AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 6, 2023

2:30 PM, STATE CAPITOL, ROOM 126

This hearing may be viewed via its live stream on the Assembly's website at https://www.assembly.ca.gov/todaysevents.

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

The public may provide public comment after all witnesses on all panels and issues have concluded, and after the conclusion of member questions. ***Toll-free: 877-692-8957, access code: 131 51 26***

ITEMS TO BE HEARD

LIST OF PANELISTS IN ORDER OF PRESENTATION

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE/PANEL 1: ANNUAL STATE OF THE STATE'S PUBLIC HEALTH

- **Dr. Tomás Aragón**, Director and State Public Health Officer, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance (DOF)
- **Will Owens**, Fiscal and Policy Analyst, Legislative Analyst's Office (LAO)

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE/PANEL 2: CALIFORNIA EMERGENCY MEDICAL SERVICES DATA RESOURCE SYSTEM BUDGET CHANGE PROPOSAL

- **Lorna Eby**, Deputy Director Project Management Division, Office of Systems Integration, California Health and Human Services Agency (CHHS)
- **Rick Trussell**, Chief of Administration, Emergency Medical Services Authority (EMSA)
- **Nina Hoang**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 3: AUTHORITY BUDGET OVERVIEW

- **Rick Trussell**, Chief of Administration, EMSA
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 4: EMS PERSONNEL HUMAN TRAFFICKING TRAINING IMPLEMENTATION (AB 2130) BUDGET CHANGE PROPOSAL

- **Rick Trussell**, Chief of Administration, EMSA
- **Kim Lew**, Chief of Personnel, EMSA
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 5: CALIFORNIA POST EREGISTRY ACT TRAILER BILL

- **Lorna Eby**, Deputy Director Project Management Division, Office of Systems Integration, CHHS
- **Rick Trussell**, Chief of Administration, EMSA
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 6: REMOVAL OF MEDICAL DOCTOR REQUIREMENT FOR THE EMSA DIRECTOR AND APPOINTMENT OF A CHIEF MEDICAL OFFICER TRAILER BILL

- **Shelina Noorali**, Finance Budget Analyst, Department of Finance (DOF)
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE/PANEL 7: DEPARTMENT BUDGET OVERVIEW

- **Brandon Nunes**, Chief Deputy Director, Operations, California Department of Public Health (CDPH)
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 8: 2022-23 BUDGET ADJUSTMENTS COVID-19 RESPONSE

- **Melissa Relles**, Assistant Deputy Director, Emergency Preparedness Office, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 9: COVID-19 RESPONSE BUDGET CHANGE PROPOSAL

- **Melissa Relles**, Assistant Deputy Director, Emergency Preparedness Office, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 10: COVID-19 WEBSITE TRANSITION AND INFORMATION TECHNOLOGY RESOURCES BUDGET CHANGE PROPOSAL

- **John Roussel**, Deputy Director, Information Technology Services Department, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 11: MAINTENANCE AND OPERATIONS OF INFECTIOUS DISEASES DATA SYSTEMS FOR SMARTER PLAN IMPLEMENTATION BUDGET CHANGE PROPOSAL

- **James Watt**, Assistant Deputy Director, Center for Infectious Diseases, CDPH (*Virtual*)
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 12: PUBLIC HEALTH WORKFORCE INVESTMENTS REVERSION

- **Susan Fanelli**, Chief Deputy Director, Health Quality and Emergency Response, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 13: *OVERSIGHT*: PANDEMIC RESPONSE, EMERGENCY PREPAREDNESS, AND PUBLIC HEALTH INFRASTRUCTURE

- **Susan Fanelli**, Chief Deputy Director, Health Quality and Emergency Response, CDPH
- **Christine Siador**, Assistant Director, Policy, Planning and Performance, CDPH
- **Julie Nagasako**, Deputy Director, Office of Policy And Planning, CDPH
- **Oussama Mokeddem**, Director of State Policy, Public Health Advocates
- **Michelle Gibbons**, Executive Director, County Health Executives Association of California (CHEAC)
- **Kim Saruwatari**, Riverside County Public Health Director, CHEAC President
- **Beth Malinowski**, Governmental Affairs Advocate, SEIU California State Council
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 14: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE

- **Sharisse Kemp**, ADAP Branch Chief, CDPH (*Virtual*)
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 15: BABYBIG INFANT BOTULISM TREATMENT AND PREVENTION PROGRAM BUDGET CHANGE PROPOSAL

- **Katya Ledin**, Infectious Diseases Laboratories Division Chief, CDPH (*Virtual*)
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 16: CALIFORNIA IMMUNIZATION REGISTRY (AB 1797) BUDGET CHANGE PROPOSAL

- **Robert Schechter**, Immunization Branch Chief, CDPH (*Virtual*)
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 17: RESTROOM ACCESS: MEDICAL CONDITIONS (AB 1632) BUDGET CHANGE PROPOSAL

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 18: LEAD RENOVATION, REPAIR AND PAINTING PROGRAM (SB 1076) BUDGET CHANGE PROPOSAL

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 19: CHILDHOOD DROWNING DATA COLLECTION PILOT PROGRAM (SB 855) BUDGET CHANGE PROPOSAL

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 20: PROPOSITION 99 UPDATES

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 21: PROPOSITION 56 UPDATES

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Miren Klein**, Deputy Director (A), Center for Environmental Health, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 22: *OVERSIGHT*: CALIFORNIA CANCER REGISTRY BUDGET

- **Dr. Allison Kurian**, M.D., M.Sc., Professor of Medicine, Epidemiology, and Population Health, Stanford University School of Medicine (*Virtual*)
- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 23: WOMEN, INFANTS, CHILDREN (WIC) PROGRAM ESTIMATE

- **Christine Sullivan**, WIC Division Chief, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 24: GENETIC DISEASE SCREENING PROGRAM (GDSP) ESTIMATE

- **Richard Olney**, GDSP Division Chief, CDPH (*Virtual*)
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 25: CALIFORNIA NEWBORN SCREENING PROGRAM EXPANSION BUDGET CHANGE PROPOSAL

- **Richard Olney**, GDSP Division Chief, CDPH (*Virtual*)
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 26: CALIFORNIA INTEGRATED VITAL RECORDS SYSTEM UPGRADES FOR DEATH CERTIFICATE CONTENT (AB 2436) BUDGET CHANGE PROPOSAL

- **Dana Moore**, Deputy Director, Center for Health Statistic and Informatics, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 27: LIMITED PODIATRIC RADIOGRAPHY PERMIT (AB 1704) BUDGET CHANGE PROPOSAL

- **John Roussel**, Deputy Director, Information Technology Services Department, CDPH
- **Miren Klein**, Deputy Director (A), Center for Environmental Health, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 28: RECREATIONAL WATER USE: REGULATION OF WAVE BASINS (AB 2298) BUDGET CHANGE PROPOSAL

- **Miren Klein**, Deputy Director (A), Center for Environmental Health, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 29: REDUCTION OF HUMAN REMAINS AND THE DISPOSITION OF REDUCED HUMAN REMAINS (AB 351) BUDGET CHANGE PROPOSAL

- **Miren Klein**, Deputy Director (A), Center for Environmental Health, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE/PANEL 30: LICENSURE OF CLINICAL LABORATORY GENETICISTS AND CLINICAL REPRODUCTIVE BIOLOGISTS (SB 1267) BUDGET CHANGE PROPOSAL

- **Robert Thomas**, Lab Field Services Branch Chief, CDPH (*Virtual*)
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ITEMS TO BE HEARD

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: ANNUAL STATE OF THE STATE'S PUBLIC HEALTH

PANEL

- **Dr. Tomás Aragón**, Director and State Public Health Officer, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance (DOF)
- **Will Owens**, Fiscal and Policy Analyst, Legislative Analyst's Office (LAO)

BACKGROUND

In order to make the most efficacious public health policy and budgetary choices, the Legislature must be knowledgeable about the most up-to-date data on morbidity and mortality statistics and trends in California. To this end, last year's health budget trailer bill required the State Public Health Officer to provide written reports on public health statistics to the Legislature and Governor every other year, beginning in 2024, and also to provide annual updates to the Budget Committees.

