the use of the funds:

2015 Budget Act:

- ***$3 million General Fund (on-going) for syringe exchange programs (SEPs).*** DPH now has a contract with a distributor of supplies to SEPs which have provided positive feedback about the positive fiscal impact this assistance has had on their programs overall. Many SEPs used to run out of supplies before the end of the year, which this funding has prevented. Also as a result of this funding, new SEPs are developing and becoming operational.

- ***$2.2 million General Fund (on-going) for Hepatitis C linkages to care projects***. DPH issued a Request For Proposals (RFP) for this funding and received 19 applications, resulting in 5 3-year awards (operating through June 2019). The five awardees include:

    1. Access Support Network – San Luis Obispo and Monterey Counties
    2. Butte County Health Department
    3. Family Health Centers of San Diego
    4. St. John's Well Child and Family Center – South East Los Angeles County
    5. San Francisco Department of Public Health

- ***$2 million General Fund (on-going) for HIV Pre-Exposure Prophylaxis (PrEP) Demonstration Projects***. DPH awarded 9 grants to implement this funding for "PrEP Navigators" who help people at high risk of HIV to get connected to care and gain access to PrEP, resulting in the creation of a statewide network of navigators. The 9 grantees are as follows:

    1. Alta Med Health Services Corporation – Los Angeles
    2. Asian Health Services – San Francisco
    3. Desert AIDS Project – Coachella Valley
    4. Friends Research Institute – Los Angeles
    5. Humboldt County Department of Health
    6. Kern County Department of Health
    7. La Clinica De La Raza – Alameda
    8. Alta Bates Medical Center – Alameda
    9. Tarzana Treatment Centers – Los Angeles

2016 Budget Act:

- ***$5 million General Fund (one-time) to prevent the spread of sexually transmitted diseases (STDs).*** DPH issues an RFP to local entities offering the opportunity to respond as they see most appropriate and effective for their local communities.

- ***$1.4 million General Fund (one-time) to prevent the spread of hepatitis.*** This funding was split between the Viral Hepatitis Program (VHP) and OA as follows:

    - VHP: This program has used the funding to purchase and distribute Hepatitis C rapid test kits and for purchase and distribution of the Hepatitis B vaccine; and

    - OA: The OA used this funding for Hepatitis C rapid test kits and to provide technical assistance to local jurisdictions and community based organizations interested in establishing new SEPs.

- ***$1 million federal and special funds (on-going) and trailer bill to cover PrEP-related copays, coinsurance and deductibles incurred by individuals accessing PrEP with annual incomes below 500 percent of the Federal Poverty Level.*** DPH explains that the pharmaceutical company offers financial assistance for PrEP users and stated that they will not continue to pay for any costs being covered by these state funds. DPH is negotiating with them to resolve this issue.

2017 Budget Act:

- **$4 million one-time (ADAP Rebate Fund) to help stabilize, and improve eligibility and enrollment functions of Office of AIDS programs**.

- **$4 million (Proposition 56 Funds) to increase the Medi-Cal rates paid under the AIDS Waiver Program**.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to provide an overview of the Center for Infectious Diseases, its proposed budget, and updates on the use of recent legislative augmentations that are detailed above. Please also respond to the following:

DPH Communicable Disease Emergency Response Program

1. How was this program utilized in the state's response to the recent Hepatitis A outbreak?

2. What were the lessons learned related to containing a Hepatitis A outbreak?

3. How could the state reach sufficient Hepatitis A vaccination rates to accomplish herd immunity?

4. What are the predictable risks of increased Hepatitis A incidence rates in light of the state's increasing homeless population?

DPH Sexually Transmitted Diseases (STD) Control Branch

5. How effective is the state controlling STD rates?

6. What else could and should California be doing to curb rising STD rates?

7. What are best practices in STD control from other states or nations?

8. Should California fund and implement a social media campaign targeting young people?

9. Department of Finance – In light of the 40% increase in STDs, combined with evidence that the state is spending $1 billion on STD-associated health care costs, what are the reasons that the state does not invest more in prevention?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 9: RICHMOND VIRAL RICKETTSIAL DISEASE LABORATORY CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

PANELISTS

- **Tim Bow**, Administration Division, Department of Public Health
- **Brian Fuller,** Finance Budget Analyst, Department of Finance
- **Koreen van Ravenhorst**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

This proposal requests a reversion of $3,799,000 and a Capital Outlay appropriation in the amount of $4,866,000 General Fund to fund the working drawings and construction phases of the CDPH Viral and Rickettsial Diseases Laboratory (VRDL) Bio-Safety Level 3 (BSL-3) upgrade project. This is a net increase of $1,067,000 over the previous total project cost appropriation.

DGS received a contract bid exceeding the contract award amount by 23 percent. As a result, this proposal requests the construction appropriation of $3,799,000 be reverted to the General Fund, and the approval of a new appropriation of $4,866,000 to fund the increased cost of the project's working drawings and construction phases.

BACKGROUND

Select agent viruses that require BSL-3 facilities include, but are not limited to: hantavirus, poxviruses, novel influenza (e.g. avian influenza viruses), Middle East Respiratory System (MERS)-CoV, Severe Acute Respiratory System (SARS), Chikungunya virus, Japanese encephalitis virus, and West Nile virus. An operational BSL-3 laboratory is needed to be able to identify these viruses for the important public health mission preparing for and responding to deadly emerging viral diseases.

At the time of construction (2000), the Richmond Campus VRDL laboratory was designed to meet the existing BSL-3 requirements as determined by the Center for Disease Control (CDC) and National Institute of Health (NIH). In 2006, in response to world health concerns, the CDC/NIH implemented enhanced requirements for BSL-3 certified laboratories. In FY 2007-08, $241,000 was appropriated and expended on Preliminary Plans and an additional $241,000 was appropriated for Working Drawings, with an expenditure of $232,000 and $9,000 in savings. In FY 2015-16, in response to the required BSL-3 enhancements, CDPH was funded with a $4,333,000 Capital Outlay Project appropriation to upgrade the VRDL.

After the enactment of the FY 2015-16 budget, CDPH engaged the services of the Department of General Services (DGS) Real Estate Services Division (RESD) to manage the project. In July 2015, CDPH transferred $534,000 into the DGS Architectural Revolving Fund (ARF) to fund the Working Drawings (WD) phase of the project. However, the fires in 2015 throughout California caused a significant delay obtaining the State Fire Marshall's approval of the final working drawings. As a result, the $3,799,000 appropriation for the construction phase was reappropriated the following year.

In FY 2016-17, CDPH received a $3,799,000 reappropriation for the construction of the laboratory. In June 2017, DGS obtained final SFM approval of the working drawings, allowing DGS to put the project out to bid for construction.

In August 2017, DGS released a solicitation for the laboratory construction. In September 2017, DGS received only one bid. However, their bid was $3,445,000, which was 23 percent, or $649,000, above the estimated $2,796,000 construction cost.

DGS evaluated the bid, contacted interested bidders, and concluded:

- There was limited interest by other bidders due to the current strength of the Bay Area construction market.
- The specialty nature of a laboratory project further limited potential bidders.
- The original construction estimate did not adequately reflect the Bay Area construction market conditions.
- Although only one bid was received, the bid was competitive and reflected the current construction market.

Because the construction bid exceeded the original estimated construction cost, the current $3,799,000 authority for the project's construction phase is being proposed to be reverted to the General Fund.

This is a request for a new $4,866,000 appropriation to fund the working drawings and construction phases of the project with the revised DGS estimate. The requested appropriation will fund approximately $64,000 for DGS project management cost associated with rebidding the project and the project's increased estimated construction cost of $4,802,000.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal and to explain the increase in the total cost of this project.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 10: VALLEY FEVER OUTREACH AND AWARENESS CAMPAIGN MEMBERS' PROPOSAL

PANELISTS

- **Assemblymember Rudy Salas**

Public Comment

PROPOSAL

Assemblymember Salas, with the support of 30 other Members of the Assembly, requests $3 million one-time General Fund in 2018-19 to fund research for a vaccine and cure for Valley Fever (through the University of California), and $1 million one-time General Fund for a statewide public outreach and awareness campaign to inform the public about the symptoms, diagnosis and treatment of this disease (through the Department of Public Health.

BACKGROUND

Assemblymember Salas provided the following background information.

Valley fever is primarily a disease of the lung, caused by a fungus, which lives in the soil and is endemic to parts of the southwestern U.S. and elsewhere in the Western Hemisphere. It spreads through the air when soil is disturbed and can be carried for hundreds of miles. Agricultural communities with open fields, such as Kern County, are especially vulnerable to valley fever outbreaks. About 60 percent of individuals who inhale the spores do not get sick at all and are unaware they are infected. For others, symptoms are similar to a cold or flu. Of those patients seeking medical care, the most common symptoms are fatigue, cough, chest pain, fever, rash, headache, and joint aches. More extreme cases include pneumonia-like symptoms. When the infection spreads to the brain and spinal cord it can cause meningitis which requires lifetime treatment and can be fatal.

