AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 2, 2020

2:30 PM, STATE CAPITOL, ROOM 126

ITEMS TO BE HEARD

NON-DISCUSSION ITEMS

ATTACHMENT: A

LIST OF PANELISTS IN ORDER OF PRESENTATION

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: STATE OF THE STATE'S PUBLIC HEALTH

PANELISTS

- **Dr. Sonia Angell,** State Public Health Officer and Director, Department of Public Health

ISSUE 2: OVERVIEW OF DEPARTMENT AND BUDGET

PANELISTS

- **Susan Fanelli**, Chief Deputy Director of Policy & Programs, Department of Public Health
- **Brandon Nunes**, Chief Deputy Director of Operations, Department of Public Health
- **Jack Zwald**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 3: MASTER DATA MANAGEMENT SUSTAINABILITY BUDGET CHANGE PROPOSAL

PANELISTS

- **Dana E. Moore**, Assistant Deputy Director of Center for Health Statistics and Informatics, Department of Public Health
- **Erin Carson**, Junior Staff Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

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

PANELISTS

- **Christine Nelson**, Division Chief, Women, Infants, & Children, Department of Public Health
- **Erin Carson**, Junior Staff Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 5: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

PANELISTS

- **Richard Olney**, Division Chief, Genetic Disease Screening Program, Department of Public Health
- **Erin Carson**, Junior Staff Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 6: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE

PANELISTS

- **Adrian Barraza**, Assistant Division Chief, Office of AIDS, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 7: ADAP ENROLLMENT SYSTEM MAINTENANCE AND OPERATIONS SUPPORT BUDGET CHANGE PROPOSAL

PANELISTS

- **Adrian Barraza**, Assistant Division Chief, Office of AIDS, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 8: INITIAL 30-DAY SUPPLY OF PrEP AND PEP MEDICATION TRAILER BILL

PANELISTS

- **Adrian Barraza**, Assistant Division Chief, Office of AIDS, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 9: ADAP MAGI INFORMATION TRAILER BILL

PANELISTS

- **Adrian Barraza**, Assistant Division Chief, Office of AIDS, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 10: 2019 BUDGET ACT UPDATES

PANELISTS

- **Adrian Barraza**, Assistant Division Chief, Office of AIDS, Department of Public Health
- **Amy Kile-Puente**, Assistant Division Chief, Division of Communicable Disease Control, Department of Public Health
- **Monica Morales**, Deputy Director, Center for Healthy Communities, Department of Public Health
- **Dr. Mark Starr**, Acting Deputy Director, Office of Health Equity, Department of Public Health
- **Artnecia Ramirez**, Assistant Deputy Director, Office of Health Equity, Department of Public Health
- **Jack Zwald**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 11: MEMBER/STAKEHOLDER PROPOSAL: STD PREVENTION - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Sylvia Castillo**, Essential Access Health

ISSUE 12: MEMBER/STAKEHOLDER PROPOSAL: SYRINGE EXCHANGE CLEARING HOUSE - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Jenna Haywood**, Harm Reduction Coalition

ISSUE 13: MEMBER/STAKEHOLDER PROPOSAL: MASTER PLAN ON HIV, STDS, HCV - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Craig Pulsipher**, APLA Health

ISSUE 14: MEMBER/STAKEHOLDER PROPOSAL: HIV HEALTH INEQUITIES - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Courtney Mulhern-Pearson**, San Francisco AIDS Foundation

ISSUE 15: MEMBER/STAKEHOLDER PROPOSAL: ADAP & PRE-AP ELIGIBILITY INCREASE - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Courtney Mulhern-Pearson**, San Francisco AIDS Foundation

ISSUE 16: MEMBER/STAKEHOLDER PROPOSAL: HCV PREVENTION - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Anne Donnelly**, San Francisco AIDS Foundation

ISSUE 17: MEMBER/STAKEHOLDER PROPOSAL: STD NAVIGATORS - COUNTY HEALTH EXECUTIVES ASSOCIATION AND ASSEMBLYMEMBER FREDDIE RODRIGUEZ

PANELISTS

- **Assemblymember Freddie Rodriguez**
- **Trudy Raymundo**, Director, San Bernardino County Public Health Department

ISSUE 18: MEMBER/STAKEHOLDER PROPOSAL: TRANSGENDER WELLNESS & EQUITY FUND - TRANSLATIN@ COALITION AND ASSEMBLYMEMBER MIGUEL SANTIAGO

PANELISTS

- **Assemblymember Miguel Santiago**
- **Michaé Pulido,** Policy Coordinator, TransLatin@ Coalition

ISSUE 19: MEMBER/STAKEHOLDER PROPOSAL: SEXUAL HEALTH INFORMATION AND EDUCATION PROGRAM - SEXUAL HEALTH EDUCATION ROUNDTABLE AND ASSEMBLYMEMBER JOAQUIN ARAMBULA

PANELISTS

- **Heather Meyers**, Regional Program Manager, Planned Parenthood Mar Monte

ITEMS TO BE HEARD

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: STATE OF THE STATE'S PUBLIC HEALTH

PANELISTS

- **Dr. Sonia Angell,** State Public Health Officer and Director, Department of Public Health

BACKGROUND

The Subcommittee has engaged with the Department about the Legislature's need to receive regular, up-to-date public health data on major causes of morbidity and mortality and trends associated with those health conditions. This information is critical to the Legislature's ability to make sound policy and fiscal choices that address the major causes of morbidity and mortality in California effectively. Ideally, the Subcommittee would like the Department to provide this information in the form of a public presentation to the Subcommittee, accompanied by a written report, on an annual basis. This "State of the State's Public Health" would provide 3-5 year incidence, prevalence and trend analysis on key causes of illness, injury and death, such as the following (as examples):

- What are the rates of sexually transmitted diseases and what are the trends?
- What are the estimated rates of youth vaping and cannabis use?
- Are suicide rates increasing or decreasing, and in which populations?
- What data is available on the health impacts of childhood trauma?
- How many cases, and how many deaths, from hepatitis A have there been each year for the past 5 years?
- How many children drown and in what types of situations (i.e., backyard pools? ocean?)?
- How many people die of cancer and what are the leading types of cancer deaths, by age, gender, race, etc.?
- How many people die from heart disease?
- What are the vaccination rates and trends?
- How many people die from gun violence in California?

DPH has indicated that to provide this information to the Legislature on an annual, or biannual basis, the department would need additional resources in the form of approximately 2-5 new full-time positions dedicated to this workload. The 2018 Budget Act included the following Supplemental Report Language (SRL):

> **ITEM 4265-001-0001—DEPARTMENT OF PUBLIC HEALTH**
> 1. ***State of the State's Public Health.*** At its first budget subcommittee hearings of the 2019-20 budget process, the Department of Public Health shall report to the health and human services budget subcommittees of both houses of the Legislature a summary of key public health statistics in California. The briefing and related handout shall include excerpted information from the County Health Status Profiles report on key public health indicators, including available information about these indicators' trends, for issues that the Department considers major existing or emerging public health issues. The briefing and related handout may, for example, provide statistics on issues such as opioid overdoses and naloxone treatments, the number of people infected with sexually transmitted diseases (STDs) and the geographic regions in which STD transmissions are highest, rates of diabetes and/or other chronic diseases among various subpopulations, or recent public health outbreaks.

In compliance with this SRL, on February 25, 2019, Dr. Karen Smith, the former State Public Health Officer and Director of the Department of Public Health, provided a report to this Subcommittee on the State of the State's Public Health which included a brief written report that is included in Attachment A to this agenda.

Coronavirus

On February 18, 2020, CDPH provided the following update on Coronavirus:

"We understand that Californians continue to be concerned about Novel Coronavirus. The health risk to the general public in California remains low at this time, however, California state and local health officials are actively engaged in preparations to keep Californians safe should the risk of infection to the general public increase. We are actively working with the federal Centers for Disease Control and Prevention, with local governments, health facilities, and health care providers across the state as new cases are detected.

Novel Coronavirus (you may hear it also referred to as COVID-19) is mainly a respiratory illness. The most commonly reported symptoms are fever and cough. Some patients have a mild illness. Others develop pneumonia. In a small percentage of patients, the illness can be fatal. There have been no deaths in California as a result of Novel Coronavirus.

CDPH has provided guidance to K-12 Schools, Colleges and Universities and Childcare and Preschools. CDPH continues to:

- Activate the California Department of Public Health's Medical and Health Coordination Center to coordinate response efforts across the state.
- Provide information about Novel Coronavirus and how to report suspect cases to local health departments and health care providers in California.
- Coordinate with federal authorities who plan to implement screening, monitoring and, in some cases quarantine of, passengers returning to the U.S. from China, through SFO and LAX.
- Assure that health care providers know how to safely manage persons with possible Novel Coronavirus and support hospitals and local public health laboratories for collection and shipment of specimens for testing at CDC for Novel Coronavirus.
- Prepare California's laboratory scientists in our California Department of Public Health – Viral and Rickettsial Disease Laboratory to be able to conduct Novel Coronavirus testing in the near future.

This is an evolving situation that we are actively monitoring and we are prepared should the situation change. For more information please visit the California Department of Public Health's website. Additional information can be found at the CDC website.

Status:

- Worldwide, there are 75,134 confirmed Novel Coronavirus cases with 2,002 deaths. There are 999 confirmed cases outside of China. 5 deaths occurred outside of China (Philippines, Hong Kong, Japan, France and Taiwan).
- In the United States, there are 15 confirmed cases (California, Washington, Illinois, Arizona, Massachusetts, Wisconsin, Nebraska and Texas).
- In California there are 8 confirmed cases.
- The additional cases being reported in the media from the cruise ship were tested in Japan. These cases are being retested by the CDC and should those individuals test positive, they will be added to the national count.
- So far, known instances of person-to-person transmission in the United States include one instance in Chicago, Illinois, and one in San Benito County, California. Both cases were after close, prolonged interaction with a family member who returned from Wuhan, was sick and tested positive for Novel Coronavirus. As the outbreak in China grows, and new clusters increase in other countries, we are actively engaged in preparing the public health and healthcare systems for the possible scenario of person-to-person spread in the U.S.

Repatriation:
You have likely heard about repatriation flights for the individuals who have been quarantined on a cruise ship in Japan. Approximately 177 Americans (no children) on the Diamond Princess cruise in Japan were flown to Travis Air Force Base and arrived over the weekend. 171 passengers remained at Travis, 6 individuals were flown to Nebraska. Passengers will be quarantined for 14 days and will be housed away from the other quarantined groups. This is a fluid situation that is being managed by the federal government and some details are still evolving.

Traveler Screening:
At this time, travelers newly entering the U.S. from mainland China will be screened by federal agencies for their risk of exposure according to criteria established by the Centers for Disease Control and Prevention. Those who are identified as having the highest risk for exposure to Novel Coronavirus in the last 14 days may be referred for federal quarantine. Others will be referred to state and local public health departments for continued monitoring for 14 days."

The media and administration reported the following update on February 26, 2020:

"The U.S. Centers for Disease Control and Prevention today confirmed a possible first case of person-to-person transmission of COVID-19 in California in the general public. The individual is a resident of Solano County and is receiving medical care in Sacramento County. The individual had no known exposure to the virus through travel or close contact with a known infected individual."

STAFF COMMENT AND QUESTIONS

1. Please include a status update and projections on Coronavirus in California in this report.
2. Please explain the different roles and responsibilities of various state agencies in the case of a pandemic, including CDPH, the Emergency Medical Services Authority, and the Office of Emergency Services.
3. Please describe how the proposed budget for CDPH reflects and responds to the data that has just been presented.
4. Are there sufficient resources being requested by CDPH within the Master Data Management Sustainability budget change proposal (item #3 of this agenda) for the department to provide annual reports to the Legislature as discussed above?

Staff Recommendation: Subcommittee staff recommends no action at this time as this is an informational item, but also recommends that the Legislature consider the value of providing resources to the Department in order to institutionalize annual written and oral reports on key public health data.

ISSUE 2: OVERVIEW OF DEPARTMENT AND BUDGET

PANELISTS

- **Susan Fanelli**, Chief Deputy Director of Policy & Programs, Department of Public Health
- **Brandon Nunes**, Chief Deputy Director of Operations, Department of Public Health
- **Jack Zwald**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED DEPARTMENT BUDGET

The Governor's proposed 2020-21 budget, displayed in the charts on the following page, provides CDPH approximately $3.2 billion overall, representing a $196.5 million (total funds), or 5.8 percent, decrease from the current year CDPH budget. This reduction reflects the following changes in the budget:

1. The General Fund reduction of $100.3 million primarily reflects one time funding included in the 2019 Budget Act for the programs and services that are detailed in issue #10 of this agenda.

2. The $67.2 million reduction in federal funds primarily reflects decreased costs in the WIC program due to decreasing participation in the program.

3. The $87.8 million reduction in special funds and reimbursements largely reflects decreasing tobacco tax revenue and the completion of one-time Mental Health Services Act funding for the California Reducing Disparities Project.

General Fund dollars of $211.7 million make up just 6.6 percent of the department's total budget while federal funds make up approximately 44.3 percent of the total department budget.

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

DEPARTMENT OF PUBLIC HEALTH *(Dollars In Thousands)*					
Fund Source	**2018-19 Actual**	**2019-20 Projected**	**2020-21 Proposed**	**CY to BY $ Change**	**CY to BY % Change**
General Fund	**$177,280**	**$312,035**	**$211,734**	**($100,301)**	**-32.1%**
Federal Funds	$1,550,453	1,482,787	$1,415,563	($67,224)	-4.5%
Special Funds & Reimbursements	$628,911	$730,125	$642,334	($87,791)	-12.0%
Licensing & Certification Fund	$163,942	$193,927	$227,127	$33,200	17.1%
Genetic Disease Testing Fund	$133,821	$144,122	$143,760	($362)	-0.3%
WIC Manufacturer Rebate Fund	$226,211	$208,188	$193,110	($15,078)	-7.2%
AIDS Drug Assistance Program Rebate Fund	$288,574	$324,239	$365,243	$41,004	12.6%
Total Expenditures	**$3,169,192**	**$3,395,423**	**$3,198,871**	**($196,552)**	**-5.8%**
Positions	3,660.7	3,611.9	3,755.4	143.5	4.0%

The following table shows proposed expenditures by program area.