The Legislature's primary interests are in knowing what the leading causes of morbidity and mortality are for Californians overall, and for various subpopulations, such as by age, race, socioeconomic status, geography, etc. It is also important that these reports cover significant increasing or decreasing trends in the prevalence of any health conditions.

The following is the budget trailer bill (SB 184) language that was adopted as part of the 2022 Budget:

> HSC 101320.3. (a) On or before February 1 of every other year, beginning in calendar year 2024, the State Public Health Officer shall submit a written report to the Governor and the Legislature on the state of public health in California. The State Public Health Officer shall present an update annually to the Assembly Committee on Budget and Senate Committee on Budget and Fiscal Review, or relevant subcommittees, during legislative budget hearings.
>
> (b) The written report shall include all of the following:
>
> (1) Information on key public health indicators that California is experiencing, as determined to be relevant by the State Public Health Officer.

(2) Information on health disparities identified as part of the indicators and trends, if any.
(3) The leading causes of morbidity and mortality in California and evidence of increasing or decreasing rates of morbidity and mortality over the prior three to five years, inclusive.
(4) Data on the incidence and prevalence of communicable and noncommunicable chronic diseases and conditions.
(5) Data on the incidence and prevalence of intentional and unintentional injuries, including data specific to suicides and gun violence.
(6) Data on the prevalence of morbidity and mortality related to mental illness and substance abuse.

(c) The department shall annually seek input from stakeholders, including legislative staff, on which public health issues to address in a written report.

STAFF COMMENTS/QUESTIONS

This year the Subcommittee is particularly interested in the following:

- Updates on Covid-19 and Mpox;
- Data on suicide and substance use disorders (including overdoses);
- Data on the most prevalent infectious and chronic diseases; and
- Data on intentional and unintentional injuries (including both fatal and non-fatal), including those that have resulted from firearms.

Staff Recommendation: This is an informational item and therefore no Subcommittee action is recommended.

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 2: CALIFORNIA EMERGENCY MEDICAL SERVICES DATA RESOURCE SYSTEM BUDGET CHANGE PROPOSAL

PANEL

- **Lorna Eby**, Deputy Director Project Management Division, Office of Systems Integration, California Health and Human Services Agency (CHHS)
- **Rick Trussell**, Chief of Administration, Emergency Medical Services Authority (EMSA)
- **Nina Hoang**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

This proposal requests expenditure authority of $1.13 million and limited-term resources equivalent to six (6.0) positions for the Office of Systems Integration (OSI) to support planning efforts for the California Emergency Medical Services (EMS) Data Resource System (CEDRS) Project.

This request is not for new, increased funding. The requested funding was originally appropriated in 2021 and reappropriated in 2022. This request is only for expenditure authority.

BACKGROUND

The administration provided the following background information:

The 2021 Budget Act (Chapter 21, Statutes of 2021) included one-time funding of $2,400,000 for EMSA to support project planning efforts and approval of CEDRS through the PAL process. For FY 2022-23, EMSA submitted and received budget change proposal (BCP) approval to reappropriate these funds. This BCP requests approval of the State staffing positions associated with those funding requests.

OSI is partnering with the Emergency Medical Services Authority (EMSA) to support project planning for the CEDRS Project, utilizing the California Department of Technology's (CDT) Project Approval Lifecycle (PAL) process. The proposed CEDRS Project is intended to create a link to various systems to increase data interoperability between hospitals, EMS agencies, and other healthcare organizations, ensuring continuity of care to currently uncovered areas of the State. Creating connections in these areas will also allow access to on-going federal funding to maintain the new connections.

The administration states that the requested resources will conduct the planning required by the PAL process, ensure stakeholder engagement and are critical in maintaining a unified and defined strategy.

STAFF COMMENTS/QUESTIONS

Subcommittee staff asked the administration for the total project cost, and they provided the following response:

> "The total project costs for CEDRS are not known at this time. CEDRS is in Stage 2 of the four stage Project Approval Lifecycle (PAL) with the California Department of Technology. PAL Stage 2 is Alternatives Analysis, which includes market research and consideration of viable alternative solutions, including cost estimates for total solution costs. EMSA requested and received planning dollars in FY 21-22 based on budget estimates that represent a mix of market research, review of past quotes, industry knowledge and comparisons with other states that have implemented similar work. No total project cost estimate was provided. Rather, EMSA's BCP articulated the intent to follow the PAL process, which includes the identification of viable solution alternatives and the associated development and implementation cost projections."

The Subcommittee requests the administration present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any major concerns with this proposal, and therefore recommends approval at a later hearing.

ISSUE 3: AUTHORITY BUDGET OVERVIEW

PANEL

- **Rick Trussell**, Chief of Administration, EMSA
- **Shelina Nooral**i, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

The 2023 January Budget proposes $53.7 million total funds ($27.6 million General Fund (GF)) for EMSA for the 2023-24 fiscal year, which is a huge decrease ($121 million) from 2022-23, primarily reflecting the discontinuation of Covid-19 response funding flowing through the Authority. The significant reduction ($21 million) in GF from 2022-23 to 2023-24 reflects various *one-time* appropriations included in the 2022 Budget Act. For more detail on the GF reduction, please see the second chart below. Proposed staffing levels remain stable from the current year (CY) to the Budget Year (BY), however there was a significant reduction in staff between 2021-22 and 2022-23 which resulted from the reduction in temporary staff associated with Covid in the CY. For more detail on the overall proposed budget for EMSA, please see the following chart:

3-YEAR EXPENDITURES AND POSITIONS

		Positions			Expenditures		
		2021-22	2022-23	2023-24	2021-22*	2022-23*	2023-24*
3820	Emergency Medical Services Authority	149.5	114.0	114.0	$54,042	$174,737	$53,691
TOTALS, POSITIONS AND EXPENDITURES (All Programs)		**149.5**	**114.0**	**114.0**	**$54,042**	**$174,737**	**$53,691**

FUNDING		**2021-22***	**2022-23***	**2023-24***
0001	General Fund	$34,083	$48,543	$27,598
0194	Emergency Medical Services Training Program Approval Fund	147	246	246
0312	Emergency Medical Services Personnel Fund	2,617	3,724	3,688
0890	Federal Trust Fund	2,205	4,534	4,465
0995	Reimbursements	14,121	115,954	15,957
3137	Emergency Medical Technician Certification Fund	869	1,736	1,737
TOTALS, EXPENDITURES, ALL FUNDS		**$54,042**	**$174,737**	**$53,691**

The following chart details the changes to GF from the current year to the budget year:

Budget Item	FY 23-24	Comments
GF Reduction	$20,945,000	FY 22-23 vs.FY 23-24
FY 22-23 BCP: CEDRS Reappropriation	-$10,000,000	Appropriation remains in FY 22-23
FY 22-23 BCP: Replacement and Upgrade of Aging Vehicle and Radio Fleet Assets	-$8,614,000	FY 22-23 one-time expenses
CEMSIS Emergency Contract Costs	-$2,937,000	FY 22-23 one-time expenses
FY 22-23 Salaries and Benefits Adjustments	-$364,000	
FY 23-24 BCP: Diversity, Equity, and Inclusion Strategic Plan Development	$100,000	New Funding request
FY 23-24 BCP: EMS Personnel Human Trafficking Training Implementation (AB 2130)	$84,000	New Funding request
FY 22-23 BCP: California Poison Control System Funding Augmentation	$414,000	Local Assistance
FY 23-24 Salaries and Benefits Adjustments	$372,000	
Balance	$0	

BACKGROUND

The following background on EMSA can be found on EMSA's website: www.emsa.ca.gov

The mission of EMSA is to prevent injuries, reduce suffering, and save lives by developing standards for and administering an effective statewide coordinated system of quality emergency medical care and disaster medical response that integrates public health, public safety, and healthcare. EMSA's program responsibilities include the following:

EMS Systems Planning and Development

The EMS Authority provides statewide coordination and leadership for the planning, development, and implementation of local EMS systems. California has 33 local EMS systems that are providing emergency medical services for California's 58 counties. Seven regional EMS systems comprised of thirty-three counties and twenty-six single county agencies provide the services. Regional systems are usually comprised of small, more rural, less-populated counties and single-county systems generally exist in the larger and more urban counties.