In 2016, a record high of 5,372 cases were reported and this number significantly increased with 7,471 cases initially reported by the California Department of Public Health (CDPH) in 2017. What is most alarming is the number of cases that go unreported. According to the Centers for Disease Control and Prevention (CDC), in addition to reported cases, an estimated 150,000 cases go unreported every year in the United States.

Because the symptoms are similar to other common illnesses, Valley Fever is often misdiagnosed, which results in delayed treatment. If left untreated, the infection can spread to any part of the body and cause serious health complications, with the most common sites being the lining of the brain, skin, lymph nodes, bones and joints.

Misdiagnosis and delayed treatment also result in increased costs in doctors' visits, hospitalizations, and long-term treatment with medications. An investigative series on Valley Fever done by the University of Southern California's Center for Health Journalism in 2012 reported that a typical hospital stay, at $100,000 on average, is more costly to treat than any of California's 25 most common conditions requiring hospitalization. The total charge statewide of hospitalizing people with cases of valley fever ranging from pneumonia-like symptoms to life-threatening cases was close to $140 million in 2010, according to an analysis by the Office of Statewide Health Planning and Development (Cal OSHA). The study also estimated that the cost for a single Valley Fever workers' compensation claim averages $60,000, a number that can significantly increase into the millions in extreme cases.

Although the disease is more prevalent in the Central Valley, Valley Fever is a statewide issue. Since 2011, cases of Valley Fever have been reported in 50 out of 58 counties. While the state has funded other health-related research programs, it has not provided adequate funding to address the Valley Fever crisis.

Currently, there is no cure or vaccine for this disease. Because there is no vaccine and exposure to the fungus is difficult to avoid in areas where Valley Fever is common, public awareness is frequently cited by experts as one of the most important ways to avoid delays in diagnosis and treatment. Studies have demonstrated that victims who know about the disease before seeking healthcare are more likely to get an earlier diagnosis of the disease. Investing in research to find a cure and development of a vaccine to prevent the disease is critical to public health. A well developed and comprehensive Valley Fever outreach and awareness campaign will help prevent the spread of the infection and possible deaths caused by the disease.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Salas to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 11: VALLEY FEVER RESEARCH MEMBERS' PROPOSAL

PANELISTS

- **Assemblymember Vince Fong**

Public Comment

PROPOSAL

Assemblymembers Fong, Salas, Fuller and Mathis request $3 million for a research grant within DPH to fund Valley Fever treatment research and outreach at the Valley Fever Institute at Kern Medical Center.

BACKGROUND

The following background was provided by the Members submitting this proposal:

Coccidioidomycosis, commonly known as “Valley Fever,” is a fungus found in the soil of dry, low rainfall areas. Valley Fever is caused by air or soil disturbance of tiny fungi, called Coccidioides, which live and breed within the soil. When the dust containing the spores is breathed in the fungus attacks the respiratory system, causing an infection that can lead to symptoms that resemble a cold, influenza, or pneumonia.

If left untreated or mistreated, infection can spread from the lungs into the bloodstream, causing inflammation to the skin, permanent damage to the lungs and bone tissue, and swelling of the membrane surrounding the brain, leading to meningitis, which can be devastating and even fatal.

Presently there is no cure or vaccine for Valley Fever. Studies show that early intervention ensures the best management of the disease. The most severe cases of Valley Fever stem from delayed diagnosis.

According to the Centers for Disease Control and Prevention (CDC), Valley Fever infection rates rose twelvefold nationwide from 1995 to 2009, and researchers estimate that the fungus infects more than 150,000 people each year who either escape detection of the disease or suffer serious ailments without knowing the cause of their illness.

Cases of Valley Fever have been reported from most counties in California. The California counties with the highest rates of infection include San Luis Obispo, Merced, Fresno, Kern, Madera and Tulare. In 2016 there were 2,310 Valley Fever cases in Kern County alone.

The Members supporting this proposal assert that Valley Fever Institute at Kern Medical is ideally suited to be the premiere center for laboratory research, since it has the largest population of patients with Valley Fever. Patients are referred to the Institute not only locally, but regionally, nationally and internationally. Dr. Royce Johnson, Medical Director for the Institute is a leading infectious disease expert who has dedicated his career to both research and treatment of patients with Valley Fever. Currently there are clinical research trials sponsored by the National Institute of Health taking place at the Valley Fever Institute dedicated to gaining insight into the effectiveness of early treatment with medication.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Fong to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 12: SEXUALLY TRANSMITTED DISEASE PREVENTION ADVOCATES' PROPOSALS

PANELISTS

- **Rand Martin,** AIDS Healthcare Foundation
- **Sylvia Castillo**, Essential Access Health

Public Comment

PROPOSALS

AIDS Healthcare Foundation (AHF) and Essential Access Health (EAH) request $10 million on-going for DPH to expand efforts to reduce the spread of sexually transmitted diseases (STDs).

BACKGROUND

AHF and EAH provided the following background information:

STDs are the most commonly reported communicable disease in California. Exacerbating the problem is the fact that because STDs are often asymptomatic, the burden of the disease is far greater than the number of reported cases.

The prevalence of STDs is correlative to the incidence of HIV. The fact that there continue to be more than 4700 new infections of HIV every year is attributable in part to the fact that the state has been unable to curb the high rates of all STDs. Stakeholders state that the inability of the state to get ahead of this rampant epidemic is due to the lack of consistent and ongoing engagement with at-risk populations.

In the 2016-17 budget, AHF successfully proposed the addition of $5 million to the existing limited budget of the STD Control Branch. These funds allowed the branch to provide state funding assistance to local health jurisdictions (LHJs) with high STD morbidity rates for STD prevention activities. The additional funds were one-time funds and allowed the branch to provide more local if time-limited funding. Stakeholders state that the dollars were stretched very thin and therefore had limited measurable impact on the extraordinarily high STD rates.

According to data from the Department of Public Health, incidence rates of STDs have continued to increase dramatically. Between 2015 and 2016, chlamydia cases grew by 5%, gonorrhea cases grew by 17% and syphilis grew by 19%. In the last five years of complete records through 2016, chlamydia rose by 17%. During the same period, gonorrhea increased by 85%, and primary and secondary syphilis, although with smaller raw numbers, more than doubled.

Many counties have been overwhelmed by double-digit increases in STD rates, including:

- Mendocino County – 81% increase
- Kings County – 41.5% increase
- Los Angeles County – 27% increase
- San Francisco County – 18% increase
- San Diego County – 35.5% increase
- Orange County – 32% increase
- Fresno County – 13% increase

The gonorrhea rate in 2016 for all Californians was 164.3 cases per 100,000 population; in 2015, it was 138.9 cases. More striking is how this disease in particular is impacting young Californians; the rate for females 15-24 was 354.9 per 100,000 population and for all males 15-24 was 393.8 per 100,000; in 2015, it was 336 cases and 349.3 cases, respectively.

The problem is even more acute in communities of color. In 2016, in every age and gender group, the rate of gonorrhea in African Americans exceeded the rate in every other group. Among black females 15-19 the rate was more than 9 times the rate among white females in the same age range. The highest raw numbers were among black males ages 25-29 (2,022.5 per 100,000) and black females ages 20-24 (1,302 per 100,000).

In a 2011 study, DPH looked at HIV co-infection rates for people with STDs based on 2009 data. High rates of HIV co-infection were observed among male primary and secondary syphilis cases (43 percent) and male gonorrhea cases (14 percent). DPH also indicated that by comparing HIV prevalence among STD cases, persons living with HIV who have not been previously reported to the Office of AIDS might be identified. The Centers for Disease Control and Prevention (CDC) has sounded the alarm: "We are currently down to one last effective class of antibiotics" to treat gonorrhea. The CDC is beginning to see signs of resistance to this last class of antibiotic.

Sexually transmitted disease (STD) rates have hit a record high in California for the third year in a row. Nearly half a million Californians were infected with syphilis, Chlamydia or gonorrhea in 2016 – up 40% since 2013. In 2016 alone, gonorrhea rates increased by double digits in the following counties: Los Angeles 27%, San Diego 35.5%, Orange 32%, San Francisco 18%, and Fresno 13%. Mendocino and Kings Counties led the increase at 81% and 41%, respectively. Young people under the age of 30, men who have sex with men (MSM) populations and communities of color are disproportionately impacted. Statewide data indicate over half of all STDs in the state are experienced among California youth ages 15 – 24 years old.