DPH Program Expenditures *(In Thousands)*					
Program	**2018-19 Actual**	**2019-20 Estimate**	**2020-21 Proposed**	**CY to BY $ Change**	**CY to BY % Change**
Emergency Preparedness	$100,364	$99,282	$91,555	($7,727)	-7.8%
Healthy Communities	$485,516	$550,130	$441,566	($108,564)	-19.7%
Infectious Disease	$666,925	$761,478	$736,707	($24,771)	-3.3%
Family Health	$1,449,156	$1,456,872	$1,391,846	($65,026)	-4.5%
Health Statistics & Informatics	$30,902	$38,298	$33,778	($4,520)	-11.8%
County Health Services	$3,955	$174	$174	$0	0%
Environmental Health	$125,903	$151,412	$131,533	($19,879)	-13.1%
Health Facilities	$291,351	$321,724	$353,018	$31,294	9.7%
Laboratory Field Services	$15,120	$16,053	$18,694	$2,641	16.5%
Total Expenditures	**$3,169,192**	**$3,395,423**	**$3,198,871**	**($196,552)**	**-5.8%**

BACKGROUND

CDPH is dedicated to optimizing the health and well-being of the people in California, primarily through population-based programs, strategies, and initiatives. DPH's goals are to achieve health equities and eliminate health disparities; eliminate preventable disease, disability, injury, and premature death; promote social and physical environments that support good health for all; prepare for, respond to, and recover from emerging public health threats and emergencies; improve the quality of the workforce and workplace; and promote and maintain an efficient and effective organization. The overall structure and organization of CDPH is as follows:

Department Director / State Public Health Officer

- Civil Rights
- California Conference of Local Health Officers
- Office of Health Equity
- Office of Quality Performance and Accreditation
- Administration and Public Affairs
- Center for Health Statistics and Informatics
- Emergency Preparedness Office
- Office of the State Public Health Laboratory Directors

Policy and Programs

- Emergency Preparedness Office
- Center for Health Statistics and Informatics
- Legislative and Governmental Affairs
- Office of State Laboratory Director
- Laboratory Field Services

Center for Chronic Disease Prevention and Health Promotion

- Chronic Disease and Injury Control
- Environmental and Occupational Disease Control
- Office of Problem Gambling
- Oral Health

Center for Environmental Health

- Environmental Management
- Food, Drug, and Radiation Safety

Center for Family Health

- Family Planning
- Genetic Disease Screening Program
- Maternal, Child, and Adolescent Health
- Women, Infants, and Children

Center for Health Care Quality

- Healthcare Association Infections Program
- Licensing and Certification

Center for Infectious Diseases

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

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present an overview of the proposed CDPH budget.

Staff Recommendation: Subcommittee staff recommends no action at this time as this is an oversight issue.

ISSUE 3: MASTER DATA MANAGEMENT SUSTAINABILITY BUDGET CHANGE PROPOSAL

PANELISTS

- **Dana E. Moore**, Assistant Deputy Director, Center for Health Statistics and Informatics, Department of Public Health
- **Erin Carson**, Junior Staff Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH requests 10 positions and $1.5 million (Health Statistics Special Fund) in 2020-21 and ongoing to "increase department-wide advanced analytics and predictive analytics for public health decision-making, continue implementing master data management strategies for improved health information management, and implementation of data-driven community interventions."

The requested positions are existing positions funded with limited-term federal grant funding that is ending; this request is to continue funding the positions with state special funds.

BACKGROUND

CDPH's Center for Health Statistics and Informatics (CHSI) is responsible for the registration of vital events, the issuance of legal vital record documents, and the collection and management of public health and vital statistics data. CHSI's Deputy Director serves as the Public Health Chief Data Officer and is responsible for implementing strategies and best practices associated with master data management, and working with the programs within Public Health in the areas of: data analytics, standards, quality, collection, curation, storage, transfer/messaging, and sharing.

The Analytics Services Unit (ASU), within Public Health's CHSI, was established using a federal fund source in 2018-19 to assist with implementation of an enterprise-level data governance structure, implementation of standard processes/procedures for master data management within CDPH programs, and to provide advanced descriptive and predictive analytics services to CDPH programs.

The ASU consists of 6 positions – 4 data positions offer analytics services to CDPH programs upon request, and the 2 information technology positions act as liaisons for communicating with CDPH programs that include mature data collection or storage systems, to assist those programs with data management services and implementation of data management practices. In addition to the ASU, the CHSI has a health information management lead. This lead position provides health information management consultative services to CDPH programs, in conjunction with the services provided by the ASU.

These 7 positions were established in 2018-19; also during that year, CHSI procured specialized, advanced analytics software, including predictive analytics applications, and staff actively developed the “menu of services” that CDPH programs are able to request. Additionally, CHSI developed a mechanism and workflow by which these data analytics requests would be submitted, processed, and satisfied.

This branch has experienced a steady expansion of staff and workload to employ strategies for master data management, set policies and procedures for safe and secure data sharing, provide increased data analytics capacity to other programs, and provide data management and surveillance consultative services. Historically, the administrative support responsibilities of the branch (e.g., training and travel coordination, timekeeping, meeting coordination, note-taking, policy analysis, legislative analysis, etc.) have been completed through temporary, part-time redirection of two CHSI staff members. However, with the expansion of these necessary programs, the part-time redirection of the two staff is not sustainable and CDPH believes that the CHSI requires dedicated permanent staff to adequately provide administrative support to the growing branch moving forward.

CDPH states that, through improved master data management policies and increased capacity for advanced and predictive analytics, the department can improve data driven decision-making in public health and ultimately improve health outcomes for all Californians. Specifically, CDPH states: "This proposal will allow Public Health to provide better, higher quality data to inform interventions, maintain partnerships, and improve the data that is reported regularly to partners in all sectors."

STAFF COMMENTS/QUESTIONS

This is a significant investment of resources into data collection, analysis, and management for the department, and CDPH states that its purpose is to: "...provide better, higher quality data to inform interventions, maintain partnerships, and improve the data that is reported regularly to partners in all sectors." Hence, it seems that there might be sufficient resources here for the department to be able to provide basic public health data to the Legislature on an annual or biannual basis.

The Subcommittee requests CDPH present this proposal and provide some specific examples of:

1. Data collection and analysis occurring at CDPH;
2. Entities outside of CDPH that can access CDPH data; and
3. Public health data provided to the Legislature.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 4: WOMEN, INFANTS, AND CHILDREN (WIC) PROGRAM ESTIMATE

PANELISTS

- **Christine Nelson**, Division Chief, Women, Infants, & Children (WIC), Department of Public Health
- **Erin Carson**, Junior Staff Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

WIC ESTIMATE

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 billion in 2020-21, a $65.5 million (6%) decrease from the 2019 Budget Act, reflecting decreasing participation in the program.

WIC Expenditures					
	2019 Budget Act	**2019-20 Estimate**	**2020-21 Proposed**	**Change from 2019 Budget Act**	**% Change**
Local Assistance (Federal Funds)	$818,462,000	$815,905,000	$776,560,000	($41,902,000)	-5.1%
Local Assistance (Manufacturer Rebate Fund)	$213,678,000	$214,929,000	$193,110,000	($20,568,000)	-9.6%
State Operations	$62,270,000	$62,270,000	$59,210,000	($3,060,000)	-4.9%
Total Expenditures	**$1,094,410,000**	**$1,093,104,000**	**$1,028,880,000**	**$65,530,000**	**-6.0%**

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 financial support 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.

CDPH 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. Local WIC agencies used to issue WIC participants paper vouchers to purchase approved foods at authorized stores, however the program is on the verge of completing its transition to electronic benefit transfer (EBT) cards. 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

CDPH 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:

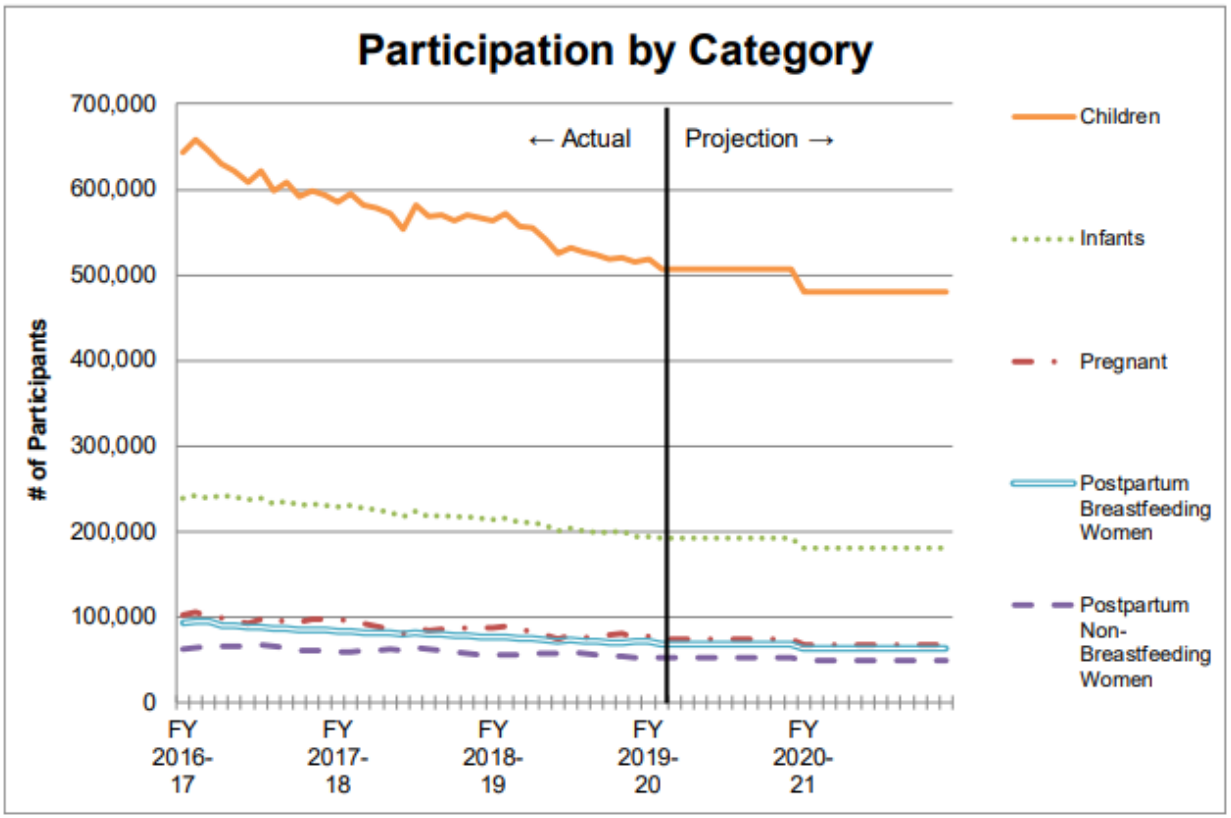
- **Food**. Food funds reimburse WIC authorized grocers for foods purchased by WIC participants. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.

- **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, at approximately 6% per year, consistent with national trends, as can be seen in the chart below:



Electronic Benefit Transfer (EBT)

The federal Healthy, Hunger-Free Kids Act of 2010 requires all states to migrate WIC from a paper-based food benefit delivery system to an EBT system no later than October 1, 2020. With USDA approval, California began pilot operations in Solano and Napa Counties on June 3, 2019 with statewide rollout beginning September 2019 and completion scheduled for spring 2020. CDPH states that the last implementation wave will start March 30th, 2020, and the full implementation will be complete by approximately June, 2020, 3-4 months prior to the federal deadline.

CDPH states that there is no data to project whether the fiscal impact of the California WIC Card rollout will result in a net increase or decrease in food costs per participant. Nevertheless, the California WIC Card will likely support easier participant access and use, though there may be some late adopters to the system. CDPH hopes that the transition to EBT cards will help stem the tide of declining participation in the program.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff requests CDPH present the WIC estimate, provide an overview of the EBT project, and describe the department's efforts to understand and address decreasing participation in the program.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate, as well as updates at the May Revision.

ISSUE 5: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

PANELISTS

- **Richard Olney**, Division Chief, Genetic Disease Screening Program, Department of Public Health
- **Erin Carson**, Junior Staff Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

GENETIC DISEASE SCREENING PROGRAM ESTIMATE

The total Genetic Disease Screening Program (GDSP) proposed 2020-21 budget is $141.5 million, a very slight decrease from the 2019 budget. Of the proposed $141.2 million, $31.7 million is for state operations while $110.8 million is proposed for local assistance.

	Genetic Disease Screening Program Expenditures				
	2019 Budget Act	**2019-20 Estimate**	**2020-21 Proposed**	**CY to BY $ Change**	**CY to BY % Change**
NBS Local Assistance	$45,343,000	$45,883,000	$47,576,000	$1,693,000	3.7%
PNS Local Assistance	$35,937,000	$35,397,000	$35,911,000	$514,000	1.5%
Operational Support Local Assistance	$30,344,000	$30,344,000	$27,400,000	($2,944,000)	-9.7%
State Operations	$31,351,000	$31,351,000	$31,679,000	$328,000	1.0%
TOTAL	**$142,975,000**	**$142,975,000**	**$142,566,000**	**($409,000)**	**-0.3%**

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 statute requires CDPH to administer a statewide genetic disorder screening program for pregnant women and newborn babies that is to be fully supported by fees.

The 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 - the Genetic Disease Testing Fund.

Prenatal Screening Program (PNS). This program screens pregnant women who consent to screening for serious birth defects. The fee for this screening is $221.60; $211.60 is deposited into the Genetic Disease Testing Fund and $10 is deposited into the California Birth Defects Monitoring Program Fund. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays the fee 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. Where applicable, this fee is paid by prepaid health plans and insurance companies. Medi-Cal also covers this fee for its enrollees. The current fee for this screening is $142.25, and beginning July 1, 2020, the NBS fee will be increased by $35 to $177.25, largely to perform the routine and ongoing workload for screening for spinal muscular atrophy (SMA) as well as new costs associated with screening for adrenoleukodystrophy (ALD) beginning this summer.

The NBS screens for over 80 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. According to CDPH, 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.

SB 1095 (Pan, Chapter 393, Statutes of 2016) requires the NBS to expand statewide screening of newborns to include screening for any disease, that is detectable in blood samples, within two years of the disease being adopted by the federal Recommended Uniform Screening Panel (RUSP).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present the GDSP estimate.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate, and May Revision updates.