Trauma Care System Planning and Development

The EMS Authority provides statewide coordination and leadership for the planning, development, and implementation of local trauma care systems. LEMSAs are responsible for planning, implementing, and managing local trauma care systems, including assessing needs, developing the system design, designating trauma care centers, collecting trauma care data, and quality assurance.

Emergency Medical Services For Children

The overall goal of the emergency medical services for children (EMSC) program is to ensure that acutely ill and injured children have access to high quality, coordinated, and comprehensive emergency and critical care services appropriate for children's special needs. The EMS Authority, using a grant from the Maternal and Child Health Bureau, U.S. Department of Health and Human Services, and with the assistance of subcommittees of experts in various aspects of pediatric care, has developed guidelines, standards, and key products that make up a comprehensive model for EMSC services. The EMSC Model provides a continuum of care, beginning with the detection of an illness or injury to emergency department care and rehabilitation.

Poison Control System

The EMS Authority oversees the operation of California's statewide poison control system. Poison control services, which can save lives, prevent disabilities, and reduce health care costs, are provided free of charge and can be accessed 24 hours a day, 7 days a week, 365 days a year by calling 1-800-222-1222 or visiting the California Poison Control website.

Prehospital Emergency Medical Care Personnel Standards

The EMS Authority is mandated by statute to develop and implement regulations that set training standards and the scope of practice for emergency medical personnel, including Emergency Medical Technician (EMT), Advanced EMTs, Paramedics, Mobile Intensive Care Nurses (MICN), Firefighters, Peace Officers and Lifeguards.

Emergency Medical Dispatcher Standards and EMS Communications Systems

The EMS Authority is developing standards for emergency medical dispatcher (EMD) training and for the provision of pre-arrival emergency care instructions (emergency medical care advice given over the telephone by EMDs to persons at the scene of a medical emergency for the provision of emergency care until qualified prehospital medical care personnel arrive at the scene and take over care of the patient). The EMS Authority is also working with experts to evaluate the status of EMS communications systems in California and to develop a state plan for EMS communications systems.

First Aid and CPR Training Programs for Child Day Care Providers and School Bus Drivers

The EMS Authority is required by statute to set standards for and approve training programs in pediatric first aid, CPR, and preventive health practices for child day care

providers and school bus drivers. Licensed child day care facilities in California are required to have at least one staff member certified in pediatric first aid, CPR and preventive health practices on duty whenever children are present. School bus drivers in California are required to have basic knowledge of pediatric medical emergencies and to be certified in first aid and CPR. The CHP tests school bus drivers in first aid and CPR; however, the test may be waived if drivers take a training course from the American Red Cross or from a training course approved by the EMS Authority.

Paramedic Licensure and Enforcement

The EMS Authority operates the State Paramedic Licensure program. This program licenses and conducts disciplinary investigations of paramedics to ensure that the care they provide meets California's high standards for prehospital care.

Disaster Medical Services Preparedness and Response

The EMS Authority, as the lead agency responsible for coordinating California's medical response to disasters, provides medical resources to local governments in support of their disaster response. This may include the identification, acquisition and deployment of medical supplies and personnel from unaffected regions of the state to meet the needs of disaster victims. Response activities may also include arranging for evacuation of injured victims to hospitals in areas/regions not impacted by a disaster. The medical response to disasters requires the contributions of many agencies. The EMS Authority works closely with the Governor's Office of Emergency Services, California Department of Public Health, California National Guard, Department of Health Services and other local, state, and federal agencies to improve disaster preparedness and response. The EMS Authority also works closely with the private sector: hospitals, ambulance companies, and medical supply vendors.

Pre-Hospital Data, Injury Prevention, and Public Education

The EMS Authority is working to increase and improve LEMSA and state EMS data capacities and capabilities; to standardize the collection of prehospital and trauma data in LEMSAs; to study the efficacy of EMS systems and traffic safety measures/conditions; and to reduce morbidity and mortality associated with traffic injuries in California by increasing the role/activity of EMS personnel in injury control activities. Injury prevention is part of EMSA's mission to coordinate and integrate emergency medical care and preventive services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA provide an overview of the proposed Authority budget and respond to any questions raised in the hearing.

Staff Recommendation: This is an oversight issue and therefore no Subcommittee action is recommended.

ISSUE 4: EMS PERSONNEL HUMAN TRAFFICKING TRAINING IMPLEMENTATION (AB 2130) BUDGET CHANGE PROPOSAL

PANEL

- **Rick Trussell**, Chief of Administration, EMSA
- **Kim Lew**, Chief of Personnel, EMSA
- **Shelina Nooral**i, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

EMSA requests $84,000 General Fund in 2023-24, 2024-25, and 2025-26 to coordinate and support the implementation of AB 2130 (Cunningham, Chapter 256, Statutes of 2022) that requires emergency medical technicians (EMT-I), advanced emergency medical technicians (EMT-IIs), and paramedics (EMT-P), upon initial licensure, to complete at least 20 minutes of training on issues relating to human trafficking. The requested resources will be used to modify regulations, configure the Central Registry, train staff in new legislative requirements, and monitor the State of California's 34 Local Emergency Medical Services Authorities' (LEMSAs') progress in approving training program curriculum updates.

BACKGROUND

The administration provided the following background:

Existing law establishes the EMSA to develop training, scope of practice, and continuing education requirements for EMT-1, EMT-IIs, and EMT-P designations. EMSA is responsible for licensing EMT-Ps, whereas 69 certifying entities are tasked with certifying EMT-I and EMT-IIs. Using EMSA's current centralized electronic licensing and registry system, My License Office (MLO), EMSA, and 69 certifying entities process and collect EMT-I, EMT-II certification, and EMT-P licensure training program requirements.

AB 2130 specifies that EMSA require EMT-I, EMT-II, and EMT-P to complete at least 20 minutes of training on issues relating to human trafficking upon initial licensure/certification. Currently, initial EMT-I, EMT-II, and EMT-P applicants are required to complete specific emergency medical service-related training. Some current training programs may include issues related to human trafficking. EMT-I applicants must complete a minimum of 170 hours of training and EMT-II applicants must complete a minimum of 160 hours of training for initial certification. EMT-P applicants must also complete a minimum of 1094 hours of training. The verification of training for licensure and certification is recorded in the MLO Central Registry licensure system.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any major concerns with this proposal, and therefore recommends approval at a later hearing.