California has the third highest syphilis rates in the nation. While 90% of all male syphilis cases in 2013 were among MSM populations, the epidemic has spread among women. Between 2015 and 2016, the syphilis rate among women of reproductive age

increased by 50%. California ranks 2nd only to Louisiana in primary and secondary syphilis rates.

Approximately $1 billion is spent annually statewide on health costs associated with STDs .

Advocates state that STD prevention is an essential primary care strategy for improving sexual and reproductive health. Despite the costs and health complications related to STDs, and the fact that they are largely preventable, STDs remain a significant public health problem nationwide. The CDC estimates that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24. The cost of STDs to the U.S. health care system is estimated to be as much as $15.9 billion annually.

Untreated STDs can lead to serious long-term health consequences. The CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile. The Human Papilloma Virus (HPV) can lead to increased risk of developing cancer in the cervix, throat, tongue, mouth, and anus. The number of HPV-related cancers in men dramatically increased in 2016. Untreated syphilis can also lead to negative maternal child health outcomes, including infant death. The CDC estimates that of the pregnant women who acquire syphilis up to four years before delivery, 80% will transmit the infection to the fetus and 40% may result in stillbirth or death. STDs also increase both the transmission and acquisition of HIV, particularly among MSM populations.

Advocates explain that, with additional funds, the branch will be able to maintain current levels of funding to continue a more robust public health response to “hot spot” areas with higher incidences of STDs. Building on the existing state assistance infrastructure in the STD Control Branch, the state will be able to enhance direct prevention and control services to high-risk populations using evidence-based interventions and requiring accountability by LHJs.

Unlike the 2016-17 appropriation, which could only be spent on one-time expenses, advocates submit that this ongoing base budget allocation of $10 million needs to be spent on routine expenses that can corral these increasing rates. Advocates note that DPH testified before Assembly Budget Subcommittee #1 last year stating that the real need is to add people on the ground to provide testing, counseling and referral, treatment and partner notification. For example, AHF spends about $1.4 million each year in Los Angeles County for STD testing and referral, but the county can afford to reimburse AHF only about $400,000. The augmentation could be used to assist all of the “hot spot” counties cover the costs of the county and its CBO partners in testing and referral.

In addition, juvenile and adult incarceration facilities are a prime opportunity for STD testing. The challenge, however, especially in juvenile facilities, is that the inmates and wards often pass through the facility very quickly. Without the necessary human resources, the facilities cannot always provide the testing opportunity swiftly enough to

reach the person who is in and out in a matter of days. According to advocates, these funds could be used to augment those testing services. Finally, a third target for funding could be increased resources available for test kits, including rectal and throat testing, as well as medications that can be provided immediately to test subjects and their partners.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests AHF and EAH to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 13: HEPATITIS PREVENTION ADVOCATES' PROPOSALS

PANELISTS

- **Andrew Reynolds,** Hepatitis C Education Manager, Project Inform

Public Comment

PROPOSAL

The California Hepatitis Alliance (CalHEP) requests $6.6 million General Fund in 2018-19 and on an ongoing basis for Hepatitis C (HCV) prevention, testing, linkage to and retention in care projects, and capacity building support services to assist new programs.

This request is an expansion of a $2.2 million demonstration program that was financed in the 2015-16 budget.

BACKGROUND

CalHEP provided the following background information:

There are an estimated 400,737 Californians living with HCV, and most do not know it. According to California Department of Public Health (CDPH), there were 33,748 newly reported cases of chronic HCV infection in 2015. This reflects a 5.5% increase from cases reported in 2011.

Similar to national trends, the rate of HCV infection among people under 30 is increasing rapidly in California. Between 2011 and 2015, rates of newly reported HCV increased 37% among females 20-29 years of age. During that same period of time, rates of newly reported HCV increased 55% among males 20-29 years of age, and 40% among males 15-19 years of age. This is believed to be related to the rapid increases in opioid use and injection of heroin and other drugs.

HCV is a major cause of hospitalizations in California. CDPH noted in a 2013 presentation that to reduce hepatitis-related hospitalizations and associated costs, earlier identification and treatment of people living with HCV is needed. As with the rest of the country, African American and Native American communities in California suffer disproportionately high rates of HCV, as do “Baby Boomers” (people born between 1945 through 1965). While HCV impacts the entire state, there have been disproportionate increases in reported cases coming from rural counties in recent years.

CalHEP states that, "We now have an unprecedented chance to eliminate the virus." Treatments are available that provide cure rates of over 95 percent, without debilitating side effects. These newer treatments, known as direct-acting antivirals, eliminate the virus from the body, stopping the virus’ attack on the liver and preventing the patient

from infecting others. For most people living with the virus, HCV can be cured in 8-12 weeks.

While some of these treatments made national headlines for their initial $1,000-a-pill prices, increased competition from new treatment options entering the market over the last four years has decreased the cost of a cure dramatically. In the Medi-Cal system, most people living with HCV can be cured with an 8-week regimen costing approximately $20,000.

CalHEP explains that, "Cured means everything for the patient and their family—reduced risk of liver cancer and liver disease, greater life expectancy, a return of energy and vitality. Cured also protects our community. Once cured, a person cannot spread the disease to other persons. Good access to testing and linkage to treatment is key to good prevention and stopping the spread of HCV in California."

In March 2017, the National Academies of Sciences, Engineering, and Medicine released “A National Strategy for the Elimination of Hepatitis B and C,” which provides a roadmap for achieving HCV elimination in the United States. Despite this roadmap, no new resources have been provided at the federal level for addressing HCV.

Demonstration Projects

The 2015 Budget Act includes $2.2 million a year for three years for HCV testing and linkage to care demonstration projects. CalHEP states that the outcomes of this pilot were excellent, and worth expanding. This funding allowed the CDPH STD Control Branch Office of Viral Hepatitis to support efforts related to three goals:

1. Using surveillance to improve HCV outcomes: Increase the proportion of clients with a reactive HCV antibody test (screening test) that receive follow-up HCV viral load testing (diagnostic test) and appropriate clinical management;

2. Hepatitis C testing and linkages to care: Increase local health jurisdiction and community-based organization capacity for and delivery of HCV screening, testing, and linkages to care services to vulnerable and underserved clients at high risk for HCV; and,

3. HCV care coordination: Increase community health center, federally qualified health center, rural health clinic, and other primary care provider capacity for and delivery of HCV clinical management and acceptance of hepatitis C care referrals.

Five organizations were selected for funding:

- Access Support Network of San Luis Obispo and Monterey Counties (Goal 2)
- Butte County Public Health Department (Goal 1)
- Family Health Centers of San Diego (FHCSD) (Goals 2 & 3)
- San Francisco Department of Public Health (SFDPH) (Goals 2 & 3)

- St. John's Well Child & Family Center – serving the Central and Southern Los Angeles area and Compton (Goal 3)

Programs in Counties of Butte, Los Angeles, Monterey, San Diego, San Francisco, San Luis Obispo to identify high-risk, high-need patients to screen for hepatitis C, and to ensure diagnosis and cure.
March 1, 2016 – December 31, 2017

	All	Known high-risk for transmission to others*	% Known high-risk
Total Screened	33897	3596	11%
Antibody Positive	2564	1447	56%
Total Tested for RNA	2854	1136	40%
RNA Positive (i.e., diagnosed with HCV)	1800	851	47%
Linked to Care/Receiving Clinical Care Management**	764	555	73%
Completed Treatment***	424	273	64%
Received SVR Testing and Achieved SVR****	273	179	66%

*Known high-risk: Persons who inject drugs and if they are HCV positive are likely to put other persons at risk of infection.

**Linked to Care/Receiving Clinical Care Management: Linked to care is defined as attending first HCV medical appointment for Goal 2 sites and as starting treatment for Goal 3 sites.

***Completed Treatment: This number is an underestimate, as Goal 2 sites do not currently report this data to CDPH

****Received SVR Testing and Achieved SVR: SVR is "sustained virologic response" and "achieved SVR" is synonymous with being cured. This is an underestimate, as Goal 2 sites do not report this data to CDPH. The number of clients that achieved SVR is also likely higher as Goal 3 sites report that clients complete medication but are not allowed to receive information to confirm achieved SVR.

The Grantees:

St. John's Well Child & Family Center: St. John's provides health care to low-income individuals in Los Angeles County. With the demonstration project funds, St. John's instituted HCV testing in its 15 clinics, as well as at Tarzana Treatment Centers (a drug treatment facility serving the San Fernando Valley, Lancaster, and Long Beach) and Community Health Project Los Angeles (a syringe exchange program serving Skid Row, Watts, Hollywood and other neighborhoods in Los Angeles). St. John's tested 15,000 people and successfully treated over 120 people. Prior to the demonstration project funds, Tarzana had no resources to provide HCV testing. With the funds, Tarzana has been able to test approximately 1000 people who inject drugs since January 2017. Community Health Project LA has been able to increase its HCV testing and provide outreach in shelters and on the street to link people who test positive for HCV to St. John's mobile clinic.