ISSUE 6: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE

PANELISTS

- **Adrian Barraza**, Assistant Division Chief, Office of AIDS, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ADAP ESTIMATE

The November 2019 AIDS Drug Assistance Program (ADAP) Estimate includes the following expenditure adjustments to the current year and budget year estimates:

- For the current year (2019-20), the Office of AIDS (OA) estimates that the ADAP budget authority need will be $431.3 million, which is a $18.2 million decrease in budget authority compared to the 2019 Budget Act. The net decrease is primarily due to a decrease in projected medication expenditures partially offset by a projected increase in private insurance medical out-of-pocket expenditures.

- For the budget year (2020-21), the OA estimates that the ADAP budget authority need will be $467.5 million, which is an $18 million increase in budget authority compared to the 2019 Budget Act. The net increase is primarily due to a projected increase in insurance premium and medical out-of-pocket expenditures partially offset by a projected decrease in medication expenditures.

The estimated ADAP revenue for Current Year and Budget Year compared to the amount reflected in the 2019 Budget Act:

- For 2019-20, the OA estimates ADAP revenue will be $363.7 million, which is a $15.2 million decrease compared to the 2019 Budget Act. The decrease is primarily due to a decrease in projected medication expenditures.

- For 2020-21, the OA estimates ADAP revenue will be $370.5 million, which is a $8.4 million decrease compared to the 2019 Budget Act. The decrease is primarily due to a decrease in projected medication expenditures.

California Department of Public Health
AIDS Drug Assistance Program
2020-21 November Estimate
Table 1: Local Assistance Budget Authority
(In Thousands)

Local Assistance	2019 Budget Act	Current Year FY 2019-20			2019 Budget Act	Budget Year FY 2020-21		
		2020-21 November Estimate	$ Change from 2019 Budget Act	% Change from 2019 Budget Act		2020-21 November Estimate	$ Change from 2019 Budget Act	% Change from 2019 Budget Act
Total Funds Requested	**$449,469**	**$431,280**	**-$18,189**	**-4.0%**	**$449,469**	**$467,464**	**$17,995**	**4.0%**
Federal Trust Fund - Fund 0890	$135,138	$116,571	-$18,567	-13.7%	$135,138	$113,259	-$21,879	-16.2%
ADAP Rebate Fund - Fund 3080	$314,331	$314,709	$378	0.1%	$314,331	$354,205	$39,874	12.7%
Caseload	34,628	32,623	-2,005	-5.8%	34,628	33,919	-709	-2.0%
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.								

2020-21 November Estimate
Table 2: ADAP Rebate Fund (Fund 3080) Revenues
(In Thousands)

Local Assistance	2019 Budget Act	Current Year FY 2019-20			2019 Budget Act	Budget Year FY 2020-21		
		2020-21 November Estimate	$ Change from 2019 Budget Act	% Change from 2019 Budget Act		2020-21 November Estimate	$ Change from 2019 Budget Act	% Change from 2019 Budget Act
Total Revenue Requested	**$378,909**	**$363,719**	**-$15,190**	**-4.0%**	**$378,909**	**$370,526**	**-$8,383**	**-2.2%**
ADAP Rebate Fund - Fund 3080	$374,909	$355,719	-$19,190	-5.1%	$374,909	$362,526	-$12,383	-3.3%
Interest Income	$4,000	$8,000	$4,000	100.0%	$4,000	$8,000	$4,000	100.0%
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.								

Caseload

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

	2019-20 Estimate	2020-21 Projected	CY to BY # Change	CY Act to BY % Change
Caseload	30,211	30,527	316	1.0%

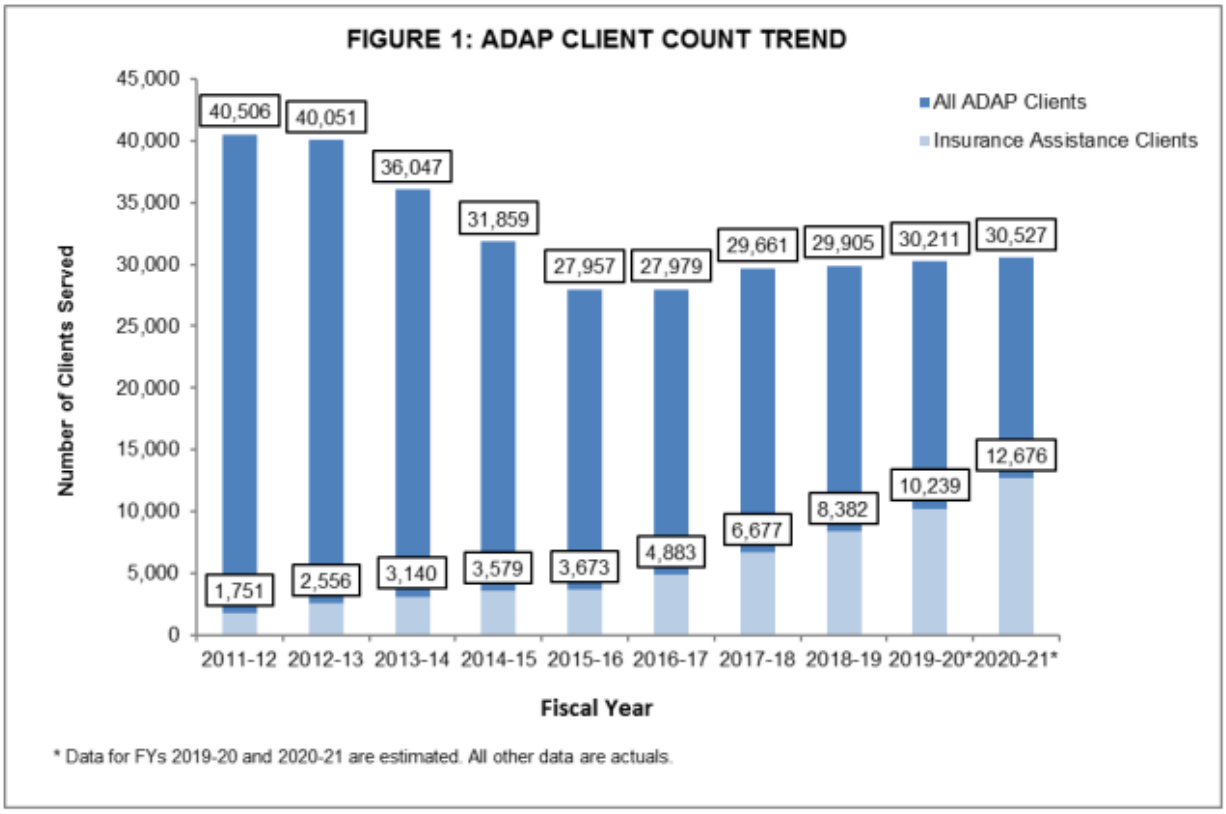


FIGURE 1: ADAP CLIENT COUNT TREND
Number of Clients Served
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
All ADAP Clients
Insurance Assistance Clients
40,506
40,051
36,047
31,859
27,957
27,979
29,661
29,905
30,211
30,527
1,751
2,556
3,140
3,579
3,673
4,883
6,677
8,382
10,239
12,676
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17
2017-18
2018-19
2019-20*
2020-21*
Fiscal Year
* Data for FYs 2019-20 and 2020-21 are estimated. All other data are actuals.

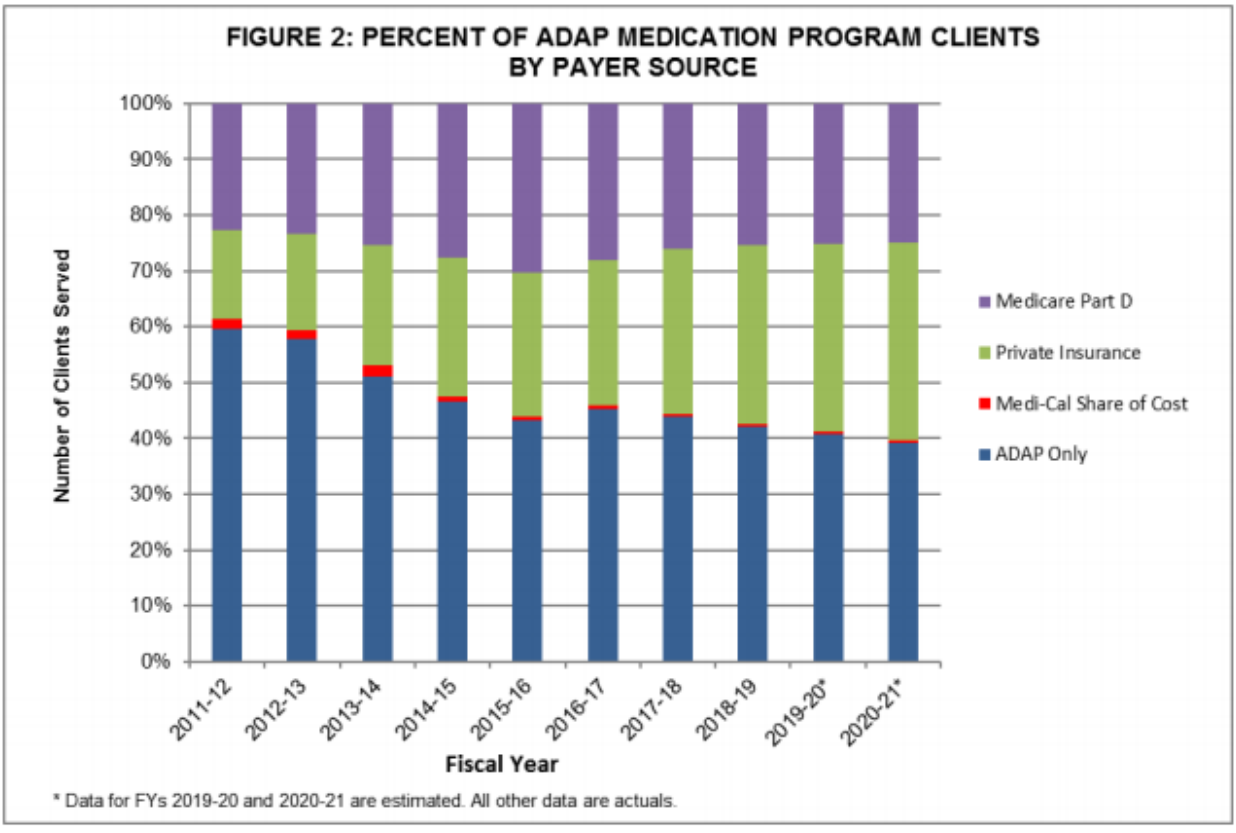


FIGURE 2: PERCENT OF ADAP MEDICATION PROGRAM CLIENTS BY PAYER SOURCE
Number of Clients Served
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Medicare Part D
Private Insurance
Medi-Cal Share of Cost
ADAP Only
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17
2017-18
2018-19
2019-20*
2020-21*
Fiscal Year
* Data for FYs 2019-20 and 2020-21 are estimated. All other data are actuals.

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-pays, medical out-of-pocket costs, and Medicare Part D health insurance premiums. Qualifying Medicare Part D clients have the option for premium assistance with Medigap supplemental insurance policies, which cover 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. For insured clients, the PrEP Assistance Program (PrEP-AP) pays for PrEP-related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's co-payment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP-related medical costs, as medication is provided free by the manufacturer's medication assistance program.

ADAP 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 disenrolled 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 system.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present the ADAP estimate. Please also describe the reorganization taking place within CDPH to integrate the department's work on HIV, STDs, and Hepatitis C.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate, and May Revise updates.

ISSUE 7: ADAP ENROLLMENT SYSTEM MAINTENANCE AND OPERATIONS SUPPORT BUDGET CHANGE PROPOSAL

PANELISTS

- **Adrian Barraza**, Assistant Division Chief, Office of AIDS, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH is requesting $4.75 million and 9 permanent positions in 2020-21 and annually thereafter from the ADAP Rebate Fund for ongoing Maintenance and Operations (M&O) for the ADAP Enrollment System (AES).

BACKGROUND

The Office of AIDS (OA) has lead responsibility for coordinating state programs, services and activities relating to HIV and AIDS. OA is made up of a Division Office and six branches, which are the HIV Care Branch, HIV Prevention Branch, Support Branch, Surveillance and Prevention Evaluation and Reporting Branch, ADAP and Care Evaluation and Informatics Branch (ACEI), and the ADAP Branch. The latter two branches are where the programs that are the primary focus of this proposal are managed.

The Interim ADAP Enrollment System (AES):
In March 2017, in response to the termination of its existing enrollment benefits management contract, OA worked with a contractor to replace its existing ADAP enrollment benefits management system with one that could serve the state's 30,000 ADAP clients. Due to the emergency nature of its creation, the interim AES went live as a minimal solution, built only with functionality necessary to manage ADAP eligibility and enrollment information, and exchange data with ADAP's Pharmacy Benefits Manager (PBM) and Insurance and Medical Benefits Management (IBM/MBM) contractors. Over time, nominal changes were implemented to meet the needs of clients, enrollment workers, and state operations.

The interim AES was built as a custom web-based solution with approximately 600 users, which include Public Health staff and enrollment workers at approximately 193 certified enrollment sites throughout California. The interim AES manages eligibility and service provision data for ADAP and PrEP-AP clients to improve client access to medication for HIV treatment and prevention and to healthcare by minimizing client application processing time and providing local ADAP enrollment workers with near real-time access to information that identifies clients at risk for an interruption in medication access or insurance coverage.

Data collected and processed in the interim AES include client-level demographic characteristics, financial eligibility documentation, clinical laboratory test results, and insurance coverage; enrollment site staff information; and medication, premium, and out-of-pocket claims information. Enrollment workers enter information provided by clients into the interim AES at the client's initial enrollment, when client information changes, and when clients recertify their eligibility. Bi-directional data interfaces exchange eligibility information and claim payment information with separate PBM and IBM/MBM systems.

Since the AES's initial implementation, the OA was also able to use the system to implement some of the new programs and expanded ADAP services approved previously by the California State Legislature. These include payment of insurance premiums and medical out-of-pocket costs for ADAP clients with employer-based health insurance, expansion of medical out-of-pocket cost assistance and assistance with Medigap premiums to ADAP clients co-enrolled in the Medicare Part D Premium Payment program, and expansion of services to HIV-negative individuals through the implementation of PrEP-AP. These enhancements significantly increased requirements on both department staff and vendors, according to CDPH.