ISSUE 5: CALIFORNIA POLST EREGISTRY ACT TRAILER BILL

PANEL

- **Lorna Eby**, Deputy Director Project Management Division, Office of Systems Integration, CHHS
- **Rick Trussell**, Chief of Administration, EMSA
- **Shelina Nooral**i, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

EMSA is proposing trailer bill language to strike through the statutory requirement to integrate the Advance Health Care Directive (AHCD) Registry into EMSA's Physician Orders for Life-Sustaining Treatment (POLST) Electronic Registry (eRegistry). The full language can be accessed here:

https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/799

BACKGROUND

The administration provided the following background:

Chapter 143, Statutes of 2021 (Assembly Bill 133) enacted the California POLST eRegistry Act on July 27, 2021, which requires EMSA to establish a statewide electronic POLST registry system for the purpose of collecting patient POLST information and providing real-time, electronic access to the form by EMS and medical providers. AB 133 also requires EMSA to incorporate the AHCD Registry, established pursuant to Part 5 (commencing with Section 4800) of Division 4.7 of the Probate Code and overseen by the Secretary of State, into the POLST eRegistry.

The POLST form is a medical order, signed by both a patient and physician, nurse practitioner, or physician assistant, that gives seriously ill patients more control over their care by specifying the type of medical treatment they wish to receive toward end of life. The AHCD is a tool to let one's physician and personal network know about their health care preferences, such as types of treatment preferences at the end of life.

The administration states: "As there is no existing electronic registry for the AHCD, integration of AHCD data into EMSA's electronic registry is not feasible without significant delays to implementation of the POLST eRegistry and additional funding. Eliminating the requirement for EMSA to incorporate the AHCD Registry into the POLST eRegistry will allow the POLST eRegistry to be implemented timely."

STAFF COMMENTS/QUESTIONS

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

1. Does it not create confusion for health care providers to have these two separate registries, and potentially lead to providers referring to outdated documents?

2. How many forms does the AHCD Registry contain, and how much resources would be needed to convert them to electronic forms?

3. Would EMSA be supportive of amending the law to simply state that the integration of the two registries shall occur when resources are made available for this purpose?

Staff Recommendation: Removing the statutory requirement to integrate the two registries does not seem to be the best or only solution to the problem that is being addressed here, and therefore staff recommends holding this item open to allow for more discussion about alternative solutions.

ISSUE 6: REMOVAL OF MEDICAL DOCTOR REQUIREMENT FOR THE EMSA DIRECTOR AND APPOINTMENT OF A CHIEF MEDICAL OFFICER TRAILER BILL

PANEL

- **Shelina Noorali**, Finance Budget Analyst, Department of Finance (DOF)
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

EMSA proposes trailer bill language to remove the medical doctor (MD) requirement that is statutorily required to be part of the eligibility criteria to serve as the Authority's Director. This trailer bill also proposes to create a new Chief Medical Officer (CMO) position within the Authority, who shall be appointed by the Governor. The full language can be accessed here:

https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/800

BACKGROUND

The administration provided the following background:

Existing law requires EMSA's Director to be a licensed physician and surgeon with substantial experience in the practice of emergency medicine. However, these requirements have limited the eligible candidate pool and made it more challenging to recruit for this leadership role in the past.

EMSA proposes to remove the MD requirement as a part of the requisite criteria to serve as the department's Director. EMSA also proposes to create a CMO of the department who is a physician and surgeon licensed in California with substantial experience in the practice of emergency medicine and who shall be appointed by the Governor upon nomination by the Secretary of California Health and Human Services.

Removing the MD requirement for EMSA's Director will assist the department with tapping into a broader candidate pool while at the same time focusing on the appropriate skillset with regards to public administration. This does not eliminate the importance of having physicians as part of the leadership team and as such, the creation of a CMO position within the leadership team will address the clinical components needed for patient safety and care while bringing substantial experience in the practice of emergency medicine.

The EMSA director role requires a high-level of public administration experience to effectively manage all aspects of the Statewide EMS system. This includes managing

non-clinical programs that include policy development and implementation, personnel licensure, disaster response operations, system design and organization, and legal review. Health and Safety Code (HSC) also currently mandates that the EMSA director be a licensed physician and surgeon in the State of California and who has substantial experience in emergency medicine. Therefore, an ideal EMSA director would need to simultaneously be both a highly experienced emergency physician as well as an effective and experienced state public administrator. Historically these requirements have made filling the position exceptionally challenging, as the pool of interested candidates meeting these requirements is limited. By removing the MD requirement from the director position and amending HSC to add a Chief Medical Officer (CMO), the Administration will be able to select an EMSA director and CMO from a much broader qualified applicant pool, each with the necessary skillsets to more effectively manage these critical functions across the organization

Stakeholder Input:

The California Professional Firefighters is supportive of this proposal, explaining:

> "By removing the existing requirement that the Director of EMSA be a licensed physician or surgeon, the trailer bill language greatly increases the pool of qualified candidates with the experience necessary to effectively lead the Authority."

The Emergency Medical Services Administrators Association of California (EMSAAC) supports this proposed trailer bill in concept, but is also requesting amendments to do the following:

1. Clarify that the new CMO will have oversight over the medical aspects of the state EMS system, including, but not limited to, licensure, scope of practice, trial studies, EMS-related training programs, and policies; and
2. Require the EMSA director to have extensive experience in EMS, health, public health, and/or related field.

STAFF COMMENTS/QUESTIONS

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

1. Wouldn't there be a cost for adding the new proposed CMO position? If so, is a request for those resources forthcoming?
2. Do you have any concerns that it might be difficult to recruit a CMO?

Staff Recommendation: Subcommittee staff is not aware of any major concerns with this proposal, however recommends holding this open to allow time for additional discussion of requested amendments to the language, and to potentially receive and consider a BCP for the resources needed for the new position.

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 7: *OVERSIGHT*: DEPARTMENT BUDGET OVERVIEW

PANEL

- **Brandon Nunes**, Chief Deputy Director, Operations, California Department of Public Health (CDPH)
- **Shelina Nooral**i, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

For 2023-24, the Governor's Budget provides $5.5 billion for the support of CDPH's programs and services, a decrease of 20.21 percent from the 2022-23 Enacted Budget, primarily reflecting the discontinuation of federal Covid-19 relief funding. General Fund (GF) in the CDPH budget decreases by almost 20 percent, which reflects: 1) approximately $200 million in one-time investments made in the 2022 Budget Act (see chart below); and 2) approximately $100 million in proposed reductions in the January Budget. Of the total Governor's Budget proposal, $2 billion is for State Operations and $3.5 billion is for Local Assistance.

Total Departmental Budget at 2023-24 Governor's Budget
Dollars in thousands*

The charts below and the narrative that follows describe the specific budget adjustments.

Fund Source	2022-23 Enacted Budget	2022-23 Revised Budget	2023-24 Governor's Budget	% Change from 2022-23 Enacted Budget
General Fund	$1,252,489	$1,303,874	$1,008,922	-19.45%
Federal Funds	$1,668,994	$1,880,931	$2,159,343	29.38%
Special Funds & Reimbursements	$3,947,608	$3,664,269	$2,312,862	-41.41%
Total Funds	**$6,869,091**	**$6,849,074**	**$5,481,127**	**-20.21%**

CDPH 3-Year Expenditures:

(Dollars in thousands)

		Positions			Expenditures		
		2021-22	2022-23	2023-24	2021-22*	2022-23*	2023-24*
4040010	Emergency Preparedness	133.0	184.6	184.6	$3,113,518	$1,923,254	$355,573
4045010	Healthy Communities	544.8	637.0	650.0	466,645	742,259	450,834
4045013	Media Campaign	-	-	-	16,429	11,857	10,364
4045015	Evaluation and Committee	-	-	-	4,004	2,000	2,826
4045017	State Administration	25.3	-	-	11,971	3,862	3,864
4045019	Local Lead Agency	-	-	-	9,150	9,150	9,150
4045021	Competitive Grants	-	-	-	17,591	10,546	11,577
4045023	Infectious Diseases	413.0	577.0	590.0	1,966,564	1,660,275	2,166,800
4045032	Family Health	558.2	633.9	639.9	1,450,802	1,786,884	1,806,047
4045041	Health Statistics and Informatics	191.4	251.5	251.5	30,940	78,486	62,317
4045050	County Health Services	3.1	3.1	3.1	-	-	-
4045059	Environmental Health	530.6	549.7	558.7	107,897	141,444	137,002
4050010	Health Facilities	1,606.9	1,632.0	1,635.0	315,501	449,165	432,796
4050019	Laboratory Field Services	87.9	112.7	113.7	16,079	29,892	31,977
9900100	Administration	254.7	446.5	446.5	57,889	109,784	105,892
9900200	Administration - Distributed	-	-	-	-57,889	-109,784	-105,892
TOTALS, POSITIONS AND EXPENDITURES (All Programs)		**4,348.9**	**5,028.0**	**5,073.0**	**$7,527,091**	**$6,849,074**	**$5,481,127**