Access Support Network (ASN), Monterey & San Luis Obispo: ASN, which serves rural counties along the central coast, increased its capacity to provide HCV testing services, including contracting with a phlebotomist in order to provide confirmatory testing and diagnosis onsite, and to engage in outreach to find people who have tested positive and bring them into care, including engaging some people who had been out of primary care for a decade or longer. Additionally, ASN linked people at-risk for and living with HCV to drug treatment and housing services.

Butte County Public Health Department (BCPHD): Starting March 2016, BCPHD communicable disease investigators looked at data to identify any clients with a HCV antibody positive result who did not have confirmatory testing. BCPHD then monitored newly reported cases of HCV to identify any clients who had a positive HCV antibody result without HCV confirmatory test reported within 30 days. BCPHD was able to facilitate all three major hospitals changing their testing policy to reflex confirmatory testing by January 2017. From March-June 2016 to April-June 2017, BCPHD went from having 74 clients who did not receive proper follow-up testing after a reactive antibody test to having 0 clients who did not receive the proper follow up.

City & County of San Francisco Department of Public Health (SFDPH): SFDPH educated clinicians within the San Francisco Health Network, clinics serving primarily low-income and vulnerable residents. Data from a program evaluation shows that between October 2014-September 2015 and October 2015-September 2016, the number of patients treated for HCV increased 123%, from 94 to 210. In addition, data from the same time-periods shows that the number of primary care providers treating HCV went from 42 to 77, an increase of 83%. Since October 1, 2014, the Network has been able to treat 389 people for HCV and reach individuals from disproportionately impacted communities (e.g., 32% of those treated identified as African American).

Family Health Centers of San Diego: FHCSD trained clinic providers and staff about HCV testing and linkage to care. Prior to receiving these funds, FHCSD did a small amount of HCV testing and had limited capacity to treat people. Since having the funds, testing has increased and their capacity to treat HCV has increased. FHCD has been able to support a health insurance enrollment specialist who helps people get into care when they come out of jail and many of these people are at risk for or living with HCV.

CalHEP states that the initial investment in these services by the Legislature has shown the great need for and success of HCV prevention, testing, and linkage to care projects, as well as the need for these services to continue and to expand into new regions of the state with funding and capacity building support. Therefore, CalHEP requests and recommends on-going funding to reduce the burden of HCV in high-risk communities, including urban, suburban, and rural settings, and that the program be streamlined to allow for CDPH to allocate according to identified need without the extra cost burdens associated with a competitive grants program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Andrew Reynolds to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 14: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE AND PROGRAM UPDATES

PANELISTS

- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ADAP ESTIMATE

The November 2017 ADAP Estimate provides a revised projection of Current Year (2017-18) local assistance costs for the medication and health insurance programs for ADAP, along with projected local assistance costs for the Budget Year (2018-19).

- For FY 2017-18, CDPH estimates that ADAP expenditures will be $398.1 million, which is a $2.4 million increase compared to the 2017 Budget Act. The increase in expenditures is mainly due to growth in caseload and continuing increases in medication prices.

- For FY 2018-19, CDPH estimates that ADAP expenditures will be $434.4 million, which is a $38.7 million (9.8%) increase compared to the 2017 Budget Act. DPH states that the overall number of clients receiving ADAP services will continue to increase each year at rates similar to pre-ACA implementation due to persons becoming newly infected with HIV. Additionally, medication prices increase annually.

California Department of Public Health
AIDS Drug Assistance Program
2017 November Estimate
Table 1: Local Assistance
(dollars in millions)

Local Assistance	2017 Budget Act	Current Year FY 2017-18			2017 Budget Act	Budget Year FY 2018-19		
		2017 November Estimate	$ Change from 2017 Budget Act	% Change from 2017 Budget Act		2017 November Estimate	$ Change from 2017 Budget Act	% Change from 2017 Budget Act
Fund:								
Total Funds Requested	$395.7	$398.1	$2.4	0.6%	$395.7	$434.4	$38.7	9.8%
Federal Funds - Fund 0890	$111.4	$111.4	$0.0	0.0%	$111.4	$132.4	$21.0	18.9%
Rebate Funds - Fund 3080	$284.3	$286.7	$2.4	0.9%	$284.3	$302.0	$17.7	6.2%
Caseload	32,003	29,896	-2,107	-6.6%	32,003	32,438	435	1.4%

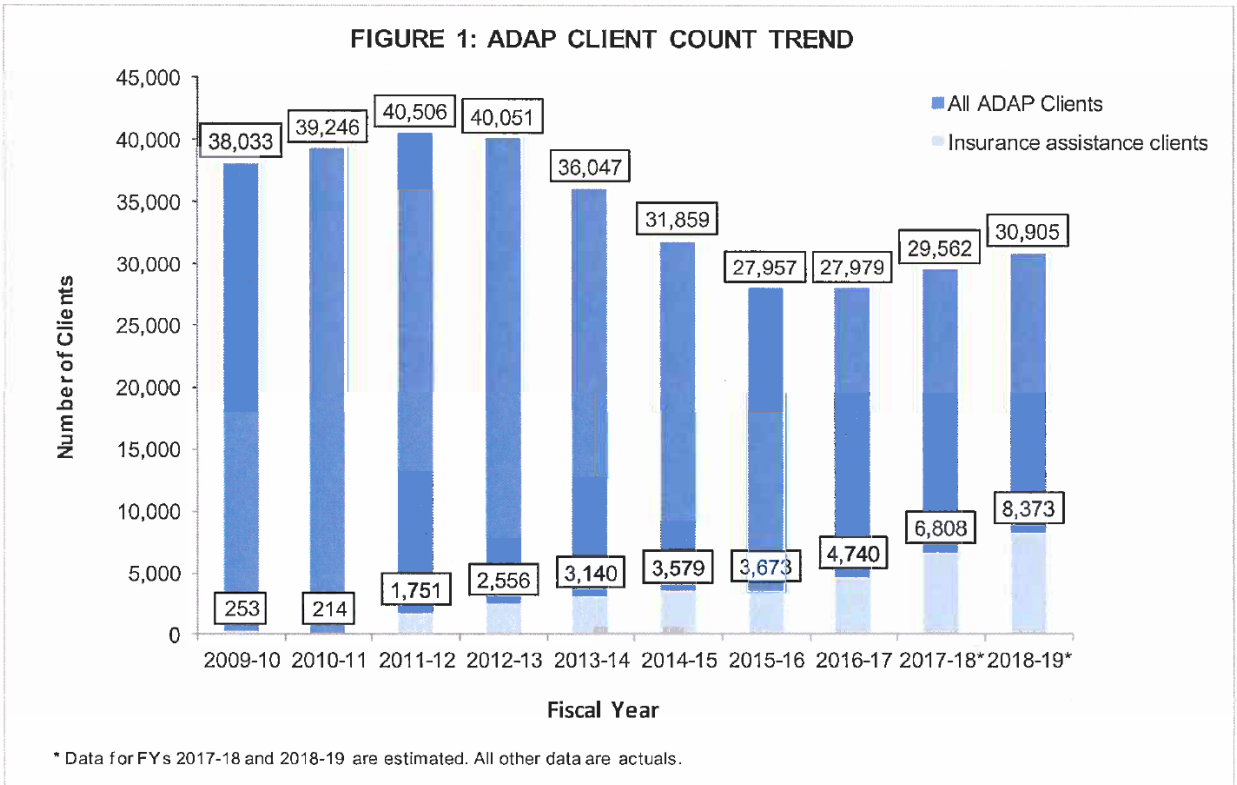
[1]Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

Caseload

As described above, the OA states that the overall number of clients receiving ADAP services will continue to increase each year at rates similar to pre-ACA implementation due to persons becoming newly infected with HIV.

	2017 Budget Act	2017-18 Estimate	2018-19 Proposed	CY Act to BY # Change	CY Act to BY % Change
Caseload	32,003	29,896	32,438	2,542	8.5%

Figure 1 (below) is a summary of total client counts in ADAP, excluding PrEP clients, by FY; the number of ADAP medication program clients who are also receiving insurance assistance is also shown. In 2014, the state began implementing the ACA which explains the significant decrease in caseload that begins that year, reflecting the large number of former ADAP-clients who gained comprehensive coverage primarily through the ACA Medi-Cal expansion.



BACKGROUND

ADAP provides access to life-saving medications for eligible California residents living with HIV, and assistance with covering costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV. ADAP services, including support for medications, health insurance premiums, and medical out-of-pocket costs, are provided to five groups of clients:

1. **Medication-only clients** are people living with HIV (PLWH) who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals. This group only receives services associated with medication costs.