CDPH now uses the interim AES to:

- Collect, process, and store eligibility data in a searchable format, using business rule-based quality control to avoid problems with adjudication or premium payments.
- Provide client status information to enrollment workers.
- Transfer processed eligibility data to the PBM contractor's system.
- Transfer processed eligibility data to the IBM/MBM contractor's system.
- Obtain feedback for processed eligibility data (i.e., payments, credits, rejections) from PBM and IBM/MBM transactions.
- Process feedback (i.e., remediate issues) from electronic data transfers.
- Assist ADAP and PrEP-AP staff to answer questions from enrollment workers, clients, and pharmacies.

- Investigate and remediate medication access issues.
- Investigate and remediate insurance claim payment issues and out of pocket claim issues.
- Perform data analysis, reconciliation, and reporting.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 8: INITIAL 30-DAY SUPPLY OF PREP AND PEP MEDICATION TRAILER BILL

PANELISTS

- **Adrian Barraza**, Assistant Division Chief, Office of AIDS, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH proposes trailer bill to allow the Pre-Exposure Prophylaxis (PrEP) Assistance Program (PrEP-AP) to pay for an initial 30-day supply of PrEP and post-exposure prophylaxis (PEP) medication, as compared to the current statutory requirement to provide a 14-day supply.

BACKGROUND

The PrEP-AP provides assistance with PrEP-related medical out-of-pocket costs and access to medications on the PrEP-AP formulary for the prevention of HIV. Current statute limits the quantity of prescriptions under the following two scenarios: a) PrEP-AP may furnish up to 14 days of PrEP and PEP medication, and b) PrEP-AP may furnish up to 28 days of PEP medication for victims of sexual assault. The combination medication tenofovir disoproxil fumarate (TDF) and emtricitabine (FTC), marketed under the brand name Truvada®, is the only FDA-approved medication for PrEP and is a component of first-line, recommended PEP regimens. Gilead Sciences is currently the only manufacturer of Truvada® and only packages Truvada® in bottles containing 30 tablets. Among the FDA's expectations is that applicable entities repackage drug products in accordance with the handling and storage instructions provided in FDA-approved labeling. The package insert provided by the manufacturer of Truvada® specifically instructs to "dispense only in original container." Additionally, the manufacturer has been sending letters to repackagers explicitly instructing them that they may not split bottles of Truvada®. Repackagers are resistant to violating these instructions and most have ceased repackaging Truvada®.

Due to these barriers, the PrEP-AP is unable to implement this provision as permitted by law. The PrEP-AP has been unable to procure PrEP and PEP in 14-day pre-packaged doses and is unable to contract with pharmacies to break-up existing bottles of Truvada®

Approximately 400 clients are estimated to be impacted by this proposal. The costs required to carry out this proposal are projected to be between $830,000 and $1.7 million annually, depending on whether the client is insured or uninsured or if they are eligible for the manufacturer's medication assistance program. CDPH OA can partially mitigate against some of the additional costs by navigating eligible clients to the manufacturer medication assistance program for immediate PrEP and PEP access. Any additional costs will be covered by existing budget authority for the ADAP Rebate Fund.

There are currently no costs for PrEP/PEP medication to the PrEP-AP for uninsured clients. PrEP is obtained through assistance programs administered by the manufacturer, who absorbs the cost of the medication. For uninsured clients, PrEP/PEP is provided free of charge, although clients must meet eligibility requirements that mirror PrEP-AP's eligibility criteria. For insured clients, the manufacturer provides up to $7,200 annually in PrEP copayment assistance.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this trailer bill proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 9: ADAP MAGI INFORMATION TRAILER BILL

PANELISTS

- **Adrian Barraza**, Assistant Division Chief, Office of AIDS, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH proposes trailer bill to allow for electronic retrieval of ADAP clients' modified adjusted gross income (MAGI) data from the California Franchise Tax Board (FTB).

CDPH proposes amending HSC Section 120962 and RTC Section 19548.2 to insert the federal definitions of "household" and "family size." This proposal also changes references to "taxpayer" to "taxpayer household." These proposed changes would streamline data collection, eliminate administrative burden, and eliminate conflicts in current law.

Under the existing three-year agreement, ADAP pays FTB approximately $37,950 per year. First-year implementation costs are minor and will be paid for through ADAP Rebate Fund. There are no anticipated ongoing costs related to this proposal.

BACKGROUND

ADAP administers assistance to people living with HIV and AIDs in California. Current law requires ADAP to use an applicant's MAGI for program eligibility. Current law only allows FTB to provide "adjusted gross income" (AGI) which does not include household data necessary to calculate MAGI. While FTB currently has all the information necessary to assess household MAGI, FTB sends tax data only for the ADAP applicant. Currently, the flat file containing all tax data received from FTB is password-protected and stored on a secure ADAP server.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH to present this trailer bill proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 10: 2019 BUDGET ACT UPDATES

PANELISTS

- **Adrian Barraza**, Assistant Division Chief, Office of AIDS, Department of Public Health
- **Amy Kile-Puente**, Assistant Division Chief, Division of Communicable Disease Control, Department of Public Health
- **Monica Morales**, Deputy Director, Center for Healthy Communities, Department of Public Health
- **Dr. Mark Starr**, Acting Deputy Director, Office of Health Equity, Department of Public Health
- **Artnecia Ramirez**, Assistant Deputy Director, Office of Health Equity, Department of Public Health
- **Jack Zwald**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

OVERSIGHT ISSUE

The 2019 Budget Act includes several new public health investments through CDPH that are described below. The purpose of this issue is for CDPH to provide updates on the implementation of these new investments.

BACKGROUND

The 2019 Budget Act includes the following:

Infectious Disease Prevention and Control. The budget includes four positions and General Fund expenditure authority of $40 million, available until June 30, 2023, to provide one-time grants to local health jurisdictions and tribal communities for infectious disease prevention, testing, and treatment. Of these resources, $32 million would be provided to local health jurisdictions and $8 million would support state administration costs. The budget also includes budget bill language to allocate up to $1 million to tribal communities and to consult with the County Health Executives Association of California, the California Conference of Local Health Officers, community-based organizations, and other stakeholders to determine a funding allocation methodology based on factors such as disease burden, population impact, and geographical area.

Comprehensive HIV Prevention. The budget includes General Fund expenditure authority of $5 million annually to support grants to local health jurisdictions and community-based organizations to provide comprehensive HIV prevention services. The budget also includes trailer bill language to implement the requirements of the grant program and to suspend the program on December 31, 2021, if certain conditions are met.

Sexually Transmitted Disease Prevention. The budget includes General Fund expenditure authority of $7 million annually to support grants to local health jurisdictions and community-based organizations for the prevention of sexually transmitted diseases. The budget also includes trailer bill language to implement the requirements of the grant program and to suspend the program on December 31, 2021, if certain conditions are met.

Hepatitis C Prevention. The budget includes General Fund expenditure authority of $5 million annually to support grants to local health jurisdictions and community-based organizations for the prevention and control of Hepatitis C. The budget also includes trailer bill language to implement the requirements of the grant program and to suspend the program on December 31, 2021, if certain conditions are met.

Peer Navigators in Harm Reduction Programs. The budget includes General Fund expenditure authority of $15.2 million, available until June 30, 2023, for Substance Use Disorder Response Navigator related activities. Of these General Fund resources, $2.6 million will support technical assistance activities and $12.6 million will support grants to local health jurisdictions and community-based organizations for the purpose of supporting syringe exchange and disposal program activities, including treatment navigators.

Safe Cosmetics Program Funding. The budget includes General Fund expenditure authority of $1.5 million in 2019-20 and $500,000 annually thereafter to increase staffing for enforcement and program improvement activities in the Safe Cosmetics Program, which provides information to consumers and other users of cosmetics regarding the presence of certain toxic ingredients.

Lesbian, Bisexual, and Queer (LBQ) Women's Health. The budget includes General Fund expenditure authority of $17.5 million in 2019-20 to support a local comprehensive grant program to address LBQ women's health disparities and fund research targeting LBQ women's health needs and inventory of existing programs.

Sickle Cell Disease Treatment Infrastructure. The budget includes General Fund expenditure authority of $15 million, available until June 30, 2022, to establish a network of sickle cell disease centers in Alameda, Fresno, Kern, Los Angeles, Sacramento, San Bernardino, and San Diego counties to: 1) provide access to specialty care and improve quality of care for adults with sickle cell disease; 2) support workforce expansion for coordinated health services; 3) conduct surveillance to monitor disease incidence, prevalence, and other metrics; 4) create a public awareness campaign; and 5) provide fiscal oversight of the resources.

Farmworker Health Study. The budget includes General Fund expenditure authority of $1.5 million, available until June 30, 2022, to support a study of farmworker health.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH provide updates on the implementation of these 2019 investments.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 11: MEMBER/STAKEHOLDER PROPOSAL: STD PREVENTION - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Sylvia Castillo**, Essential Access Health

Public Comment

PROPOSAL

This proposal is from the "End the Epidemics Coalition" which includes: APLA, San Francisco AIDS Foundation, Essential Access Health, and the Harm Reduction Coalition. The proposal is for an additional ongoing General Fund investment of $3 million – for a total of $10 million for the Department of Public Health's STD Control Branch to dispense throughout the state to support a comprehensive, evidence-informed approach to STD prevention and improve the capacity of local health jurisdictions to address rising STD rates in their region. Funding will be prioritized to serve communities disproportionately impacted by STDs, and will be distributed through a competitive grant process to local health jurisdictions (LHJs). Once the funds are received, LHJs would be required to sub-grant out at least 50% of the funding to community-based organizations.

The fiscal year (FY) 2019-2020 state budget included a $2 million ongoing allocation to the STD Control Branch for STD treatment and prevention activities, and as well as an additional $5 million each year for a period of three years (through FY 2021-2022), to be evaluated in subsequent years and updated based on state budget projections. In his FY 2020-2021 budget proposal, Governor Newsom extended the suspension date to FY 2022-2023.

The ETE coalition supports the Governor's proposal to extend the suspension date, and requests an additional $3 million – for a total of $10 million – ongoing from the General Fund to support STD prevention activities statewide and improve the capacity of LHJs to address rising STD rates in their region. Funding could be used to:

1. Conduct surveillance activities to track and share data
2. Support culturally appropriate and responsive outreach and health promotion efforts
3. Implement innovative community-based projects to effectively reduce local STD rates.

BACKGROUND

The following background was provided by the stakeholder making this request:

STD rates are at an alarming and historic high in California and across the country. Nearly 340,000 Californians were infected with syphilis, chlamydia, or gonorrhea in 2018 – up 40% since 2013. In 2016 alone, gonorrhea rates increased by double digits in the following counties: Los Angeles 27%, San Diego 35.5%, San Francisco 18%, and Kings 41%. Mendocino and Sacramento counties led the increase at 81% and 50%, respectively. STD rates in these counties and throughout the state continued to climb in 2017 and 2018. California also has the second highest syphilis rates in the nation. Between 2008 and 2018, the syphilis rate among women of reproductive age increased by 743%.

Untreated STDs can lead to serious long-term health consequences. The CDC estimates that 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. 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. In 2018, more than 329 babies were born with congenital syphilis in California and there were 20 stillbirths associated with the disease. STDs also increase both the transmission and acquisition of HIV.

Although our STD public health crisis is affecting communities across the state, youth, people of color, bisexual and transgender women, and gay and bisexual men are disproportionately impacted. Statewide data indicate over half of all STDs in the state are experienced among California youth ages 15-24 years old. Currently, African Americans are 500% more likely to contract gonorrhea and chlamydia than their white counterparts.

Approximately $1 billion is spent annually in California on health costs associated with STDs. Federal funding for STD prevention in the state has dropped by roughly 40% over the last 15 years. As funding withered, county public health departments and local health jurisdictions adjusted by shutting down stand-alone STD clinics, reducing staff levels and suspending surveillance and case management programs. Currently, only a few counties employ disease investigators that monitor STDs and most focus on employing low-cost strategies – such as improving inter-department collaboration and patient linkages to existing programs. The proposed funding will improve the capacity of LHJs to address rising STD rates in their region.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Essential Access Health to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 12: MEMBER/STAKEHOLDER PROPOSAL: SYRINGE EXCHANGE CLEARING HOUSE - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Jenna Haywood**, Harm Reduction Coalition

Public Comment

PROPOSAL

This proposal is from the "End the Epidemics Coalition" which includes: APLA, San Francisco AIDS Foundation, Essential Access Health, and the Harm Reduction Coalition. In order to reduce the rate of overdose deaths, as well as rates of HIV and viral hepatitis among people who inject drugs, the End the Epidemics coalition urges the legislature to increase the annual budget for the Office of AIDS Syringe Exchange Supply Clearinghouse from the current $3 million to $8 million per year. This change is urgently needed to meet the rapid expansion of programs, and the increased number of people seeking assistance to prevent fatal overdose and the transmission of potentially deadly infections. These funds will provide hundreds of thousands of Californians with the tools they need to protect themselves and their families.

The End the Epidemics coalition requests $5 million ongoing funds for this proposal. This would increase the current clearinghouse supply budget from $3 million per year to $8 million per year.

BACKGROUND

The following background was provided by the stakeholder making this request:

California syringe service programs (SSPs) distribute supplies to program participants who use drugs to prevent transmission of HIV, hepatitis C and B, skin and soft tissue infections, and other health conditions. Supplies include sharps containers for the safe recovery and disposal of syringes, syringes, fentanyl test strips, sterile water, and other materials to provide for sterile injection and safer sex. This is consistent with CDC guidelines for HIV prevention among people who use drugs. In 2016, naloxone kits to reverse overdoses were added to the Clearinghouse and in 2019 harm reduction supplies for other routes of administration were added, enabling harm reduction providers to connect to people at risk who may not be injection drug users.

SSPs are effective public health programs, reaching people often described as “hard to reach” and in need of services. The supplies offer a public health resource for marginalized communities and serve as a tool to connect people to care. Sterile syringes are the most cost-effective HIV and HCV prevention tool available. A 2019 study looking at cost-effectiveness of syringe access in Philadelphia documented a $240 million dollar savings each year due to averted HIV treatment. This did not account for savings related to prevention of other infectious diseases. Growth in demand for sterile syringe drives uptake of other vital services as well. From 2015 to 2017, there was a 77% increase in the number of SSPs providing HIV testing, and a 233% increase in on-site HCV testing. This investment of an additional $5 million will save California far more than that in averted HIV and HCV cases, prevented overdose deaths, and linkage of people to care and treatment.