The following chart details the one-time GF investments made in the 2022 Budget Act that explain the reduction in GF in the January Budget:

2022-23 Budgetary Adjustments	One-time GF (in thousands)
Budget Adjustment for Monkeypox State of Emergency Resources per Chapter 249, Statutes of 2022 (AB 179)	41,429
Children and Youth Suicide Prevention Grants and Outreach Campaign	40,000
Reproductive Health Awareness, Education, and Research	17,000
Accountable Communities for Health	15,000
Transgender Wellness and Equity Fund Reappropriation	13,000
Alzheimer's Healthy Brain Initiative	10,000
Books for Low Income Children	10,000
Clinical Dental Rotations	10,000
Fitness Council	7,000
Children and Youth Behavioral Health Initiative: Public Education and Change Campaign Reappropriation	5,000
Increased Capacity, Training, and Care for LGBTQ+ Youth	5,000
Sickle Cell Disease Treatment Infrastructure	5,000
Skilled Nursing Facilities Staffing Audits	4,000
Extreme Heat Package (AB 179)	3,000
Budget Adjustment for Amyotrophic Lateral Sclerosis Association, Golden West Chapter per Chapter 249, Statutes of 2022 (AB 179)	2,000
Control Section 19.56 State Operations Resources per Chapter 249, Statutes of 2022 (AB 179)	1,500
Car Seats for Infants	1,000
Hospice Fraud Prevention Taskforce	1,000
Priority Inland Water-Contact Recreation Sites: Water Quality Monitoring (AB 1066) Adjustment	195
Subtotal	**191,124**

Proposed Reductions

The January Budget includes the following two proposed reductions, or "budget solutions," within the CDPH budget:

1. A reduction of $49.8 million General Fund (out of a total of $97.5 million) over four years for public health workforce training and development programs. This proposal is issue #12 on this agenda; and

2. A reduction of $25 million General Fund in 2022-23 for Climate and Health Resilience Planning Grants, funding that will be restored in January 2024 if the state has sufficient General Fund to do so. This proposal will be discussed at the Subcommittee's hearing on May 1, 2023.

BACKGROUND

The following background information can be found on the CDPH website:

www.cdph.ca.gov

The California Department of Public Health (CDPH) works to protect the public's health in the Golden State and helps shape positive health outcomes for individuals, families and communities. The Department's programs and services, implemented in collaboration with local health departments and state, federal and private partners, touch the lives of every Californian and visitor to the state 24 hours a day, 7 days a week.

The essential functions of the Department are critical to the health and wellbeing of people and communities. CDPH's fundamental responsibilities are comprehensive in scope and include infectious disease control and prevention, food safety, environmental health, laboratory services, patient safety, emergency preparedness, chronic disease prevention and health promotion, family health, health equity and vital records and statistics.

CDPH's key activities and services include protecting people in California from the threat of preventable infectious diseases like Zika virus, HIV/AIDS, tuberculosis and viral hepatitis, and providing reliable and accurate public health laboratory services and information about health threats.

Other critical services include providing nutritional support to low-income women, infants and children, and screening newborns and pregnant women for genetic diseases. CDPH also works to ensure the safety of food and bottled water, helps reduce smoking and its impacts and works to prevent chronic diseases and conditions such as diabetes, cardiovascular disease, cancer, asthma and obesity.

The Department also protects patient safety in hospitals and skilled nursing facilities, maintains birth and death certificates and prepares for, and responds to public health emergencies.

CDPH works continuously to reduce health and mental health disparities among vulnerable and underserved communities to achieve health equity throughout California.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH provide an overview of the proposed CDPH budget, and respond to any questions raised in the hearing.

Staff Recommendation: This is an oversight issue and therefore no Subcommittee action is recommended.

ISSUE 8: 2022-23 BUDGET ADJUSTMENTS COVID-19 RESPONSE

PANEL – PRESENTERS

- **Melissa Relles**, Assistant Deputy Director, Emergency Preparedness Office, CDPH
- **Shelina Nooral**i, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

This issue provides an overview of adjustments to both current year and budget year expenditures for Covid-19 response.

2022-23 Budget Adjustments
In the current year, the Governor's Budget reflects a decrease of $614 million in the California Emergency Relief Fund (Fund 3398). The decrease is driven in large part by reduced response activities since the peak of the COVID-19 pandemic, and unspent contingency funds.

2023-24 Budget Adjustments
For the budget year, the Governor's Budget includes a one-time increase of $101.3 million in General Fund (Fund 0001) State Operations to provide COVID-19 response activities, including: testing, vaccinations, and operations support. Of the $101.3 million, $50 million has been included in emergency contingency funds, and therefore may not be needed or expended.

Although Covid-19 is decreasing, CDPH explains that $101.3 million is a very small amount of money relative to the COVID-19 expenditures over the past three years. The 2022-23 Budget Act included $1.8 billion one-time California Emergency Relief Fund for CDPH to maintain COVID-19 activities at peak response levels through June 30, 2023.

The priority for these funds will be to continue efforts to protect the most vulnerable populations in the state, including long-term care facilities and areas of the state where there's little-to-no care or treatment for COVID-19. There are ongoing needs for distribution of both test kits and vaccine, and for surveillance work.

Please also see the next issue in this agenda for more information on the 2023-24 request for funding.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH provide an overview of budget adjustments being made to funding for COVID-19 response activities, and respond to the following:

1. Please provide an overview of activities that are being discontinued and those that are being continued, and what the thinking and planning around COVID looks like at this point in time.

1. How much monitoring does CDPH do of vaccination rates of both patients and staff in skilled nursing facilities (SNFs)? How would you assess the overall vaccination rates of these two populations?

2. Which populations are still at highest risk, and most likely to experience COVID at a severity that requires hospitalization?

Staff Recommendation: Subcommittee staff recommends no action at this time in order to consider any new information and/or adjustments to COVID response funding included in the May Revise.

ISSUE 9: COVID-19 RESPONSE BUDGET CHANGE PROPOSAL

PANEL

- **Melissa Relles**, Assistant Deputy Director, Emergency Preparedness Office, CDPH
- **Shelina Nooral**i, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

As discussed in the prior issue, CDPH requests $101.3 million General Fund in 2023-24 to continue the state's efforts to protect public health and safety against the spread of COVID-19 and implement the state's SMARTER Plan. Funding requested will support vaccinations, testing, and operations support. Of the $101.3 million, $50 million is requested in contingency funding.