2. **Medi-Cal share of cost (SOC) clients** are PLWH enrolled in Medi-Cal who have a SOC for Medi-Cal services. ADAP covers the SOC for medications for these clients. This group only receives services associated with medication costs.

3. **Private insurance clients** are PLWH who have some form of health insurance, including insurance purchased through Covered California, privately purchased health insurance, or employer-based health insurance; therefore, this group is sub-divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive services associated with medication costs, health insurance premiums, and medical out-of-pocket costs.

4. **Medicare Part D clients** are PLWH who are enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group receives services associated with medication co-insurance and Medicare Part D health insurance premiums. As of July 1, 2017, qualifying Medicare Part D clients have the option for premium assistance with Medicare Part B medical insurance and Medi-gap policies, which cover their medical out-of-pocket costs.

5. **PrEP clients** are individuals who are at risk for, but not infected with HIV, and have chosen to take PrEP as a way to prevent infection. This group receives services associated with medication costs and medical out-of-pocket costs.

ADAP collects full rebate for prescriptions purchased for all client types listed above except Medi-Cal SOC and PrEP clients. As the primary payer, Medi-Cal has the right to claim federal mandatory rebate on prescriptions for Medi-Cal SOC clients. In order to ensure duplicate rebate claims are not submitted to manufacturers by both programs, which is prohibited, ADAP does not invoice for rebates on these claims.

Historically, the majority of clients ADAP served were ADAP-only clients without health insurance, because PLWH were unable to purchase affordable health insurance in the private marketplace. However, with the implementation of the ACA, more ADAP clients have been able to access public and private health insurance coverage. ADAP clients are screened for Medi-Cal eligibility, and potentially eligible clients must apply. Clients who enroll in full-scope Medi-Cal are dis-enrolled from ADAP, because these clients have no SOC, drug co-pays, or deductibles, and no premiums. All clients who obtain health coverage through Covered California or other health plans can remain in ADAP's medication program to receive assistance with their drug deductibles and co-pays for medications on the ADAP formulary. Eligible clients with health insurance can co-enroll in ADAP's health insurance assistance programs for assistance with their insurance premiums. Assisting clients with purchasing health insurance is more cost effective than paying the full cost of medications. In addition, assisting clients with purchasing and maintaining health insurance coverage improves the overall health of Californians living with HIV because clients have comprehensive health insurance and access to the full spectrum of medical care, rather than only HIV outpatient care and medications through the Ryan White (RW) system.

ADAP Operational Contracts

The ADAP program experienced significant operational problems over the past approximately 1-2 years, a direct result of a new contract with a new vendor (AJ Boggs) that began in July of 2016 for enrollment services. Prior to July 2016, the ADAP program had a contract with Ramsel, a vendor that managed both enrollment and pharmacy benefits for ADAP for many years. When the contract with Ramsel came up for renewal, DPH issued an RFP, as usual, which resulted in not renewing the contract with Ramsel, and instead DPH signed three separate contracts with three new, separate vendors: 1) AJ Boggs for enrollment; 2) Magellan for pharmacy benefits; and 3) Pool Administrators, Inc. that handles a new contracted function involving processing of all out-of-pocket cost payments, thereby protecting consumers from having to pay out of pocket costs, to be reimbursed later.

CDPH explains that they had two goals in splitting one contract into three: 1) to reduce costs; and 2) to enhance consumer services and increase quality of the program. The goal of reducing costs was the focus of the pharmacy benefits contract while the second goal, to improve the program, was primarily the goal associated with the enrollment benefits contract. DPH explains that while there were no problems with the enrollment system and services provided by Ramsel, the Ramsel system had limits to its functionality, and their RFP did not offer the kinds of program improvements that DPH was looking for, and that were included in the AJ Boggs' proposal.

Legislative staff began hearing complaints from key HIV/AIDS advocates in the fall of 2016 about significant disruptions and problems for ADAP clients in the form of delays in accessing medication, insurance policies being cancelled, difficulty for clients to access reimbursements for medical expenses, and eventually the enrollment website going off-line due to security concerns. For several months, the OA attempted to address these problems, working with AJ Boggs and advocates. These efforts finally culminated in early March 2017 with the termination of the contract with AJ Boggs, effective March 31, 2017.

In light of ending the contract for enrollment services, DPH has taken steps to bring this function in-house, as is discussed in more detail in the next issue in this agenda.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the ADAP estimate and respond to the following:

Please present the "Laying a Foundation for Getting to Zero Plan."

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 15: ADAP ELIGIBILITY AND ENROLLMENT BUDGET CHANGE PROPOSAL

PANELISTS

- **Karen Mark, MD, PhD**, Chief, Office of AIDS, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSALS

CDPH requests $250,000 in AIDS Drug Assistance Program (ADAP) Rebate Fund expenditure authority to support two (2) administratively established positions for Fiscal Year (FY) 2017-18 and $2.7 million in ADAP Rebate Fund expenditure authority and 15 permanent positions for FY 2018-19 and ongoing, to manage the increased workload involved in transitioning ADAP eligibility and enrollment services to the CDPH Office of AIDS (OA).

BACKGROUND

The CDPH OA ADAP pays for life-saving prescription drug medications, insurance premiums, and medical out-of-pocket costs for eligible individuals living with HIV. Since 1997, CDPH OA has contracted with a Pharmacy Benefits Manager (PBM) to manage a network of pharmacies throughout California to provide prescription services for ADAP clients for drugs on the ADAP formulary. Prior to July 1, 2016, ADAP's PBM contract was limited to pharmaceutical and enrollment services for clients in the ADAP medication program. With the implementation of the Affordable Care Act and the resulting requirement that health insurers not deny coverage due to a pre-existing health condition like HIV, more ADAP clients are able to purchase private health insurance. The rapid growth of ADAP's insurance assistance programs as a result of the Affordable Care Act exceeded the operational capacity of ADAP's existing infrastructure, which had, thus far, relied largely on manual processes performed by CDPH staff. Integrated data on utilization of both the medication program and the insurance programs was needed to ensure ongoing client access to services, program management, and the development of accurate budget estimates.

In April 2016, ADAP re-procured its PBM and Enrollment Benefits Manager (EBM) vendors under two separate contracts. The new EBM, which was expected to support a fully-functional enrollment benefits system, did not meet the required contract deliverables. As a result, the EBM contract was terminated, effective March 31, 2017. To ensure no disruption in services and medications to the state's approximate 29,000 ADAP clients, CDPH quickly developed and assumed eligibility and enrollment services, effective March 6, 2017 to the present. These efforts include, but are not limited to, ensuring client access to life-saving medication and health care, navigating clients through the ADAP eligibility process, ensuring enrollment documents are completed

timely, and answering questions for clients and approximately 600 enrollment workers throughout California.

In anticipation of terminating the EBM contract and bringing enrollment services in-house, CDPH, in consultation with the California Department of Technology, began the development of an emergency replacement enrollment system, designed by an outside contractor but owned by CDPH. Due to the urgent nature of this change, the system was designed as a basic, interim and scalable solution that could be leveraged in the future based on further evaluation. CDPH also established an ADAP Call Center, Data Processing, and Eligibility Section in order to conduct eligibility and enrollment services in-house, a required component of the terminated EBM contract. To staff these functions, CDPH temporarily redirected 21 staff from throughout the Department.

CDPH explains that bringing these functions in-house provided immediate access to knowledgeable CDPH staff for both clients and enrollment workers, and optimized customer service. The effect of redirecting staff from throughout CDPH to ADAP had significant impact on other areas of CDPH. Completion of important tasks were delayed, including conducting criminal background reviews of certified nurse assistants and home health aide applicants and certificate holders, and processing Center for Health Care Quality adverse actions, personnel related activities, including hiring, resolving unpaid bills for generally licensed devices in the Radiologic Health Program, contract execution, completion of various infectious disease reports, processing of Wild Animal Importation and Permitting, processing Export Certificate requests from industry among other things.

Due to the impact, this redirection could only be sustained for a short period, and staff returned to their respective areas June 30, 2017. Eleven (11) temporary staff positions for eligibility and enrollment work have been established and recruited, with ongoing increased daily hours worked by OA staff and supervisors to cover until approval of the permanent positions.

Procuring specialized expertise for insurance assistance programs, including payment of the medical out-of-pocket cost and the execution and management of electronic payment for insurance premiums, and insourcing eligibility and enrollment activities increased the workload for two OA Branches, the ADAP Branch and the Surveillance, Research and Evaluation Branch, including shifting tasks previously performed by a contractor to existing OA staff. OA staff also have to provide oversight for information transfers between vendors, as well as, ongoing monthly matches with external databases (e.g.. Franchise Tax Board income data) to validate eligibility. These data management activities are currently performed by OA staff and occur independently of the IT system used for eligibility and enrollment.