Last year, $15 million over four years was included in the state budget to support staffing at SSPs and provide ongoing technical assistance and program administration; this funding is not available for supplies. Those funds will allow for critical expansion of services for harm reduction programs. However, without a similar increase in the Clearinghouse supply budget these programs may not be able to provide the full range of the supplies their participants need. This requested budget increase will enable California to experience the full benefits of the $15 million already invested in these essential services.

Since 2015, when the Clearinghouse was established, 13 new SSPs have been authorized in California, reaching 10 additional counties. An estimated 6 new programs will open in 2020, reaching 5 additional counties. This growth in programs represents the implementation of legislative intent and is meeting the growing need for services, particularly in rural areas with high rates of overdose and hepatitis C. The Office of AIDS reports a 50% increase in the number of program participants in just two years, from 2015 to 2017. There are now more programs than ever before, and the average amount of syringes distributed by programs increased by 53.2% from 2015 to 2017. In 2018, SSPs were asked if they felt that the demand for supplies was higher, about the same, or lower compared to 2017. Of the 32 programs that responded, 85% indicated that demand for supplies was higher in 2018 compared to 2017, 15% reported it was about the same, and no program reported that demand had decreased. The addition of $5 million to support the clearinghouse supply budget will address these increases in demand and vast growth of SSPs that have occurred since 2015 and the anticipated growth of 2020 and beyond.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Harm Reduction Coalition to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 13: MEMBER/STAKEHOLDER PROPOSAL: MASTER PLAN ON HIV, STDS, HCV - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Craig Pulsipher**, APLA Health

Public Comment

PROPOSAL

The End the Epidemics coalition requests $2 million general fund one-time for the Secretary of Health and Human Services and the Chief of the Office of AIDS to develop a Master Plan on HIV, HCV, and STDs. This proposal will provide HHS and OA with additional resources to convene a stakeholder advisory committee and work with relevant state agencies to set targets for ending the HIV, HCV, and STD epidemics and identify recommended programs, policies, strategies, and funding for achieving these targets. This proposal is consistent with SB 859 (Wiener).

The End the Epidemics coalition requests $2 million general fund one-time for this proposal. This proposal is modeled after SB 228 (Jackson), which requires the Secretary of Health and Human Services to lead the development and implementation of a statewide Master Plan on Aging. According to the July 2019 Assembly Appropriations Committee analysis, SB 228 would require unknown costs, likely in the mid- to high-hundreds of thousands of dollars for salary, operating expenses, equipment and support staff for the individuals leading the development of the Master Plan. In addition, the bill would require unknown costs, likely in the mid-hundreds of thousands of dollars, for a state agency to establish and administer a task force (similar to the stakeholder advisory committee outlined in this proposal). This would include consulting services and state staff support to provide research and administrative support to the task force. The bill would also result in potentially minor costs to other departments for additional workload necessary for the heads of departments to participate in the development of the Master Plan. Based on this information, we estimate $2 million general fund one-time will be adequate to support the development of a statewide Master Plan on HIV, HCV, and STDs.

BACKGROUND

The following background was provided by the stakeholder making this request:

HIV, hepatitis C (HCV), and sexually transmitted diseases (STDs) remain among the most serious public health issues in California. According to the Department of Public Health, California's STD rates continue to climb and are at the highest levels in 30 years. Most concerning is the continued steep increases in the number of congenital syphilis cases, which are nearly 900% higher than in 2012. The state's HCV epidemic is also growing rapidly, with rates of newly reported chronic HCV increasing 50% among young people from 2014-2016. New HIV diagnoses declined roughly 9% from 2014-2018, but communities of color remain disproportionately impacted and health inequities continue to increase.

With the highly effective prevention and treatment tools now available, states and cities across the country are scaling up efforts to reduce new infections and ultimately end these epidemics. In 2014, Governor Cuomo launched a statewide initiative to end AIDS as an epidemic in New York. The state has committed more than $20 million annually to implement the strategy and new HIV diagnoses have already declined 40%. This dramatic progress has led New York to commit to a statewide HCV elimination plan. New York's success provides evidence that a comprehensive strategic plan, coupled with strong political will and adequate resources, can drive significant progress in reducing new transmissions and improving the health of people living with these conditions.

Similar efforts are now underway at the federal level. Most significant is the effort by the Department of Health and Human Services, Office of the Assistant Secretary for Health to develop the first federal STD action plan. This plan is scheduled for release in calendar year 2020, along with updates to the National HIV/AIDS Strategy, National Hepatitis Action Plan, and the End HIV Initiative. According to a November 2019 report from the National Academy of Public Administration, "This new STD effort offers an opportunity to bring cohesion and coordination to STD prevention and control efforts across the federal government. Moreover, intensified efforts to combat hepatitis, HIV, and STDs can be tied together through a cross-cutting plan to bring different entities to the table and to design funding opportunities and programs that will allow for more flexibility in the dollars provided. As the STD action plan develops, emphasis should be placed on developing cohesion across federal entities and providing tools for states and localities to do the same. Greater coordination between entities with intertwined goals, as in the case of STD and HIV elimination, can reduce program conflicts, provide a greater pool of available funding, and enable public health services in different program areas to reach patients they may otherwise miss."

California has an opportunity to demonstrate bold leadership by becoming the first state in the nation to develop a comprehensive strategy to simultaneously address HIV, HCV, and STDs. These epidemics affect similar vulnerable populations and can be effectively addressed using many of the same prevention and treatment tools. They are also driven by similar social and economic conditions, including stigma, poverty, and unstable housing. Integrating the state's response to these epidemics is critical to better leverage public health and health care delivery infrastructure and more effectively reach and care for vulnerable individuals and communities.

HHS has already taken a critical step toward the creation of a statewide Master Plan on HIV, HCV, and STDs. HHS recently approved a proposal from the California Department of Public Health to integrate its HIV, viral hepatitis, and STD activities into a single new Division. As part of the integration process, OA is updating its Integrated HIV Surveillance, Prevention and Care Plan with the goal of addressing the interrelated epidemics of HIV, HCV, and STDs.

However, these actions will fail to have their desired impact without increased inter-agency collaboration, community engagement, and new resources to fully implement the plan. A statewide Master Plan will only be successful if it is a shared priority for all state agencies that serve people living with and vulnerable to these conditions. Currently, California is missing key opportunities to positively impact these epidemics due to limited cross-departmental prioritization and collaboration. For example, the Department of Health Care Services recently launched California Advancing and Innovating Medi-Cal (CalAIM), a multi-year initiative to implement broad reforms across the Medi-Cal program and help address the complex challenges facing California's most vulnerable residents. Unfortunately, HIV, HCV, and STDs have not been adequately prioritized in CalAIM to ensure that Medi-Cal enrollees are properly screened for these conditions and linked to appropriate prevention and treatment services.

This proposal will provide HHS and OA with additional resources to develop a cross-departmental, community-informed statewide Master Plan on HIV, HCV, and STDs. HHS and OA will be required to convene a stakeholder advisory committee, including representation from local government, health care providers, health plans, community-based organizations, academic researchers, and people living with and vulnerable to these conditions. HHS and OA will also be required to work with relevant state agencies to develop the Master Plan, including, but not limited to, the Department of Public Health, the Department of Health Care Services, the Department of Social Services, the Department of Aging, the Department of Corrections and Rehabilitation, the Department of Housing and Community Development, and the Department of Education.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests APLA Health to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 14: MEMBER/STAKEHOLDER PROPOSAL: HIV HEALTH INEQUITIES - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Courtney Mulhern-Pearson**, San Francisco AIDS Foundation

Public Comment

PROPOSAL

The End the Epidemics coalition requests $15 million general fund ongoing to address HIV health inequities, particularly among communities of color. While new HIV cases declined roughly 9% from 2014 to 2018, progress has been uneven and Black and Latinx communities remain disproportionally impacted by the epidemic. The proposed funding will support biomedical and structural interventions to improve HIV health outcomes among the state's most underserved residents, particularly Black and Latinx people living with and vulnerable to HIV. Funding will be distributed by the Office of AIDS through a competitive grant process to local health jurisdictions and community-based organizations.

Last year, the Legislature allocated $5 million general fund to increase HIV prevention services for the state's most vulnerable residents. This funding is currently being distributed to community-based organizations and health departments through a competitive process designed specifically to address health inequities among African American and Latinx communities. The funding opportunity – entitled Project Empowerment – will support the strategic planning and implementation of innovative and culturally responsive programs that reduce health inequities, HIV-related stigma, medical mistrust, and barriers to HIV prevention, care and treatment services.

These investments are a step in the right direction, but available data suggest they are not nearly enough to address HIV health inequities statewide. The Office of AIDS received 55 applications totaling roughly $16.5 million for this funding opportunity.

Project Empowerment Applications				
	Population Focus	Award Amount	Applications Received	TOTAL
Track A	African American	$1,000,000	5	$7,250,000
		$250,000	9	
Track B	Hispanic/Latinx	$1,000,000	1	$8,000,000
		$250,000	28	
Track C	Staffing and Capacity	$100,000	12	$1,200,000

In order for California to make more significant progress in addressing HIV health inequities, the state must build on last year's investment and allocate additional funding to support local health jurisdictions and community-based organizations in their efforts to reach communities most impacted by HIV. The End the Epidemics Coalition requests an additional $15 million ongoing to expand and support implementation of evidence-based and strength-based strategies that include biomedical and structural interventions tailored to the needs of the state's most underserved residents, particularly African American and Latinx individuals living with and vulnerable to HIV.

BACKGROUND

The following background was provided by the stakeholder making this request:

Preliminary 2018 HIV surveillance data indicate that California is beginning to make more significant progress in the fight against HIV. Following years of stagnation, the state's annual number of new HIV diagnoses declined by just over 9% (5,249 to 4,747) from 2014 to 2018. This progress can likely be attributed to a number of factors, including the state's accelerated efforts to identify people living with HIV who remain undiagnosed, increase use of pre-exposure prophylaxis (PrEP), and ensure people living with HIV have access to ongoing care and treatment.

Since $33 million in general fund support for HIV prevention services was cut during the 2009 fiscal crisis, California has restored roughly $13 million general fund annually to support an array of HIV prevention programs. The state also recently allocated an additional $15.2 million general fund one-time over 4 years to fund staff positions in harm reduction programs.

General Fund Support for HIV Prevention Activities	
Strategic HIV Prevention Projects	$3 million annually
PrEP Education and Navigation	$2 million annually
Syringe Exchange Supply Clearinghouse	$3 million annually
Project Empowerment	$5 million annually through FY 2022-23
Harm Reduction Navigators	$15.2 million one-time over 4 years

Despite this progress, however, HIV health inequities continue to increase. From 2014 to 2018, the number of new HIV diagnoses decreased over 20% among whites (1,487 to 1,187), while decreasing only 4% among Latinxs (2,365 to 2,272) and increasing 2% among African Americans (840 to 857). Among gay and bisexual men, who account for roughly three-quarters of new HIV cases, HIV diagnoses declined nearly 28% among whites (1,080 to 781), but declined just over 5% among Black (478 to 452) and Latinx (1,686 to 1,589) gay and bisexual men.

Black and Latinx individuals are less likely to be virally suppressed (55% and 58%, respectively) than their white counterparts (67%). Similarly, PrEP uptake has been lowest among populations most impacted by HIV, including Black and Latinx gay and bisexual men and transgender women. These communities may experience multiple barriers to accessing PrEP and achieving viral suppression, including stigma, medical mistrust, mental health and substance use issues, and structural barriers such as poverty and homelessness. Increasing inequities underscore the urgent need to improve and expand HIV prevention efforts for these populations.

Research demonstrates that retaining people living with HIV in care in order to achieve viral suppression is the most efficacious strategy for reducing HIV incidence. Meanwhile, with the emergence of various new evidence-informed HIV prevention interventions over the last several years, researchers and providers have come to recognize that no single approach aimed at increasing viral suppression is sufficient to control HIV, and that even the most efficacious interventions are not likely to succeed if they are delivered in isolation. Rather, they should include a combination of strategic prevention strategies that encompass prevention and care, and include biomedical, behavioral, and structural interventions. Components that address cultural, social, economic, and other factors such as stigma and intimate partner violence, which directly influence HIV prevention and transmission, are also a valuable part of an overall strategy.

The proposed funding will provide grants to local health jurisdictions and community-based organizations to support implementation of evidence-based and strength-based strategies that include biomedical and structural interventions tailored to the needs of the state's most underserved residents, particularly African American and Latinx individuals living with and vulnerable to HIV. The intended outcomes include increasing viral suppression, increasing linkage to and retention in HIV care, increasing knowledge of HIV status, and increasing linkage to and uptake of PrEP. Funding will be distributed by the Office of AIDS through a competitive grant process. Because the specific needs of local health jurisdictions vary widely, applicants will identify the range of HIV prevention services needed in their geographic area.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the San Francisco AIDS Foundation to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 15: MEMBER/STAKEHOLDER PROPOSAL: ADAP & PRE-AP ELIGIBILITY INCREASE - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Courtney Mulhern-Pearson**, San Francisco AIDS Foundation

Public Comment

PROPOSAL

The End the Epidemics Coalition requests budget authority to increase ADAP and PrEP-AP eligibility from 500% FPL to 600% FPL in order to align with the new state subsidies for individuals enrolled in Covered California. ADAP rebates can be used to fund this increased eligibility limit. This proposal will be implemented by the Office of AIDS.

BACKGROUND

The following background was provided by the stakeholder making this request:

California's AIDS Drug Assistance Program (ADAP) and PrEP-Assistance Program (PrEP-AP) are the backbone of the state's efforts to end the HIV epidemic. ADAP provides financial support for medications, health insurance premiums, and medical out-of-pocket costs for low-income residents living with HIV. The program serves over 31,000 Californians each year. The PrEP-AP covers PrEP- and PEP-related medical expenses and medication costs for low-income residents who are at risk of acquiring HIV. Since it was launched in 2018, the program has already helped over 3,500 individuals access PrEP for HIV prevention.

As a covered entity in the 340B Drug Discount Program, ADAP collects mandatory rebate for a majority of prescriptions purchased for ADAP clients. The program also receives voluntary supplemental rebates, over and above the 340B mandatory discount, that are negotiated at the federal level through the ADAP Crisis Taskforce. Mandatory and voluntary supplemental rebates from drug manufacturers account for roughly three-quarters of California's ADAP budget. For FY 2020-21, the Office of AIDS estimates that ADAP expenditures will be nearly $470 million with just over $355 million in rebate revenue. The remaining $115 million comes from federal funds.