Areas of Expenditure and Funding Requested (Total Funds)

Areas of Expenditure	2022-23 Budget Act	2023-24 Proposal
Vaccinations (including boosters)	$ 93,000,000	$ 8,000,000
Testing	$ 530,000,000	$ 28,000,000
Operations Support	$ 165,133,000	$ 15,000,000
Public Health Readiness & Response (Formerly Contact Tracing)	$ 18,284,000	$ -
Enhanced Surveillance	$ 16,465,000	$ -
Test to Treat Therapeutics	$ 158,129,000	$ -
Border Operations	$ 411,025,000*	$ -
IT Pandemic Response	$ -	$ 300,000
Staffing	$ 140,000,000	$ -
Emergency Contingency Funds	$ 250,000,000	$ 50,000,000
TOTALS	**$ 1,782,036,000**	**$ 101,300,000**

**$411,025,000 reflects funding included in the 2022 Budget Act. There is also an additional $57,363,000 DREOA carryover available.*

Noteworthy funding for service agreements in 2023-24 includes:

- $28 million to purchase 12 million test kits in support of the SMARTER Plan
- $9 million for consultants to continue CDPH's response to COVID-19 through activities related to county monitoring, testing strategies, and support for CDPH's COVID-19 website and public information campaign services
- $3 million for redirection of CDPH staff funded by special funds and non-COVID allowable federal funds to continue COVID-19 response efforts, an 85 percent reduction in redirected staff
- $3 million for MHCC and RSS costs related to service agreements to provide specialized business, and technical services to support response to and recovery

from the pandemic, in addition to legal settlements for COVID-19-related litigation including challenges to state public health orders and guidance
- $5 million for grant incentive programs to provide support to pediatric providers to administer vaccines for ages 0-5
- $3 million for vaccine staffing to validate and mitigate errors in CAIR data, the provider call center that will continue to give support to providers enrolled in the mycavax program, and program management and communication activities for LHDs and providers
- $300 thousand for IT Infrastructure, and
- $50 million for emergency contingency funds to support pandemic response efforts that exceed identified areas of expenditure.

BACKGROUND

The administration provided the following background on the state's past and planned COVID response activities:

CDPH has played a crucial role in slowing community transmission and saving the lives of many Californians by providing vaccinations (including boosters), testing, contact tracing, medical surge staffing, and border operations activities (including testing and isolation/quarantine services). This 2023- 24 budget proposal reflects the changing nature of COVID-19, including the end of some policies that the state and federal government enacted in response to the pandemic, as well as the continued implementation of the state's SMARTER Plan approach to COVID-19 going forward. As the COVID-19 pandemic evolves from an acute crisis to an ongoing public health concern, the state's strategy for responding to COVID-19 also continues to evolve.

Throughout the pandemic, the state has leaned on science and relied on tools and strategies that create protection, such as vaccines and boosters, masks, tests, isolation, and quarantine, improving ventilation, and community outreach within the hardest-hit communities. Looking ahead, and based on the evolving conditions of the virus, the state will continue to leverage effective and targeted strategies to prepare for and mitigate surges in cases, hospitalizations, and deaths.

The SMARTER plan continues to guide core mitigation and prevention functions detailed below:
- Shots—Vaccines are the most powerful weapon against hospitalization and serious illness.
- Masks—Properly worn masks with good filtration help slow the spread of COVID-19 or other respiratory viruses.
- Awareness—The state will continue to stay aware of how COVID-19 is spreading and of evolving variants. The state will communicate clearly how people should protect themselves and coordinate our state and local government response.

- Readiness—COVID-19 isn't going away, and the state needs to be ready with the tools, resources, and supplies needed to quickly respond and keep public health and the health care system well prepared.
- Testing—Getting the right type of tests—PCR or antigen—to where they are needed most. Testing will help California minimize the spread of COVID-19.
- Education—California will continue to work to keep schools open and children safely in classrooms for in-person instruction.
- Rx—Evolving and improving treatments will become increasingly available and critical as a tool to save lives.

To continue the critical work of responding and maintaining preparedness, the state will continue to supply test kits to high-risk populations, promote the bivalent booster campaign with a focus on vulnerable individuals who are at risk for severe disease and hospitalizations, and work with healthcare systems to improve their incorporation of testing and treatment for their patients. Several efforts are winding down, such as the gradual demobilization of community testing sites as demand decreases, the Public Testing Lab Network, staffing deployments, and COVID-19 therapeutics initiatives as this work will eventually transition to the health care system. This request prioritizes the most critical activities that need to continue so that California's most vulnerable populations are protected and to maintain a state of readiness.

Vaccinations

As of December 28, 2022, California has administered over 87 million vaccinations, and with a new bivalent booster recommendation from the CDC, there is a continued need to provide timely access and distribution of the vaccine to ensure Californians continue to have ongoing protection from the updated vaccine.

This request prioritizes state efforts to continue to increase the rate of vaccination in the hardest-hit communities and state-wide. Maintaining the state's vaccine infrastructure is especially important as the state seeks to maintain the highest level of protection for families in the face of emerging variants. In 2023- 24, CDPH will focus its efforts for COVID-19 vaccination in the Fall in conjunction with influenza activities. The department has successfully implemented the Kids Vax Grant, which has incentivized pediatric providers to enroll in the COVID-19 program and offer additional clinic hours to provide vaccines. In 2023-24, CDPH plans to offer another grant opportunity to providers in areas with the most need so that adolescents and children have access to COVID-19 vaccines.

Testing

As of September 2022, the CDPH's Testing Task Force (TTF) procured more than 83 million COVID-19 over-the-counter (OTC) antigen test kits and 18 million professional Clinical Laboratory Improvement Amendment (CLIA)-waived antigen tests to distribute to Californians. The distribution of the over 83 million antigen test kits has been to the following groups, such as:

- K-12 students
- Teachers and staff
- Community organizations serving priority populations
- Childcare facilities
- Skilled nursing facilities
- Long-term care facilitates for visitations
- Healthcare workers for return-to-work

TTF developed a robust community testing infrastructure with more than 6,700 active testing programs utilizing professional antigen and polymerase chain reaction (PCR) or other molecular testing. During the Winter 2021-22 Omicron surge, these sites became critical access points for testing expansion. Finally, these sites have become the nidus for early access to life-saving COVID-19 therapeutics as they were transitioned into Test-to-Treat sites. In addition to mobile Test-to-Treat sites, the state's lab network has been operational since May 2022.

During 2023-24, TTF will continue to provide access to testing for California's uninsured and those without access by supporting the existing TTF testing infrastructure with OTC test kits. To do so, TTF expects to purchase 1 million OTC tests per month for 12 months. These tests will be allocated to the uninsured and other priority populations working or living in high transmission risk settings. The focus of test distribution will be on directing resources to organizations that support individuals who are uninsured/under-insured, and targeted outreach to other communities with disproportionate impact and accessibility issues. TTF intends to link resources to Test-to-Treat programs by providing OTC kits to organizations that are providing health education around treatment.

Operations Support

Redirected CDPH staff and contract staff continue to provide emergency preparedness, response, recovery support, and invoice staffing resources to the various task forces and initiatives outlined in the SMARTER Plan to enhance their operations. A large component of pandemic response includes providing resources (e.g., personal protective equipment, test kits, therapeutics, and vaccine supplies, other medical supplies, etc.) for public health and medical entities. CDPH has been distributing OTC and CLIA-waived tests to both public health and medical partners, schools and County Boards of Education, Department

of Social Services facilities, and several other non-public health and medical entities via the CDPH Receiving Staging Storage (RSS) warehouse. As outlined in the SMARTER Plan, making sure testing kits and supplies are readily available, as well as maintaining warehousing functions to quickly distribute critical supplies and resources when needed, is a critical component to help California minimize the spread of COVID-19.

Information Technology

The pandemic required CDPH's information technology (IT) to rapidly implement new systems, data, and services to respond to the public health threat and to meet CDPH's COVID-19 IT infrastructure needs. The magnitude of the COVID-19 response and the ongoing public health threat has increased as well as the reliance on SAS for data analytics. As a result, CDPH requires statistical analysis system (SAS) premium support for a dedicated resource to assist with SAS advanced analytics, business intelligence, predictive analytics, and system-related support related.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH provide an overview of this BCP and a status update on the state of COVID in California.