CDPH has worked to assess the ongoing needs and long-term direction of this project and concluded that CDPH would best serve client and enrollment worker needs and ensure excellent customer service by permanently bringing ADAP eligibility and enrollment services in-house. This proposal addresses the ongoing staffing needs related to enrollment, eligibility, and data integrity/oversight. Concurrently, and in

consultation with the California Department of Technology, CDPH continues to evaluate long-term options for the enrollment benefits system in the Project Approval Lifecycle (PAL) Stage 2 Alternatives Analysis, and will adopt that which best meets the needs of system users and clients. For this, CDPH's Information Technology Services Division (ITSD) is working with OA to implement the PAL process.

Once an option is identified and selected in the PAL Stage 2 Alternatives Analysis, CDPH will follow the PAL process to obtain a permanent enrollment benefits system. Any resource needs for development, implementation, and maintenance of the long-term IT solution will be funded by the ADAP Rebate Fund, and will be evaluated through the normal budget development process.

The transition from the previous model (one vendor who provided pharmacy benefits management and eligibility services for the ADAP medication program, with in-house management of insurance benefits) to the multi-component integrated model comprised of two separate vendors and in-house ADAP eligibility and enrollment services has increased the capacity needed by the ADAP program to implement ADAP service enhancements. All of the requested staffing is needed regardless of the decision made through the PAL process regarding the IT system.

CDPH explains that the combination of the new multi-component integrated model, data sensitivity, and the increased complexity and volume of insurance benefits transactions that need to be processed, require stringent oversight, increased communication to ensure the continuous coordination of these components, increased programmatic project management due to the scaling up of the services offered to individuals enrolled in ADAP's insurance assistance programs, and increased data management, data analysis, and reporting activities.

The ADAP Call and Data Processing Center's primary function is to receive incoming calls from clients and enrollment workers to ensure that life-saving medications and services are provided for ADAP clients timely. The services the Call and Data Processing Center provide are critical to ensure clients' medication and health care remain uninterrupted. The ADAP Call Center, Data Processing, and Eligibility Section is often the first point of contact for 29,000 ADAP clients and approximately 501 ADAP Enrollment Workers.

Insourcing ADAP Call Center functions entails providing technical assistance and a high degree of customer service. Additionally, the data processing center has absorbed mailing, incoming faxes and data entry functions that used to be managed by the EBM. Further, the data processing center is responsible for entering the documentation of medical, dental, and vision health plan information for clients co-enrolled in ADAP's insurance assistance programs.

Internal OA management are currently redirected to support the increased workload associated with insourcing eligibility and enrollment functions, and the implementation of enhanced ADAP services. The Care Research and Evaluation Section Chief currently spends the majority of her time on the new system, including project management and

oversight, data management oversight, and communications with stakeholders. Additionally, the Surveillance, Research, and Evaluation Branch Chief and Assistant Chief, spend the majority of their time on the new system. CDPH states that the redirection of management resources may put California at risk of audit findings related to federal funding long-term.

Absorbing the new workload related to insourcing the ADAP Enrollment System and redirecting management to these activities is not sustainable long-term. Therefore, to ensure the ADAP Enrollment System meets client needs and this workload can be fully supported, CDPH requests to permanently oversee all ADAP data-related activities, including all ADAP Enrollment System oversight, system requirements development, data management, analysis, and fiscal forecasting. To support this work, CDPH requests $691,000 for a contractor specializing in informatics to provide the necessary expertise to implement required data management and data transfer activities, since there are no comparable state classifications with similar duties. An informatics contractor is also needed to ensure data meets quality standards, problems can be quickly investigated, and that data meets the full spectrum of operational, quality monitoring, and evaluation needs. These contract resources are necessary to develop queries and algorithms to implement and ensure efficient processing, linkage, and management of ADAP insurance, medical, and pharmacy claim transactions; and external data (e.g., from the Franchise Tax Board).

The contractor also will monitor almost 1,000 data transfers and matches monthly between OA, vendors, and other state agencies, to ensure that clients have uninterrupted access to medication and insurance, and that program eligibility requirements are consistently applied. The contractor will identify, troubleshoot, and respond to transfer errors and assist in the development and testing of new file transfer formats, as needed (e.g., changes to ADAP program designs or one or more data systems change).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 16: HIV/AIDS PREVENTION ADVOCATES' (CA HIV ALLIANCE) PROPOSALS

PANELISTS

- **Anne Donnelly**, Director of Health Care Policy, Project Inform
- **Craig Pulsipher, MPP, MSW,** State Affairs Specialist, Government Affairs, APLA Health

Public Comment

PROPOSALS

The California HIV Alliance (Alliance) requests the following:

1. $10 Million General Fund Annually – Support Comprehensive HIV Prevention Services Including PrEP and PEP;

2. $2 Million General Fund Over 3 Years – Support Demonstration Projects to Address Economic Empowerment and Linkage to HIV Care and Prevention Services for Transgender Women;

3. $3 Million General Fund Over 3 Years – Support Demonstration Projects to Address the Health and Psychosocial Needs of Older Adults Living with HIV;

4. $1 Million General Fund Annually – Support Public Health Detailing to Educate Medical Providers about HIV and STD Prevention;

5. ADAP Rebate Fund – Modify PrEP Assistance Program to Provide More Comprehensive Coverage for PrEP and PEP.

BACKGROUND

The Alliance provided the following background information on these five proposals.

Proposal #1:
$10 Million General Fund Annually – Support Comprehensive HIV Prevention Services Including PrEP and PEP
Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are highly effective HIV prevention strategies in which HIV-negative individuals take antiretroviral medications to reduce their risk of acquiring HIV. Increasing uptake of these interventions is a key goal of California's Laying a Foundation for Getting to Zero plan, which aims to have 60,000 Californians at high risk for HIV infection on PrEP by December 2021. However, estimates suggest that only 9,000 individuals were taking PrEP in 2016. The California HIV/AIDS Research Program recently analyzed PrEP use among Medi-Cal enrollees and identified troubling disparities. Uptake was significantly lower among Blacks, Hispanics, women and people between the ages of 13-24.

Although some local health jurisdictions have implemented programs to increase uptake of PrEP and PEP, most parts of the state lack sufficient resources to reach even a fraction of those who could benefit from these interventions. The CDC is currently funding several local health jurisdictions to promote PrEP implementation (i.e., San Diego, Orange, Alameda, Los Angeles and San Francisco Counties, as well as Desert AIDS Project in Riverside County), but these awards expire at the end of the year. The California Department of Public Health (CDPH) Office of AIDS (OA) is also funding nine community-based organizations to provide PrEP navigation, but the roughly $2 million General Fund allocated for these projects is not nearly enough to meet statewide demand.

CDPH OA recently contracted with the California Prevention Training Center to conduct an assessment of PrEP implementation in the state and identified major gaps in funding for PrEP-related services. According to the report, "Very few organizations participating in this assessment had funding specific to their PrEP programs. Most described trying to add PrEP education and outreach activities onto existing HIV or STD projects, utilizing existing staff and incorporating PrEP into existing activities. While this worked well in some circumstances…many interviewees explicitly noted that they wished to expand PrEP-specific education, outreach, and navigation but were limited in their ability to do so given lack of direct PrEP funding."

The Alliance states that PrEP and PEP are cost-effective interventions with the potential to dramatically reduce new HIV infections. A recent modelling study showed that, even absent of any other strategies, PrEP use by 25 percent of gay and bisexual men would prevent 30.7 percent of HIV infections in the United States. Therefore, the Alliance urges the state to allocate $10 million General Fund annually to provide grants across the state to support comprehensive HIV prevention services including PrEP and PEP. This includes funding for PrEP and PEP outreach and navigation, HIV testing for high-risk populations (including staff costs and test kits) and related prevention services. Because the specific needs of local health jurisdictions vary widely, the Request for Proposals should allow applicants to identify the range of HIV prevention services needed in their individual communities. Special attention should be given to applicants serving key populations in resource-limited areas. Applicants may include individual health departments and community-based organizations as well as collaborations between multiple community-based organizations and/or health departments.

Proposal #2:
$2 Million General Fund Over 3 Years – Support Demonstration Projects to Address Economic Empowerment and Linkage to HIV Care and Prevention Services for Transgender Women

In the United States, approximately 22 percent of transgender women are living with HIV and transgender women of color—particularly African Americans—are disproportionately impacted. According to the CDC, certain risk factors directly tied to transphobia and the marginalization of transgender individuals contribute to such high infection rates. These risk factors include commercial sex work, mental health and substance use issues, incarceration, homelessness and unemployment. Transgender

individuals also face stigma and discrimination that prevent them from fully participating in society including accessing healthcare, education, employment and housing.