Over the past several years, California has used rebate dollars to make several critical improvements to its ADAP and PrEP-AP to provide more comprehensive coverage for enrollees. ADAP was expanded to include coverage for medical out-of-pocket costs, employer-based health insurance premiums, and Medigap policies. PrEP-AP is being

expanded to provide coverage for youth and insured individuals with confidentiality concerns, among other changes. In 2015, the ADAP income eligibility level was increased from a flat cap of $50,000 to 500% FPL in order to align program eligibility with other high cost states.

Since that time, however, the cost of living in California has continued to rise and millions of low-income residents struggle to make ends meet. The 2019-20 budget included funding for new state subsidies to help more low- and middle-class Californians afford health coverage through Covered California. The new subsidies made California the first state in the nation to offer financial assistance to qualified individuals with incomes between 400% and 600% FPL.

The End the Epidemics coalition urges the Legislature to increase ADAP and PrEP-AP eligibility from 500% FPL to 600% FPL in order to align with the new state subsidies for individuals enrolled in Covered California. We estimate that this change would have a very small impact on the number of individuals served by these programs but for this limited number of individuals will provide the assistance necessary to access lifesaving medication and related medical services for HIV treatment and prevention.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the San Francisco AIDS Foundation to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 16: MEMBER/STAKEHOLDER PROPOSAL: HCV PREVENTION - END THE EPIDEMICS COALITION AND ASSEMBLYMEMBER TODD GLORIA

PANELISTS

- **Anne Donnelly**, San Francisco AIDS Foundation

Public Comment

PROPOSAL

The End the Epidemics coalition is requesting a $15 million ongoing investment in HCV prevention, linkage to and retention in care, centering services for people who use drugs. This proposal will be implemented by the Department of Public Health, Office of Viral Hepatitis Prevention. Funding will be allocated to community-based organizations and local health departments that demonstrate expertise, history, and credibility working successfully in engaging the most vulnerable and underserved individuals living with or at high risk for HCV.

California has invested in funding HCV treatment, which represents a cure for more than 95% of those treated, throughout the state. However, the state has made very little investment, currently just over $5 million, in the public health efforts, including health navigation and linkage services, necessary to ensure that Californians living with HCV know their status and are supported in engaging in culturally competent care and the treatment that can cure their chronic HCV. This limited investment has crippled the ability to build the infrastructure necessary to provide and measure the efficacy of needed prevention, linkage and retention services.

Currently, more than half of the estimated 400,000 Californians living with HCV are unaware of their status. The epidemic is growing at alarming rates among California youth, driven by the opioid epidemic and other drug use. In order to improve health outcomes, cure Californians living with HCV, prevent the further spread of the virus, avert the significant costs associated with untreated HCV, and ultimately end the epidemic, the End the Epidemics coalition is requesting a $15 million ongoing investment in HCV prevention, linkage to and retention in care, centering services for people who use drugs. This proposal will be implemented by the Department of Public Health, Office of Viral Hepatitis Prevention. Funding will be allocated to community-based organizations and local health departments that demonstrate expertise, history, and credibility working successfully in engaging the most vulnerable and underserved individuals living with or at high risk for HCV.

The proposed investment of $15 million general fund ongoing would support approximately 25-30 programs, centering people who use drugs, and serve over 166,000 Californians with evidence-based and innovative HCV outreach, screening, and linkage to and retention in care. Four California demonstration projects funded in FY 2015-16 tested over 35,000 people for HCV with a positivity rate of 7.5%. It is estimated the projects resulted in the cure of 95% of those linked to and retained in medical care. In spite of the success of the demonstration projects, they were not refunded. The $15 million proposed investment would maintain and expand this important infrastructure. It would also fund much needed staff in the state Office of Viral Hepatitis Prevention to ensure oversight, technical assistance, enhanced monitoring, and the most effective and efficient funding allocation. Because the specific needs of local health jurisdictions and community-based organizations vary widely, funded entities will identify the range of HCV prevention, testing, and linkage to care services needed in their geographic area.

BACKGROUND

The following background was provided by the stakeholder making this request:

National estimates indicate there are approximately 400,000 Californians living with hepatitis C (HCV) and over half (55%) are unaware of their infection. Left untreated, HCV can cause scarring of the liver (cirrhosis), end-stage liver disease, liver cancer and death. The CDC reports that HCV is responsible for more deaths than the next 59 infectious diseases combined. The rate of HCV infection among youth, those under 30, is increasing rapidly. From 2014 to 2016, a total of 13,683 HCV cases were reported among people ages 15-29, and the rate increased 50% over this time period. These dramatic increases are related to the increase in opioid use, injection of heroin, and other drug use. There were 38,656 newly reported cases of HCV in 2016 and California ranked first in new cases among all states that published their surveillance data.

Yet, in spite of these alarming statistics, California invests only slightly more than $5 million general fund in HCV prevention and linkage to and retention in care. These services are essential to support those living with HCV and at risk for infection, particularly for young people who are using drugs, who are often disenfranchised from traditional resources and health care networks and who are most at risk for transmitting HCV. A recent report by the National Academies of Science, Engineering and Medicine found that a key barrier to entering care for those using drugs to was self and societal stigma. It found that stigma surrounding both opioid use disorder and infectious disease may prevent patients from seeking or accessing care and provider stigma may inhibit a productive patient – provider relationship. The U.S. Department of Health and Human Services' National Viral Hepatitis Action Plan included as two key strategies ensuring that people who use drugs have access to viral hepatitis prevention services and improving

access to and quality of care and treatment for people infected with viral hepatitis. Research from the American Association for the Study of Liver Diseases (AASLD) found that undiagnosed and untreated young adults represent a growing proportion of HCV patients and addressing gaps in prevention and care among young patients is essential to treating HCV infection. Finally, the largest study of real-world HCV linkage to care from 2013 – 2016 found that linkage to an HCV specialist remains a large hurdle in the HCV care cascade, especially for those young patients at highest risk to transmit HCV.
Supporting prevention and screening services at the places that young people using drugs are welcomed and served without stigma and discrimination and ensuring that navigation services and peer support are available to connect those who test positive with culturally appropriate and quality viral hepatitis care is necessary to improve health outcomes and reduce HCV transmission.

We have an unprecedented chance to end the HCV epidemic in California. Treatments provide cure rates of over 95%, with an 8-12 week simple, relatively inexpensive protocol with minimal side effects. Direct acting antivirals (DAAs) eliminate the virus, stop the attack on the liver, improve health, avert health costs associated with chronic HCV, and prevent ongoing transmission. Curing HCV changes lives for individuals, families and communities. It improves health outcomes, energy levels, dramatically increases life expectancy, and reduces health care expenses. Adequately funding the public health efforts that support people, particularly those most disenfranchised from health care networks, in accessing culturally competent, quality HCV testing, linkage to and retention in care and treatment is key to ending this epidemic and improving the lives and health of some of the most vulnerable Californians.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the San Francisco AIDS Foundation to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 17: MEMBER/STAKEHOLDER PROPOSAL: STD NAVIGATORS - COUNTY HEALTH EXECUTIVES ASSOCIATION OF CALIFORNIA AND ASSEMBLYMEMBER FREDDIE RODRIGUEZ

PANELISTS

- **Assemblymember Freddie Rodriguez**
- **Trudy Raymundo**, Director, San Bernardino County Public Health Department

Public Comment

PROPOSAL

The County Health Executives Association of California (CHEAC) is requesting $20 million General Fund in targeted resources to local health departments for specific activities to target individuals who are experiencing reinfections or who are infected with multiple STDs at the same time, with the goal of decreasing the STD infection rate.

$20 million in ongoing state General Fund
The estimated average cost of a public health nurse is $160,000 and closer to $200,000 for larger jurisdictions. This funding level would fund roughly 100 to 125 public health nurses, but would allow flexibility for other staffing levels depending on the need and circumstances within each jurisdiction.

The funding – which would be appropriated to the California Department of Public Health – and allocated to all 61 local health departments to provide the following service to 1) individuals who are experiencing reinfections of syphilis, chlamydia, and gonorrhea, 2) individuals who are diagnosed with more than two STDs at the same time, and 3) individuals with diagnosed with HIV and STDs.

The navigation and coordination services that local health departments would provide include, but is not limited to, all of the following:

1. Assess the health and social needs of clients.
2. Identify and resolve client risk factors and obstacles to care.
3. Establish routine contact with clines, including those who may be difficult to locate.
4. Coordinating referrals and connections to address health and social needs, including behavioral health services, housing, homelessness assistance, and harm reduction counseling and services.
5. Ensure clients receive care and follow-up in a timely manner including follow-up with primary care providers.
6. Provide outreach and navigation services to the client's sexual partners.
7. Routine follow-up education and access to prevention and screening services.

BACKGROUND

The following background was provided by the stakeholder making this request:

Sexually transmitted diseases (STDs) are increasing in all regions of the state, among both men and women. In 2018, the number of reported sexually transmitted disease (STD) cases in California was 25,344 for syphilis (all stages), which is 265% more than 10 years ago; 79,397 for gonorrhea, which is 211% more than 10 years ago; and 232,181 for chlamydia, which is 56% more than 10 years ago.

California needs a strategy to address the STD reinfection rates, which vary from county to county and in some instances are roughly a quarter (or 25 percent) of reported cases. There are several underlying drivers of the increase in STDs, including poverty, homelessness, substance use, disparities in access to care, changes in sexual behaviors, and the exchange of sex for money, housing, and other resources. More intensive outreach, coordination, navigation and connection to health and social services will help local jurisdictions decrease the growth in STDs rates. Local health departments are well-positioned to provide face-to-face navigation and coordination of services for vulnerable and hard to reach populations who have STDs.

Syphilis is a major public health problem in California and has increased in all regions of the state, and among both males and females. In 2018, according to the U.S. Centers for Disease Control and Prevention (CDC), California was ranked second in the nation for primary and secondary syphilis rates.

The number of infants born with congenital syphilis in California increased for the 6th year in a row in 2018. Congenital syphilis can cause severe illness in babies including premature birth, low birth weight, birth defects, blindness, and hearing loss. It can also lead to stillbirth and infant death. In 2018, according to the CDC, California ranks fifth in the nation for congenital syphilis rates.

Chlamydia and gonorrhea are the most commonly reported STDs in California. Although these STDs are curable, they often do not show symptoms and go undetected, which can lead to serious complications like infertility. Chlamydia and gonorrhea disproportionately impact people in their teens and twenties.

Local health departments are underfunded. There is no specific funding source to address individuals experiencing reinfections. State and federal funding for communicable disease control activities have considerably declined over time and are primarily siloed based on the disease.

While the funding provided in the 2019-20 state budget addresses screening and treatment of sexually transmitted disease, it was not intended to address the high-touch work associated with individuals who experience reinfections. Individuals experiencing reinfections of syphilis, chlamydia, or gonorrhea have several underlying complex health and social issues, which may include poverty, homelessness, substance use, disparities in access to care, the exchange of sex for money/housing/other resources, and other changes in sexual behavior.

Under state law, local health departments are mandated to investigate all infectious venereal diseases, including syphilis, gonorrhea, and chlamydia, within their jurisdictions and to take measures to prevent the transmission of the infection.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Rodriguez and CHEAC present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 18: MEMBER/STAKEHOLDER PROPOSAL: TRANSGENDER WELLNESS & EQUITY FUND - TRANSLATIN@ COALITION AND ASSEMBLYMEMBER MIGUEL SANTIAGO

PANELISTS

- **Assemblymember Miguel Santiago**
- **Michaé Pulido,** Policy Coordinator, TransLatin@ Coalition

Public Comment

PROPOSAL

The TransLatin@ Coalition proposes to establish the Transgender Wellness and Equity Fund and appropriate $15 million one-time General Fund to that fund to be distributed as grants to transgender-led nonprofit organizations. These funds will be used to create, facilitate and fund holistic healthcare programs focused on coordinating health, behavioral health (mental health and substance use disorders), and social services, including supportive housing to address the mental health needs of people that identify as transgender, gender non-conforming, and/or intersex (TGI).

BACKGROUND

The following background was provided by the stakeholder making this request:

In a 2015 National U.S. Trans Survey, one-third (33 percent) of those who saw a health care provider in the past year reported having at least one negative experience related to being transgender, with higher rates for people of color and people with disabilities. These negative experiences include being refused treatment, verbally harassed, physically or sexually assaulted, or having to teach the provider about transgender people in order to receive appropriate care. While California has historically provided funding for LGBTQI+ programs and services, this would be the first state fund designated to address the specific medical and mental healthcare needs of TGI people, such as hormone therapy, transition surgery and mental health counseling. State funding is necessary for transgender-led organizations across the state to increase their capacity and expertise to provide TGI people with appropriate care.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Santiago and the TransLatin@ Coalition to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 19: MEMBER/STAKEHOLDER PROPOSAL: SEXUAL HEALTH INFORMATION AND EDUCATION PROGRAM - SEXUAL HEALTH EDUCATION ROUNDTABLE AND ASSEMBLYMEMBER JOAQUIN ARAMBULA

PANELISTS

- **Heather Meyers**, Regional Program Manager, Planned Parenthood Mar Monte

Public Comment

PROPOSAL

The Sexual Health Education Roundtable, comprised of over 50 stakeholder organizations, proposes an allocation of $33.5 million in state general funds for Information & Education (I&E) Program grants, operated by the Maternal, Child and Adolescent Health division of the California Department of Public Health (CDPH).

This proposal is intended to restore funding that used to be expended by the state prior to the 2008 recession and subsequent budget cuts. Following the 2008 recession, three of California's five Teen Pregnancy Prevention Programs (TPP Programs) dedicated to improving adolescent sexual health were eliminated, and funding for the two remaining programs were significantly cut to the point of a 94% decline in participants served. From 2008-2020, overall funding for TPP Programs dropped from $46.4 million to $18.5 million. Of the two remaining programs, I&E Program is flexible in terms of federal matching funds and therefore not subject to federal policy views, which currently contradict aspects of California law.

BACKGROUND

The following background was provided by the stakeholder making this request:

The I&E Program provides funding to deliver community-based sex education in high-need communities statewide. Of the five pre-recession TPP Programs, the allocation for the I&E Program was among the smallest, but it was cut nonetheless. According to the California Department of Finance, total funding for the I&E Program currently stands at $3.1 million, with $1.5 million of that dedicated towards local assistance. Only nine organizations in nine counties received grants for the current cycle, which ends in 2021, and grant amounts are now less than $125,000 per year.