Staff Recommendation: Subcommittee staff is unaware of any major areas of concern with this BCP, and recommends Subcommittee approval at a future hearing.

ISSUE 10: COVID-19 WEBSITE TRANSITION AND INFORMATION TECHNOLOGY RESOURCES BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **John Roussel**, Deputy Director, Information Technology Services Department, CDPH
- **Shelina Nooral**i, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests $900,000 General Fund in 2023-24, 2024-25, and 2025-26 to support security and translation services to optimize maintenance of the COVID-19 website.

BACKGROUND

The administration provided the following background information:

To implement CDPH's COVID-19 strategy, multiple information technology systems have been improved or created, and COVID19.CA.GOV was established and has become the primary starting point for statewide COVID-19 information, cited directly in marketing, social media, and press appearances, with approximately 1 million unique visitors in June 2022. In addition, there are 14 other major state agency stakeholders identified in Table 1 that either approve or contribute content to the COVID-19 website. The platform serves as the primary channel for state government to push out policy changes, new policies, guidance, and resources.

Table 1 – Primary State Agency Stakeholders of COVID19.CA.GOV

1.	California Department of Public Health (CDPH)	9.	California Department of Social Services (DSS)
2.	California Business, Consumer Services and Housing Agency (BCSH)	10.	California Governor's Office of Business and Economic Development (GO-Biz)
3.	California Department of Food and Agriculture (CDFA)	11.	Governor's Office
4.	California Housing Finance Agency (CalHFA)	12.	California Government Operations Agency (GovOps)
5.	California Department of Technology (CDT)	13.	California Department of Housing and Community Development (HCD)
6.	California Health and Human Services Agency (CHHS)	14.	Office of the California Surgeon General (OSG)
7.	California Department of Health Care Services (DHCS)	15.	California COVID-19 Testing Task Force (TTF)
8.	Labor and Workforce Development Agency (LWDA)		

The COVID-19 site aims to enable users to find the information they need, understand it quickly, and act accordingly. Critical information provided includes current safety measures, vaccines, vaccination records, masks, travel, testing, financial help, education and childcare, and safety in the workplace. It offers answers to top questions, data on COVID impact and response measures, and guidance about how to prevent from getting sick or have a severe illness, reopen, and operate businesses and facilities safely, and access relief.

The COVID-19 pandemic is the largest and most pervasive public health emergency in recent California history. To date, COVID-19's effect on California has been devastating. As of December 29th, 2022, California had recorded over 10.8 million cases with more than 97,700 total deaths due to COVID-192. To respond to the statewide pandemic, expanded IT tools to engage with public and private sector clinics and resources to support contact tracing, vaccine management and disease surveillance at a large scale were needed. In addition, several groups of Californians are at higher risk of disease or more severe outcomes due to infectious disease outbreaks. There are disparities in disease incidence among Latino, African American, and Native Hawaiian and Pacific Islander communities.

A critical piece of statewide disease control efforts is raising public awareness and consistent messaging from state agencies to their respective constituencies. The COVID-19 website leverages and consolidates important data from a variety of technology solutions implemented since the start of the pandemic across CDPH and other state agencies. The clarity and consistency of information found on the website has made it a valuable information hub for Californians.

Table 2 (below) identifies the variety of services delivered by the COVID-19 website that stakeholders rely on daily and expect to continue without interruption.

Table 2 – COVID19.CA.GOV Service Level Agreements

Service Level Agreement	Description
1. Multi-language	• Website content availability in seven languages • Translation within 24 hours, with urgent content being prioritized
2. Web Performance	• Above 90 Lighthouse scores measured on mobile setting* • Less than three seconds to interactive experience for user
3. Data Visualization	• Less than five seconds to interactive experience for user
4. Bug Fixes	• Standard to critical issues fixed within hours*
5. Content Publishing	• Publish new content from staging to production in 25-minutes or less
6. Content Correction	• Document written approval from stakeholders • Regular review of programs and/or policies to refresh potentially outdated content • Correct outdated or incorrect information within two hours

*** Websites that are identified by a search engine are evaluated with a score between 0 – 100 based on four categories: Performance, Accessibility, Best Practices, and Search Engine Optimization (SEO). The better your lighthouse score the higher up your webpage will appear on a search engine. To date there have been two major incidents since launch, each lasting less than one day.**

STAFF COMMENTS/QUESTIONS

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

1. Will this website transition/evolve into something broader than COVID as COVID diminishes?

2. Does it make sense to invest so much in something that's going away?

Staff Recommendation: Subcommittee staff is unaware of any major areas of concern with this BCP, and recommends Subcommittee approval at a future hearing.

ISSUE 11: MAINTENANCE AND OPERATIONS OF INFECTIOUS DISEASES DATA SYSTEMS FOR SMARTER PLAN IMPLEMENTATION BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **James Watt**, Assistant Deputy Director, Center for Infectious Diseases, CDPH (*Virtual*)
- **Shelina Nooral**i, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests $74.4 million General Fund in 2023-24 for the maintenance and operations (M&O) of critical infectious disease data systems established during the COVID-19 pandemic that will continue to support the state's emergency preparedness and response efforts to maintain situational awareness and support effective public health investigation across California, consistent with the Administration's SMARTER Plan.

BACKGROUND

The administration provided the following background information:

The cornerstone of public health surveillance and disease response is timely access to current, complete, accurate, and reliable information, which begins with data collected by laboratories, healthcare providers and local health departments (LHD). COVID-19 exposed limitations in the ability of CDPH to collect these data. Specifically, CDPH data systems were not able to manage the high volume of data associated with COVID-19. In addition, there were substantial quality problems with the data that were collected, including:

- Incomplete fields such as race and ethnicity
- Duplicate reports from laboratories
- Incorrect/incomplete information for accurate patient matching (name, address, DOB, gender); and
- Inconsistent use of codes and text labels for laboratory test and result values

CDPH did not have sufficient tools to enable holistic monitoring of system performance to support pre-emptive action to avoid system down-time. Interoperable systems to support local case investigation, patient and contact education, and contact tracing did not exist.

During the COVID-19 pandemic, extensive upgrades to CDPH data systems were implemented and new systems were launched to manage large data volumes, facilitate data flow, support case investigation, and contact tracing data, collect outbreak investigation data, enable digital exposure notification, provide data automation, and provide advanced analytic tools. Many of these systems interact with each other, creating a need for strategic coordination, planning, and maintenance.

Two important systems, the California COVID Reporting System (CCRS) and CalCONNECT, are described below. M&O for these systems is needed to support California's response to the COVID19 pandemic. In addition, these tools are being used for other reportable conditions and enable California to have better surveillance for infectious diseases in general. These systems can also allow for more rapid and robust response to future infectious disease outbreaks and emergencies.

California COVID Reporting System (CCRS) for Electronic Lab Reporting

CCRS was implemented in October 2020 to address the challenges of managing COVID-19 laboratory data. CCRS also provided upgraded capabilities for managing all communicable disease laboratory data sent electronically. CDPH receives laboratory results for COVID-19 and other infectious diseases related to California residents from laboratories across the U.S. in accordance with state regulations. The great majority of laboratory results are submitted electronically and managed by CCRS. More than 350 entities are connected directly to this system and submitting results on behalf of thousands of entities. These entities include laboratories that report their own results, and aggregators or hubs that report results for multiple laboratories. Incoming laboratory results are compared against existing laboratory results to identify, match, and remove duplicate records. Processed laboratory results are transferred to CDPH's Enterprise Rhapsody Gateway for routing to downstream public health systems, including the California Reportable Disease Information Exchange (CalREDIE), Los Angeles, and San Diego County disease surveillance systems. Data processed through CCRS is used to monitor infectious disease and testing trends.