Transgender individuals, particularly transgender women, who have been discriminated against in employment are more likely to engage in survival sex work, which may put them at greater risk for contracting HIV and other STDs. The National Transgender Discrimination Survey examined the experiences of over 6,400 transgender adults across the United States and found that transgender people experience high levels of discrimination in the workplace. Nearly 70 percent of transgender sex workers reported experiencing an adverse job outcome in the traditional workforce, such as being denied a job or promotion or being fired because of their gender identity or expression.

Some community-based organizations have developed employment programs for transgender individuals, but these programs are predominately located in large urban centers and funding is extremely limited. The Los Angeles LGBT Center's Transgender Economic Empowerment Project, for example, offers a wide range of services to help transgender people find employment including legal name and gender change assistance, career development support, resume preparation and leads on jobs with trans-welcoming employers. These programs also provide linkage to HIV care and prevention services including HIV testing, PrEP and PEP, treatment and other support services. In April 2017, a statewide group of experts convened by the California HIV/AIDS Policy Research Centers recommended that economic empowerment programs be expanded to address the disproportionate impact of HIV among transgender individuals.

These demonstration projects should include assessing client needs and potential barriers to employment, client-centered career development trainings, referrals to inclusive and affirming employers and culturally competent referrals to HIV care and prevention services. Applicants may include individual health departments and community-based organizations as well as collaborations between multiple community-based organizations and/or health departments.

Proposal #3:
$3 Million General Fund Over 3 Years – Support Demonstration Projects to Address the Health and Psychosocial Needs of Older Adults Living with HIV
It is estimated that by 2020, more than half of the 1.2 million people living with HIV in the United States will be over the age of 50. In large cities like Los Angeles and San Francisco, where the majority of HIV cases have occurred, this number is closer to 60 percent.

Research and evidence from clinical practice suggest that people aging with HIV face a set of clinical and psychosocial issues that distinguish them from younger people living with HIV and from the general population of aging individuals. HIV itself, through the inflammation it produces, appears to speed the aging process. Older people living with HIV also experience increased cardiovascular disease, liver and kidney disease, HIV and non-HIV related cancers, decreased bone density and frailty, cognitive issues and dementia. On the psychosocial side, many older people living with HIV, particularly

those who have experienced profound loss of loved ones in the course of the epidemic, deal with issues of isolation and depression. Many older people living with HIV are experiencing significant financial and housing challenges due to their long-term disability.

The Alliance explains that HIV service providers in California are beginning to develop services to address these unique needs, but there are too few programs, and those that exist are inadequately funded. Only one program, the Golden Compass program at UCSF/San Francisco General Hospital Ward 86, currently addresses HIV and aging comprehensively, but its long-term funding is in doubt. Golden Compass addresses four major areas: cardiovascular health, frailty, cognitive issues and psychosocial issues. A valuable model for other providers throughout California, it is important to further develop, sustain and evaluate this program and others like it.

The Alliance urges the state to allocate $3 million General Fund over 3 years to establish demonstration projects across the state that address the health and psychosocial needs of people living with HIV over the age of 50. Ideally the demonstration projects will serve both rural and urban jurisdictions as well as diverse groups of clients. Applicants may include individual health departments and community-based organizations as well as collaborations between multiple community-based organizations and/or health departments. The demonstration projects should include an evaluation component and a plan for disseminating lessons learned in order to strengthen ongoing programs. The proposals should be evaluated based on multiple factors including need in the area, population served, competency of the entity applying, project design and evaluation design. CDPH OA should oversee the demonstration projects in consultation with the Department of Aging.

Proposal #4:
$1 Million General Fund Annually – Support Public Health Detailing to Educate Medical Providers about HIV and STD Prevention

Because the vast majority of individuals at risk of HIV and STD infection will receive health care from primary care providers (PCPs), it is critical to train and engage this large clinical workforce in HIV and STD prevention efforts. The benefits of screening for HIV and STDs during routine medical visits have been endorsed by the CDC, which now recommends opt-out screenings for HIV in all health-care settings. In 2007, California passed legislation to eliminate the requirement for written consent for an HIV test when ordered by a medical care provider. As of January 1, 2014, California also requires that an opt-out HIV test be offered whenever blood is drawn at a primary care visit. Nevertheless, studies suggest that HIV and STD testing have yet to become a routine part of medical care as recommended by the CDC.

The benefits of PrEP and PEP for individuals at risk of HIV infection have also been well documented, yet awareness and utilization of these interventions among PCPs remain limited. Despite comprehensive PrEP clinical practice guidelines from the CDC in 2014, national surveys of PCPs suggest that only about 7 percent of these clinicians have ever prescribed PrEP. California passed legislation in 2016 requiring providers to educate high-risk patients about PrEP and PEP following an HIV test, but evidence

suggests implementation of this law has been limited. In addition, California will launch a PrEP financial assistance program in 2018 and many providers are still unaware of this critical resource for patients. To accelerate awareness and use of PrEP and PEP by PCPs, some public health departments have launched innovative educational outreach programs known as academic detailing, which entail PrEP and PEP experts conducting focused, 1-on-1, interactive educational visits with PCPs at their practice sites to educate them and help them develop solutions to perceived barriers to PrEP and PEP provision. In New York City, a public health detailing initiative for PrEP was associated with an increase in first-time prescribing of PrEP by PCPs, suggesting that dissemination of this strategy could help expand the number of PrEP prescribing PCPs. The Los Angeles County Department of Public Health developed a public health detailing initiative in 2017 and successfully educated nearly 1,000 medical providers and over 600 staff about PrEP and PEP.

The Alliance urges the state to allocate $1 million General Fund annually to provide grants to local health departments, technical assistance organizations, and/or community-based organizations across the state to develop public health detailing initiatives for HIV and STD prevention at the city, county or regional level. Applicants may include individual health departments and community-based organizations as well as collaborations between multiple community-based organizations and/or health departments. Available data should be used to identify PCPs who serve populations most at risk of HIV and STD infection and would be most likely to benefit from these initiatives. This funding also could be used to provide capacity building assistance to grantees and develop user-friendly educational resources and decision-support tools for medical providers and their staffs.

Proposal #5:

ADAP Rebate Fund – Modify PrEP Assistance Program to Provide More Comprehensive Coverage for PrEP and PEP

In the 2016 Budget Act, CDPH OA received statutory and budgetary authority to develop a statewide PrEP Assistance Program (PrEP-AP) for individuals with annual incomes below 500 percent of the Federal Poverty Level. For individuals with health insurance, the program will cover PrEP-related medical copays, coinsurance, deductibles, and drug costs not covered by the individual's health insurance plan or manufacturer's copay assistance program. For uninsured individuals, the program will cover PrEP-related medical costs only. The program is expected to be implemented in 2018. Currently the program is limited to individuals 18 years old and above, does not provide financial assistance for post-exposure prophylaxis (PEP) and is not authorized to provide health insurance premium support. The program is also not authorized to cover the full cost of PrEP and PEP medications under any circumstances. These limitations prevent the program from providing adequate safety-net coverage for PrEP and PEP to those who qualify.

The Alliance proposes the following changes to the PrEP-AP:

- Change program eligibility to include all residents of California who are at least 12 years of age. The PrEP-AP is currently only authorized to serve clients who are at least 18 years old. These eligibility guidelines are inconsistent with California's minor consent laws, which allow minors 12 and older to consent to medical care related to the prevention and treatment of HIV. Moreover, youth under 24 years old accounted for 1 in 5 of all new HIV infections in California in 2015. The Alliance states that, in order to address the disproportionate impact of HIV among youth, it is critical to change the eligibility guidelines of the PrEP-AP to include clients 12 years old and above.

- Authorize program to provide financial assistance for PEP. PEP is currently covered by Medi-Cal, Medicare and most major health insurance plans in California. Pharmaceutical manufacturers also have patient assistance programs which provide free medication to uninsured individuals. However, these programs do not cover costs associated with doctors' visits, HIV testing and related medical expenses. In order to increase uptake of PEP, The Alliance proposes that the PrEP-AP be explicitly authorized to provide the same financial assistance for both PrEP and PEP.

- Authorize program to cover the full cost of PrEP and PEP medications for uninsured individuals under 18 years old. Although PrEP can be prescribed to individuals less than 18 years old, it is currently considered "off label" because Truvada® has only been approved by the FDA for adults 18 and older. Gilead recently submitted a supplemental new drug application (sNDA) for PrEP in adolescents based on data from the Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN) and a decision is expected soon. However, until the sNDA is approved, uninsured individuals less than 18 years old are prohibited from using Gilead's patient assistance program. The Alliance proposes that California's PrEP-AP cover the full cost of PrEP and PEP medication for uninsured individuals under 18 years old until they can use Gilead's patient assistance program.