Although the program was initially designed to focus on pregnancy prevention, it has evolved to address STI and HIV prevention, as well as connections to clinical services for testing and treatment. The public health benefits of sex education to reduce STIs and unintended pregnancies are well established. Additionally, sex education that is comprehensive, medically accurate, age appropriate, and inclusive can also equip youth with the knowledge and skills necessary to make informed decisions about their health and relationships. A recommitment of funds to the I&E program would ensure that this critical education reaches the Californians who are currently faced with some of the highest barriers to getting the information and care they need for their health and the health of their communities.

Reinstating funds for health education grants in the state starting in the 2020-2021 fiscal year would come at a critical time for costly public health challenges. Reported cases of syphilis, gonorrhea, and chlamydia hit their highest levels in 30 years. According to CDPH, disparities are the highest among young people (ages 15-24), African Americans, and men who have sex with men. Moreover, nearly 12% of California high school students have experienced sexual dating violence, and approximately 10% have experienced physical dating violence. While the state has begun to bring funding levels back up for local public health departments, comprehensive and long-term prevention must include education work in settings beyond public school classrooms.

There will be accompanying trailer bill language amending the authorizing statute (Welfare and Institutions Code Section 14504.3) to:

- align with modern terminology and updated code sections relating to sexual health education
- codify some of the best practices developed by the program administrators
- ensure stakeholder engagement in future adjustments to eligibility and standards relating to the selection of programs for funding
- establish the complementary nature between community-based adolescent sexual health programs and school-based instruction, governed by the California Healthy Youth Act

If funding is approved in the budget (including TBL) summer 2020, CDPH will have roughly five months to operationalize the expansion in grants and any correlating adjustments to eligibility before the RFA for the 2021-23 grant is published in January 2021. The proposed funds should be made available through I&E grants for the 2021-23 and 2023-25 grant cycles, at minimum, for a total allocation of $33.5 through at least 2025, including administrative overhead.

Given that sexual health education is an investment in preventing costly public health problems such as STIs, HIV/ AIDs, and intimate partner violence, it is worth noting the rate and consistent increase in STIs as an example of the potential cost savings within Health and Human Services:

The most common reportable disease in California is chlamydia (CT), which remains at the highest level since mandated reporting began in 1990. Looking at chlamydia and other infections, there are significant disparities within infection rates. Data indicates that juvenile detention facilities continue to have high rates of female CT infection, with the highest being 16.4% in Fresno County in 2018. Additionally, early syphilis infections among women of reproductive age reported increased 283% between 2014 and 2017. Among the more shocking STI statistics, is that the number of infants born with congenital syphilis (CS) increased for the sixth consecutive year in 2018, leading to 22 stillbirths or neonatal deaths in 2018 alone. Black Californians are impacted by CS at a rate than four times Latino and White Californians. Counties with the highest number of cases include Los Angeles, Kern, Fresno, San Bernardino, and San Joaquin.

These disparities among different populations are striking, but it is important to note that the STI epidemic spans urban, rural, north, central, and south regions of the state. Per the CPDH 2018 STD Surveillance Report, the 13 counties with chlamydia rates higher than the state average were San Francisco, Alpine, Kern, Sacramento, Solano, Fresno, Los Angeles, San Diego, Kings, San Bernardino Santa Barbara, Merced, and Alameda. In 2018, nearly one-third of counties reported a 10% or greater increase in gonorrhea (GC). The ten counties with rates higher than the state average were San Francisco, Los Angeles, Lake, Kern, Sacramento, Del Norte, Solano, Alameda, Fresno, and Yuba.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Sexual Health Education Roundtable to present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

NON-DISCUSSION ITEMS

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

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ISSUE 20: CYBER-SECURITY PROGRAM AUGMENTATION BUDGET CHANGE PROPOSAL

PROPOSAL

CDPH Information Technology Services Division (ITSD) and the Office of Legal Services (OLS) Privacy Office (Privacy Office) request expenditure authority of $1.9 million from various fund sources for 2020-21 and ongoing. This includes expenditure authority of $1.2 million for 9 positions, and $700,000 for security infrastructure tools.

These resources are needed to address the increasing number and sophistication of cybersecurity attacks and the unmitigated information security and privacy risks identified by security assessments conducted by the California Military Department's Cyber Network Defense, California Department of Technology's Office of Information Security, two independent security assessments, internal reviews, and Health and Human Services' Office for Civil Rights.

BACKGROUND

Privacy Office
The Privacy Office is responsible for ensuring the maintenance of the Privacy Program when the Department collects, uses, maintains, discloses, or disposes of personal or confidential information. The primary responsibility of the Privacy Office is to oversee and ensure the implementation of and compliance with California and federal privacy laws, including the California Information Practices Act (IPA) and the federal Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. The analysts supporting the Privacy Office draft correspondence, respond to inquiries from the public, assist in developing Privacy Office procedures, guidelines, and forms, support the analyses, investigation and response to privacy incidents, and assist with departmental privacy compliance activities.

According to CDPH, the Privacy Office is unable to promptly support all current department objectives or maintain compliance with federal, state, and industry privacy standards with current staffing levels. The Public Health Privacy Office currently has 7 OLS staff supporting the office with varying percentages of time addressing privacy issues.

ITSD Information Security Office (ISO)
The Information Security Office has the overall responsibility for ensuring the balanced protection of the confidentiality, integrity, and availability of the Public Health's electronic and physical information resources, computing systems, and software applications. Currently, the Public Health ISO has 6 staff. The IT Specialist I staff are focused on incident management and response, vulnerability management, state/federal compliance requirements, and technology recovery planning. CDPH states that the current staffing is insufficient to address all required activities of an ISO Office and all significant cybersecurity threats. Program activities not being addressed include: Enterprise Security Architecture and Strategic direction of Networks, Infrastructure, Middleware, Applications and, Systems and Services Management systems; Compliance checkpoints and reviews for HIPAA requirements; Role based Security Awareness training and periodic security newsletter development and publication; Fully develop a Computer Incident Response Team (CIRT) program and training; System Risk Management assessment reviews, mitigation strategies and, post implementation audits; Policy compliance variance tracking and reviews; Network infrastructure security configuration reviews; Perform scheduled periodic reviews to ensure compliance with CDPH, NIST, SAM and SIMM statutory and regulatory compliance; Assisting programs in the development of their recovery strategies within the Technical Recovery Plan (TRP); Conduct validation reviews of the TRP and its recoverability processes; Third party contractual security and risk assessments and audits; Data security and privacy categorization and classification.

ITSD Application Development and Support Branch (ADSB)
The ADSB provides support for new business applications and information technology systems; as well as, ongoing development and operational support for existing business applications and systems. The staff within the branch are organized around a typical 3-tier applications support structure consisting of tier 1: help desk and customer communications; tier 2: general support and business analyst; and tier 3: specialist positions. The ADSB is primarily a customer focused organization with the mission of supporting and troubleshooting 175 business applications and ensuring maximum up time for Public Health applications. Security is certainly an area of focus; however, Public Health's current security resources primarily come from a systems and infrastructure background and are in operational support roles. This leaves a large gap in application development and application security competencies where application security is the

primary focus. While CDPH is engaged in significant development activity both in house and contracted and routinely deploying internal and public facing applications on premise and in the cloud, CDPH lacks any resources specifically dedicated to application security architecture and testing. There are currently no dedicated staff working on security in this Branch.

ITSD Security Operations Center (SOC)
A Security Operations Center (SOC) was established in FY 2019-20 to address immediate operational security needs in the areas of threat analytics, cloud security, network intrusion detection, host-based intrusion detection, Security Information and Event Management (SIEM) monitoring and event orchestration, vulnerability scanning and remediation, systems configuration and patching, data sharing with CDT SOC and incident response. Staff positions redirected from existing operational units to address the immediate security needs oversee all incident responses with support from student assistants. There are currently the equivalent of 5 staff assigned; 4 half-time civil service staff and 3 student assistants. A part-time ITS III serves as a lead technical architect for the Department. The other 3 civil service staff continue to be directed back to workload on non-security related issues on a regular basis to address critical issues. The SOC with additional staff will extend operations hours (earlier & later) and add on call duties as well.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 21: IMMUNIZATION MEDICAL EXEMPTION PROGRAM (SB 276, SB 714) BUDGET CHANGE PROPOSAL

PROPOSAL

The CDPH, Center for Infectious Diseases, requests expenditure authority of $3.4 million in 2020-21, $3.1 million in 2021-2022 and annually thereafter for 15 permanent positions. These resources are necessary to meet the mandated workload related to standardizing the process for submitting and reviewing medical exemptions from immunizations required for admission to child care or school. SB 276 (Pan, Chapter 278, Statutes of 2019) and SB 714 (Pan, Chapter 281, Statutes of 2019) require building new capacity into an existing database (the California Immunization Registry [CAIR]) to implement a new program by January 1, 2021.

BACKGROUND

SB 276 and SB 714 require Public Health to develop, by January 1, 2021, a standardized medical exemption form to be used statewide by physicians and surgeons for a child whom a physician does not recommend immunization. Statute provides the minimum criteria that must be included in the form, including physician contact information, child and parents' names, a statement certifying physical examination of the child, and a description of the medical reason for which the exemption is required. The medical exemption form shall be transmitted directly into CAIR. CDPH is mandated to establish a system to monitor immunization rates at schools and institutions and review these rates annually. Under state law, the department must review the medical exemptions for any schools or institutions with rates less than 95 percent, who do not report, or of physicians who have submitted five or more medical exemptions in a calendar year. The department has the authority to review any exemption. If medical exemptions do not meet applicable Centers for Disease Control, Advisory Committee on Immunization Practices, or American Academy of Pediatrics criteria, or are found to be otherwise invalid by this new program, then the State Public Health Officer or designee is required to review and is authorized to revoke the exemptions. Parents are permitted to appeal an exemption revocation to the Secretary of the California Health and Human Services Agency (Agency). The statute outlines a framework for this appeal process and Public Health and Agency will develop specific procedures for appeals. The department is required to report physicians that meet certain criteria to the medical licensing boards of California.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 22: PREGNANCY-RELATED DEATHS AND SEVERE MATERNAL MORTALITY DATA BUDGET CHANGE PROPOSAL

PROPOSAL

CDPH requests 2 positions and $348,000 in General Fund expenditure authority in 2020-21 and annually thereafter to comply with SB 464 (Mitchell, Chapter 533, Statutes of 2019).

BACKGROUND

SB 464 requires Public Health to track and publish data on pregnancy-related deaths and severe maternal morbidity (SMM), including information about underlying cause and racial/ethnic identity. SB 464 modifies the current California Death Certificate and requires more detailed information about decedents' pregnancy status be collected electronically. Tracking and publishing data on SMM and maternal deaths is expected to help to inform the development of, and monitor the effectiveness of, quality improvement interventions aimed at reducing these burdens.

SMM is experienced, annually, by approximately 7,500 resident California women hospitalized for labor and delivery—with Black women experiencing the burden disproportionately (SMM rates for Black women are about twice those of white women). SMM includes labor and delivery related outcomes which were unexpected, and which can impair a woman's health, perhaps significantly, in the short or long term. SMM is on the rise in California and disparities persist, and the reasons are not entirely clear. It is likely the population of women giving birth has changed in ways that would explain the increase in SMM and the persistent disparities. Such changes could include increases in pre-pregnancy obesity, pre-existing chronic medical conditions, and maternal age.

In contrast to the large number of SMM cases, there are only about 60 maternal deaths annually—again, with Black women experiencing the burden disproportionately. In California, the rate of maternal mortality has decreased 55 percent since 2006. For women of color, however, and particularly Black women, the maternal mortality rate remains three to four times higher than White women. Although Black women make up only five percent of the birth cohort in California, they comprise 21 percent of pregnancy-related deaths.

This proposal will allow Public Health, through accurate data collection and publishing of findings regarding pregnancy-related deaths and SMM, to identify trends and develop informed policies and practices aimed at improving maternal health outcomes for women of color throughout the state.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 23: PROTECTING HEALTH THROUGH WEATHERIZATION AND ENERGY EFFICIENCY PROGRAMS BUDGET CHANGE PROPOSAL

PROPOSAL

CDPH requests 1 position and $140,000 ongoing in General Fund expenditure authority. These funds will be used to support the mandated activities of AB 1232 (Gloria, Chapter 754, Statutes of 2019), which directs the California Department of Public Health's Office of Health Equity (OHE) to assist the Department of Community Services and Development (CSD) with further implementation of the Energy Efficiency Low-Income Weatherization Program (LIWP), including development of a recommended action plan, providing health and financial benefits, and an assessment of the program.

BACKGROUND

SB 862 (Committee on Budget and Fiscal Review, Chapter 36, Statutes of 2014) directed CSD to develop and administer the Energy Efficiency LIWP.

SB 350 (De León, Chapter 547, Statutes of 2015) established California's 2030 greenhouse gas reduction target of 40 percent below 1990 levels. To achieve this goal, SB 350 sets targets for energy efficiency and renewable electricity, among other actions. It declared that there is insufficient understanding of the barriers for low-income customers to access renewable energy, and it required the Energy Commission to publish a study on these barriers and make recommendations on how to increase access to energy efficiency and weatherization investments to low-income customers.

SB 89 (Committee on Budget and Fiscal Review, Chapter 24, Statutes of 2017) required the Energy Efficiency LIWP to develop new program processes and solicitations regarding its single-family housing program.

The LIWP installs solar panels, solar hot water heaters, and energy efficiency measures in low-income single-family and multi-family dwellings in disadvantaged communities to reduce greenhouse gas (GHG) emissions through energy savings. As a California Climate Investments Program funded by the state's Greenhouse Gas Reduction Fund (Cap-and-Trade Program), LIWP makes investments within disadvantaged communities identified by the California Environmental Protection Agency (CalEPA) through the CalEnviroScreen tool. In October 2014, CalEPA designated the 25 percent of census tracts with the highest CalEnviroScreen scores as disadvantaged communities for the purpose of investing Cap-and-Trade proceeds. Eligibility is based on the tenant, not the property owner. Renters can reach out directly to service providers to have an

assessment conducted. However, services must be approved by the landlord, and there is an agreement that both the tenant and the landlord must sign.

Public Health's Climate Change and Health Equity Program (CCHEP) in the OHE embeds health and equity strategies in California climate change policy and planning. The Program helps to implement California's climate change laws, and shape state grants, plans, and policies to direct funding and other resources to communities facing inequities. The Program provides health and climate vulnerability data and indicators, conducts research, and creates tools for partners to improve health through climate action. This has included work to elevate the health impacts of, and policies and strategies to, address housing displacement through California Climate Investments Programs.

In 2017, CCHEP staff worked with CSD, Contra Costa Health Services, and Regional Asthma Management and Prevention Program (RAMPP) to develop a pilot project that created systems for cross-referrals between public health services and weatherization services in Contra Costa County. This collaboration resulted in a document that describes the health and economic benefits of residential weatherization and energy efficiency services as well as how health professionals can connect medically vulnerable clients with these services. This project and guidance serve as a model that could be replicated in communities across California.

CCHEP staff also served on the state's SB 350 Interagency Task Force on addressing barriers for low-income customers and disadvantaged populations to accessing clean energy and clean mobility options. CCHEP provided the public health and health equity perspective, including giving input to various SB 350 "Barriers" Task Force implementation plans and reports, participating in Task Force meetings and public workshops, and helping to showcase the Contra Costa County collaboration model, described above.

LIWP was created to provide low-income households with energy efficiency upgrades that both help the state meet its climate goals, while also improving living conditions for impacted communities. At the same time, the housing crisis across the state has resulted in gentrification and displacement that put the very households LIWP is intended to support at risk. Many renters feel vulnerable to these pressures and are wary of the potential for LIWP dollars invested in their homes to have the unintended consequence of pushing them out. A variety of policies, incentives, and mechanisms exist to maintain the affordability of units that receive LIWP funds and protect tenants and ensure that LIWP is achieving its intended mission of providing energy efficiency improvements that benefit low-income households.

AB 1232 required CSD to coordinate with California Energy Commission and Public Health's OHE to (a) Ensure greater cross-referral between public health agencies, Public Health's OHE, and the LIWP for comprehensive energy and healthy home improvements for low-income multifamily residents in disadvantaged communities; (b) promote projects that provide health benefits to tenants in low-income multifamily properties; (c) provide increased indoor air quality and address asthma or respiratory issues triggered by mold and moisture; (d) assess the effectiveness of the LIWP; (e) create a database of conditions found in homes that impact or could impact health negatively, to track neighborhood hotspots and provide data for environmental screening and social determinants of health tools; and (f) create mechanisms for enforcing state energy upgrade program requirements to maintain the affordability of units to low-income tenants.

STAFF COMMENTS/QUESTIONS

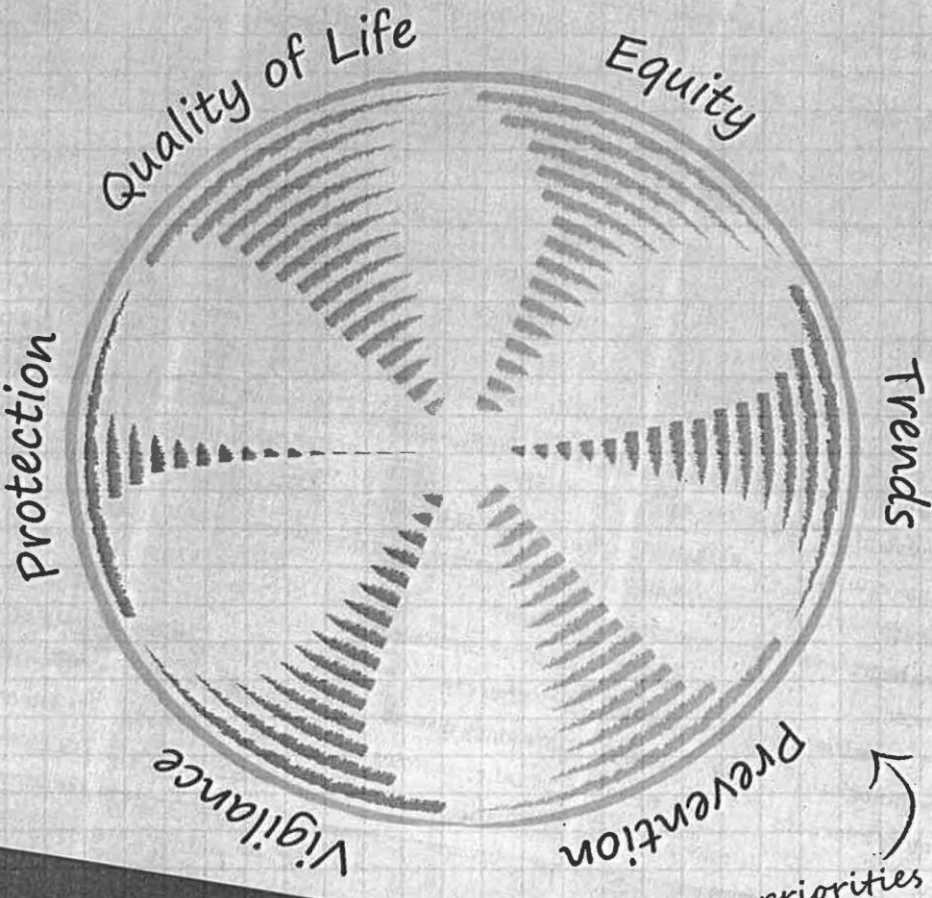
The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

Attachment A on the following page.

Measuring Public Health Status in California

A Summary



Only by understanding and addressing what creates, and what limits, the opportunities for health in our communities, can we implement a successful vision for a healthy California for everyone.

- Karen L. Smith, MD MPH
State Public Health Officer and Director

California Department of PublicHealth

February 25, 2019

Many ways to view the health status of Californians

Public health looks across multiple measures to identify significant trends and public health challenges.

Number of Deaths

Measures how many people died from a given condition.

1. Ischemic heart disease	37,800
2. Alzheimer's disease	24,880
3. Stroke	16,230
4. COPD*	13,260
5. Lung cancer	11,530
6. Hypertensive heart disease	11,530
7. Other cardiovascular	10,980
8. Unintentional injuries	9,509
9. Kidney disease	7,549
10. Congestive heart failure	7,172
11. Other cancer	6,965
12. Cirrhosis of the liver	6,648
13. Other neurological	6,403
14. Respiratory infections	6,333
15. Diabetes	5,993

While ischemic heart disease has decreased, it remains the top ranked condition based on multiple measures including total number of deaths. Alzheimer's disease was the second ranked condition.

Premature Deaths (Years of Life Lost)

Measures premature death based on the difference between the age at which a person actually dies and the age at which they would be expected to die in an ideal healthy population.

1. Ischemic heart disease	1,633
2. Unintentional injuries	872
3. Substance use	639
4. Stroke	633
5. Alzheimer's disease	605
6. Lung cancer	594
7. COPD*	533
8. Cirrhosis of the liver	521
9. Hypertensive heart disease	487
10. Suicide	474
11. Other cardiovascular	464
12. Other cancer	412
13. Kidney disease	375
14. Other neurological	343
15. Diabetes	332

Based on this measure the second and third highest ranking conditions become unintentional injury and substance use, two conditions affecting relatively younger people. Ischemic heart disease is still ranked first because of the large numbers of deaths from this condition.

Greatest % Increase in Deaths

Measures the change in the death rate over time and shows which conditions are increasing most rapidly.

1. Kidney disease	68.7
2. Ill-defined conditions **	41.9
3. Alzheimer's disease	32.8
4. Congestive heart failure	25.7
5. Substance use	22.2
6. Other neurological	20.2
7. Other infectious	16.1
8. Endocrine, blood, immune	14.8
9. Hypertensive heart disease	13.3
10. Liver cancer	10.8
11. Uterine cancer	7.3
12. Maternal conditions	7.0
13. Suicide	7.0
14. Other respiratory	5.4
15. Cirrhosis of the liver	(0.1)

Several conditions have increased substantially in California from 2007 to 2017 including Kidney diseases and Alzheimer's disease.

These measures prevent several different ways of ranking conditions that **cause deaths.**

California Department of PublicHealth

* COPD refers to chronic obstructive pulmonary disease.

** Ill-defined conditions refer to symptoms and signs not elsewhere classified. More research is nee number of deaths in this category relate to data coding issues, and/or issues of health care access

*** Social determinants of health are social, economic, and environmental factors that create or limi erfully influence health outcomes for entire populations.

Disparity Ratio

Measures the difference in the death rate between population groups (in this case race / ethnicity) for the same condition.

HIV and other STDs	16.5
Homicide	13.4
Tuberculosis	9.9
Skin cancer	8.4
Substance use	7.0
Ill-defined conditions**	4.7
Prostate cancer	4.4
Maternal conditions	4.3
Cardiomyopathy	4.2
10. Cirrhosis of the liver	3.9
11. Meningitis	3.2
12. Neonatal conditions	3.2
13. COPD*	3.2
14. Endocrine, blood, immune	2.9
15. Suicide	2.8

Persistent disparities in health remain, with a range of social determinants of health*** leading to some populations experiencing higher burdens of disease than others. The widest gaps are for HIV and homicide, in which the rates for the group with the worst outcomes are many times higher (16.5 and 13.4) than the group with the best outcomes.†

Years Lived With Disability

Measures the number of years during life where quality of life is decreased due to disability from each condition.

1. Low back pain	1,226
2. Headache disorders	866
3. Depressive disorders	730
4. Drug use disorders	663
5. Diabetes mellitus	642
6. Anxiety disorders	587
7. Hearing loss	522
8. Other musculoskeletal	512
9. Neck pain	509
10. COPD*	481
11. Falls	439
12. Stroke	313
13. Dermatitis	286
14. Osteoarthritis	264
15. Psoriasis	247

Back, head and neck pain, and mental health-related conditions are top ranking conditions based on years lived with disability. Diabetes and hearing loss also contribute greatly to years lived with disability.

Infectious Disease

Measures the number of new communicable disease cases.

1. Influenza	2,650,000
2. Chlamydia	472,000
3. Gonorrhea	287,000
4. Campylobacter	260,000
5. Giardia	165,000
6. Salmonella	140,000
7. E. coli 0157	77,000
8. Shigella	68,000
9. Cryptosporidiosis	42,500
10. Hepatitis C	33,748
11. Syphilis	28,000
12. Hepatitis B	10,169
13. Valley Fever	5,372
14. HIV	5,061
15. Tuberculosis	5,000

Common communicable diseases include respiratory infections (influenza), sexually transmitted infections (chlamydia, gonorrhea, syphilis), and gastrointestinal/food-borne infections (campylobacter, giardia). For some communicable diseases that do not "rank high" currently, there is potential for rapid epidemic increases and deaths if current control measures are not maintained.

These measures present conditions that impact **quality of life**.

† Disparity Ratio, Worst Rate : Best Rate per condition: 1. Black : Asian; 2. Black : Asian; 3. Asian : White; 4. White : Asian; 5. White : Asian; 6. Black : Asian; 7. Black : Asian; 8. Black : Asian; 9. Black : Asian; 10. Hispanic : Asian; 11. Black : Asian; 12. Black : Asian; 13. White : Asian; 14. Black : Asian; 15. White : Hispanic

The data above represent the most recent years available for each measure, More detail on back.

RELATED CDPH DATA RESOURCES

Let's Get Healthy California

CCB

Let's Get Healthy California is the state health assessment and improvement plan for advancing the health and wellbeing of California.

County Health Status Profiles Local health departments and epidemiologists choose and report selected public health indicators for each county in California.

Portrait of Promise is the state plan for health and mental health equity, presenting information on root causes and consequences of health inequities in California.

California Community Burden of Disease is an application developed by CDPH for epidemiologic analysis and scientific insight, exploring the intersection between health disparities and community conditions.

MEASURE DETAILS AND LIMITATIONS

Number of deaths (2017) describes the absolute magnitude of the disease or condition and is a clear and easily understood measure. This measure does not take into account the "age distribution" or size of the population, so can be misleading if making comparisons. All measures using vital statistics death data are limited based on the accuracy of the coding of cause of death on the death certificate.

Premature Deaths: Years of Life Lost (YLL) (2017) tilts towards conditions that cause more deaths among younger people, so YLL is sometimes referred to as "premature deaths". The number of years of life lost for deaths at each age are determined here using the "Global Burden of Disease" methods from the World Health Organization. Years of Life Lost are expressed here as rates per 100,000 population.

Percent Increase measures the change in the death rate over time and shows which conditions are increasing (or decreasing) most rapidly. This is measured here by showing the percentage increase in the age-adjusted death rate from 2007 to 2017. "Age-adjusted" death rates are used to account for the impact of the changing age distribution of the California population on the measure.

Disparity Ratio measures the difference in the death rate between population groups for the same condition using combined data from 2015 to 2017. Here the measure is based on differences between racial/ethnic groups. The measure compares the age-adjusted death rate in the group with the highest rate to the group with the lowest rate. A large ratio between the two rates indicates a large disparity.

California Department of PublicHealth

Years Lived with Disability (2015) is based on calculations and modeling done by the Institute for Health Metrics and Evaluation. These models utilize assumptions and multiple data sources to produce reliable California-specific estimates of years lived with disability. (expressed here as rate per 100,000 population)

Infectious Disease estimates are included for conditions that are "reportable" to public health authorities and for influenza, which is generally not reportable, but is a focus of substantial public health effort. All communicable diseases are associated with some level of morbidity and mortality, and most cases are preventable with known public health control measures. This measure uses "estimated" number of cases rather than reported numbers because, for a variety of reasons, for many conditions a large portion of cases that actually occur are not reported.

Chart footnotes:

1. Average of low and high estimates for 2015-2016 season based on national estimates for influenza
2. Condition not reportable to Public Health
3. 2011 CDC national foodborne burden of illness estimate
4. 2008 national estimates adjusted by CA proportion of population and increasing reports from 2008-2016
5. STEC O157 underreporting and underdiagnosis multipliers used for reports of shiga-toxin positive stools and hemolytic-uremic syndrome;
6. Number of cases of chronic infection newly reported in 2015
7. Number of cases reported in 2016
8. New HIV infections diagnosed and reported in 2016

Data Sources

1. Number of Deaths, Years of Life Lost, Percent Increase, and Disparity Ratio: Fusion Center analysis prepared using CDPH Vital Statistics Death Data Files, 2007-2017. www.cdph.ca.gov/Programs/CHSI/Pages/Data-and-Statistics-.aspx
2. Years Lived With Disability: Institute for Health Metrics and Evaluation (IHME). GBD Compare. Seattle, WA: IHME, University of Washington, 2015. vizhub.healthdata.org/gbdcompare
3. Infectious Disease: Center for Infectious Diseases, California Department of Public Health. www.cdph.ca.gov/Programs/CID/Pages/CID.aspx