- Authorize program to provide health insurance premium support. Increasing health insurance premiums impact the ability of individuals to access and adhere to PrEP and PEP. Covered California premiums increased by an average of 12.5 percent in 2018 and increases could be even greater in coming years given recent actions by the Trump administration. Washington State's PrEP assistance program already covers health insurance premiums for some individuals. The Alliance proposes that California's PrEP-AP be authorized to provide partial assistance with health insurance premiums for clients with premium costs that exceed a certain percentage of their income. The Alliance is seeking technical assistance from the Office of AIDS to determine how this program will be developed and implemented.

- Authorize program to cover the full cost of PrEP and PEP, including medication and medical costs, for individuals unable to use their insurance for confidentiality or safety reasons. For some individuals, accessing PrEP or PEP through their health

insurance is not possible for confidentiality or safety reasons—particularly for those insured as dependents on a parent's or partner's health plan. These individuals are also prohibited from using manufacturer patient assistance programs. Although California lawmakers enacted the Confidential Health Information Act in 2013 to address privacy concerns of individuals insured as dependents on a parent's or partner's health plan, the law also does not prevent the Explanation of Benefits (EOB) and other documents from showing a decreasing deductible which can raise the alarm for some policyholders. Additionally, it can take up to six weeks for the health plan to guarantee that sensitive information will not be shared with the main policy holder. The Alliance proposes that PrEP-AP cover the full costs of PrEP and PEP, including medication and medical costs, for individuals unable to use their insurance for confidentiality or safety reasons. PrEP assistance programs in other states, including Illinois and Washington, already provide full coverage for individuals in these circumstances.

- Authorize program to cover all PrEP- and PEP-related drug costs not covered by the individual's health insurance plan when manufacturer's copay assistance program imposes an undue burden. For insured individuals, the PrEP-AP is currently only authorized to cover drug costs not covered by the individual's health insurance plan or manufacturer's copay assistance program. Some pharmacies, however, do not accept Gilead's copay card and patients are required to pay for the medication upfront and subsequently seek reimbursement. The Alliance states that this imposes a tremendous burden on low-income individuals attempting to access PrEP and therefore proposes that California's PrEP-AP be authorized to cover all PrEP- and PEP-related drug costs not covered by the individual's health insurance plan when the manufacturer's copay assistance program imposes an undue burden on the client.

- Authorize program to cover starter packs for PrEP and PEP. Timely access to PrEP and PEP is critical to the success of these interventions. PEP must be initiated within 72 hours after being exposed to HIV, but challenges with insurers or manufacturer patient assistance programs can delay access. In addition, PrEP initiation can take 1-2 weeks from the screening visit to the medication initiation visit. The potential loss-to-care and risk of acquiring HIV for vulnerable clients could be high during those 1-2 weeks and delays could dissuade some individuals altogether. Providers in other states have begun offering starter packs, or a set amount of medication, for PrEP and PEP in order to provide uninterrupted access if patients experience delays due to insurance issues (e.g., prior authorization) or problems with manufacturer patient assistance programs. The Alliance proposes that California's PrEP-AP be authorized to cover starter packs for PrEP and PEP to improve rapid initiation of preventive treatment. The Alliance is seeking technical assistance from the Office of AIDS to determine how this program will be developed and implemented.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Anne Donnelly and Craig Pulsipher present these proposals.

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 17: HIV/AIDS PREVENTION ADVOCATES' (INLAND COALITION) PROPOSAL

PANELISTS

- **Gabriel Maldonado**, Executive Director / CEO, TruEvolution Inc.

Public Comment

PROPOSAL

The Inland Coalition for AIDS Resources in Rural Regions (iCAR3) (membership listed below) requests $10 million one-time, in the form of a grant to the Riverside Community Health Foundation, for the California Department of Public Health (DPH), State Office of AIDS (OA) to fill the gaps in available resources for sexual health services and programs and to expand opportunities for testing, outreach, retention and treatment adherence services throughout San Bernardino and Riverside counties. This proposal includes trailer bill that directs DPH to use these funds to subcontract with community-based organizations and health service entities in order to implement the objectives of this request.

BACKGROUND

TruEvolution, Inc. provided the following background information:

U.S. Statistics:

- More than 1.1 million people in the U.S. are living with HIV today, but 1 in 7 of them don't know it.
- An estimated 37,600 Americans became newly infected with HIV in 2014.
- From 2008 to 2014, the estimated number of annual HIV infections in the U.S. declined 18%.
- In 2016, 39,782 people were diagnosed with HIV in the U.S. Gay and bisexual men, particularly young African American gay and bisexual men, are most affected.

California Statistics:

Prevalence

- Number of people living with diagnosed HIV in 2014: 119,589
- Rate of people living with diagnosed HIV in 2014 per 100,000 people: 371
- 88% of people living with diagnosed HIV in 2014 were men, and 12% were women.
- 18% of people living with diagnosed HIV in 2014 were black, 35% Hispanic/Latino, and 41% white.

New Diagnoses
- Number of new HIV diagnoses in 2015: 4,720
- Rate of new HIV diagnoses in 2015 per 100,000 people: 15

iCAR3 asserts that California's budget does not address significant HIV/AIDS policy and budgetary issues in rural and suburban counties throughout the state. This gap in available resources creates a disproportionate ability for jurisdictions to meet the goals set in the California Getting to Zero Plan. As a suburban-rural mixed region, the Inland Empire is comprised of Riverside and San Bernardino counties, with 27,298 square miles of territory, and fifty-nine cities within the two-county region.

Receiving approximately $7M through the federal Health Resources and Services Administration (HRSA) through Ryan White Part A grant, the Inland Empire leverages these limited resources to serve the over 9,000 people living with HIV in both Riverside and San Bernardino counties as a single Transitional Grant Area (TGA) designated by the federal government. iCAR3 states that this inadequate constraint has placed the region in a precarious position contributing to insufficient resources available to meet the needs of the community. Moreover, iCAR3 explains that the sheer geography of the region creates overwhelming challenges for healthcare providers and community-based organizations to reach the most vulnerable populations operating in rural pockets of the region. These disparities are exacerbated by complex social determinants such as:

i. Inadequate transportation services;

ii. Lack of affordable housing;

iii. The rising net migration of residents from Los Angeles and San Diego to the Inland Empire due the more affordable cost of living in the Inland Empire; and,

iv. Insufficient federal and state investments contributing to climbing rates of sexual health disparities in the region.

iCAR3 advocates for an aggressive, targeted and direct approach to addressing the gaps and disparities in rural and suburban counties outside of major metropolitan areas, especially in the Inland Empire through strategic, ongoing, sustainable investments in these underfunded regions.

Specifically, this proposal is for the following:

1. Increase resources to fill gaps for underfunded regions and address disparities in rural communities in order to achieve goals set in National HIV/AIDS Strategy and the California State Getting to Zero Plan…

In addition, trailer bill is requested to direct DPH to:

i. Research the impact of gaps in federal investments to underfunded regions on local jurisdictions' capacity to adequately achieve goals set in the National HIV/AIDS Strategy (NHAS) and the California State Getting to Zero Plan; and,

ii. In correlation with objective (i), develop a needs-based state formula for identifying and investing supplemental resources in underfunded, rural regions.

2. Expand access…

The budgeted funds would be used to fill the gaps within already available resources for sexual health services and to:

i. Expand access to Pre-Exposure Prophylaxis (PrEP) education and treatment;

ii. Expand access to Post-Exposure Prophylaxis education and treatment;

iii. Increase opportunities for HIV testing through storefront and mobile testing initiatives;

iv. Improve overall linkage, treatment, viral suppression and retention into care for people living with HIV; and,

v. Address co-morbidities, such as substance abuse and mental health disorders and other related health disparities.

3. Ensure the state achieves the objectives…

iCAR3 proposes that the strategic actions to achieve these objectives include:

- Improve PrEP utilization
- Increase and improve HIV testing
- Improve linkages to care
- Improve retention in care
- Improve overall quality of HIV-related care
- Improve availability of HIV care
- Improve and increase case management for people living with HIV

The Inland Coalition for AIDS Resources in Rural Regions (iCAR3) coalition was established in 2016 and is comprised of community-based organizations (CBOs), AIDS-service organizations (ASOs), federally-qualified healthcare centers (FQHCs), and in cooperation with Riverside University Health Systems, Department of Public Health, HIV/STD Branch and San Bernardino County Department of Public Health, Ryan White HIV/AIDS Program. Specifically, the Coalition includes:

- American Cancer Society, Riverside
- Borrego Community Health Foundation
- Foothill AIDS Project
- Desert AIDS Project
- Inland Empire Health Plan
- Inland Region Equality Network
- Planned Parenthood of the Southwest
- Riverside Community Health Foundation
- San Bernardino LGBTQ Center
- Transgender Community Coalition
- TruEvolution

In cooperation:

- San Bernardino County Department of Public Health
- Riverside University Health System – Public Health
- UC Riverside School of Medicine
- Equality California

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Gabriel Maldonado present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time.