Additionally, the CCRS is closely integrated with CalCONNECT. The functions of CCRS must be sustained and appropriately resourced for the ongoing operations of state and local public health surveillance efforts for COVID-19 and other infectious diseases that depend on laboratory reporting.

In August of 2020, CDPH conducted a challenge-based procurement to develop and implement the CCRS system. To maintain this system, CDPH engaged in a new challenge- based procurement process in March 2022, resulting in a contract with a new vendor. A transition between the old and new vendor was completed by December 31, 2022. CDPH received an appropriation of $26.3 million in 2022-23 to provide M&O for one year to support and operate CCRS. The one-year funding strategy was designed to allow CDPH to obtain updated M&O costs through the re-competition and include these

costs in a proposal for 2023-24. As part of the transition, CCRS was renamed to the Surveillance and Public Health Information Reporting and Exchange (SaPHIRE) to recognize that the system receives data for all reportable conditions, not just COVID-19.

CalCONNECT

CalCONNECT is California's system for case and outbreak investigation, contact tracing, symptom monitoring of exposed individuals, and communication with affected persons, including the dissemination of isolation and quarantine guidance to cases and contacts. CalCONNECT was developed during the COVID-19 pandemic and has now been expanded to support the monkeypox (mpox) response. CalCONNECT has also incorporated a new generic disease condition function that can be utilized for monitoring persons exposed to avian influenza, Ebola, and other infectious entities. CalCONNECT also supports outbreak investigations by providing workplaces and schools streamlined ways to report exposure events directly to their LHD and CDPH. As a result of CalCONNECT's success related to COVID-19, numerous stakeholder groups, including LHDs, have requested that CDPH build upon the system and expand its functionality to support additional disease conditions that require case investigation and contact tracing such as tuberculosis, HIV, syphilis, perinatal hepatitis B, and measles.

CDPH received an appropriation of $39.6 million in 2022-23 to provide M&O for one year to support and operate CalCONNECT. The one-year funding strategy was designed to allow CDPH to obtain ongoing M&O costs for CalCONNECT through a recompetition and include these costs in a proposal for 2023-24. CDPH engaged in a new challenge-based procurement process in March 2022, resulting in a new contract with the existing vendor.

IT Infrastructure and Security

The increased volume and complexity of data and data types received, processed, and retrieved through the various systems require the CDPH Information Technology Services Division (ITSD) to oversee that the growing infrastructure needs are met and that the ever- changing security landscape is addressed. The security needs for protecting Personally Identifiable Information (PII) and Protected Health Information (PHI) continue to grow in complexity. Examples of security functions that need to keep up with these needs include data access, incident management/response, and vulnerability management. Infrastructure and security software will need to keep up with these concerns. Hence, infrastructure and security costs will continue to include annual software license fees, maintenance, and support costs.

STAFF COMMENTS/QUESTIONS

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

1. Please explain the connection between this proposal and last year's BCP, entitled: "Disease Surveillance Readiness, Response, Recovery, and Maintenance of IT Operations."

2. What is the total cost and timeline of this project?

Staff Recommendation: Subcommittee staff recommends holding this item open to allow for further discussion on the proposal and May Revise updates.

ISSUE 12: PUBLIC HEALTH WORKFORCE INVESTMENTS REVERSION

PANEL – PRESENTERS

- **Susan Fanelli**, Chief Deputy Director, Health Quality and Emergency Response, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

The January Budget proposes to reduce funding for public health workforce development activities, as follows:

Current Year (2022-23) Reduction

The Governor's Budget reflects a decrease of $5.0 million in General Fund State Operations that supports Public Health Workforce Investments. The Budget reduces funding for various public health workforce training and development programs by $49.8 million General Fund over four years to help address the budgetary problem.

Budget Year (2023-24) Reduction

The Governor's Budget reflects a decrease of $19.9 million in State Operations and $928,000 in Local Assistance General Fund that supports Public Health Workforce Investments. The Budget reduces funding for various public health workforce training and development programs by $49.8 million General Fund over four years to help address the budgetary problem.

BACKGROUND

The 2022 Budget Act includes substantial funding for health care workforce development programs. Most of that funding was proposed by the Governor. The Legislature was also successful in adding resources to this area of the budget, specifically for certain types of health care providers that had been overlooked. Moreover, one of the Legislature's highest priorities in this context was to go beyond *health care* providers to also support the public health workforce, and $97.5 million was included in the final budget for this purpose. The proposed reduction of $49.8 million General Fund is more than half of the funding included in last year's budget.

Counties and public health advocates provided the following background information:

Local public health departments are the first line of defense against all public health threats, and these departments rely on a highly skilled and specialized workforce that are often stretched far too thin. Even before the pandemic, public health departments have faced significant workforce challenges. Fewer than one in six graduates from schools of public health go on to work in governmental public health. Nationwide, public health lost roughly 50,000 jobs after the Great Recession. The COVID-19 pandemic has exacerbated these challenges as public health workers have grappled with burnout and harassment, while also being heavily recruited by other sectors.

The proposed $49.8 million cut would impact some or all of the following public health workforce training and development programs:

- ***Public Health Workforce Career Ladder Education and Development Program*** that provides education and training for existing employees within the public health workforce. The program would provide stipends to offset up to 12 hours per workweek to complete educational requirements and would make local health department employers, eligible for enhanced grants to hire additional employees to support the goals of the program.
- ***California Public Health Pathways Training Corp*** administered by CDPH, provides a workforce pathway for early-career public health professionals from diverse backgrounds and disproportionately affected communities to conduct communicable disease prevention and control, community engagement, and emergency response activities at local health department host sites.
- ***California Microbiologist Training*** increases the number of Public Health Microbiologist Trainee spots in California, a requirement that must be fulfilled to become a California Certified Public Health Microbiologists.
- ***Public Health Lab Aspire*** addresses the severe shortage of trained and qualified public health laboratory directors.
- ***California Epidemiologic Investigation Service (Cal-EIS)*** prepares epidemiologists for public health leadership positions throughout California. Fellows are placed in CDPH offices or in local health departments throughout the state.

Stakeholder Input:

The California Can't Wait Coalition is strongly opposed to these cuts citing the significant public health workforce shortages that existed before the pandemic, and which were clearly and significantly exacerbated by the pandemic. This coalition includes the following organizations: County Health Executives Association of California, Health Officers Association of California, SEIU California, California State Association of Counties, Rural County Representatives of California, Urban Counties of California, and Public Health Advocates.

STAFF COMMENTS/QUESTIONS

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

1. In this first year of a recession, the January Budget includes relatively few cuts; please explain how (in this last year of the pandemic), cutting first-time investments in growing the public health workforce makes sense and rises to the top of the list of potential reductions.

2. Please provide an assessment of the public health workforce? Are we more, or less, ready for another pandemic?

3. Are there federal funds available to backfill this reduction?

Staff Recommendation: Subcommittee staff recommends holding this item open to allow for additional discussion and consideration of the proposal, and also recommends urging the administration to consider withdrawing the proposal as part of the May Revise.

ISSUE 13: *OVERSIGHT*: PANDEMIC RESPONSE, EMERGENCY PREPAREDNESS, AND PUBLIC HEALTH INFRASTRUCTURE

PANEL

- **Susan Fanelli**, Chief Deputy Director, Health Quality and Emergency Response, CDPH
- **Christine Siador**, Assistant Director, Policy, Planning and Performance, CDPH
- **Julie Nagasako**, Deputy Director, Office of Policy And Planning, CDPH
- **Oussama Mokeddem**, Director of State Policy, Public Health Advocates
- **Michelle Gibbons**, Executive Director, County Health Executives Association of California (CHEAC)
- **Kim Saruwatari**, Riverside County Public Health Director, CHEAC President
- **Beth Malinowski**, Governmental Affairs Advocate, SEIU California State Council
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

OVERSIGHT ISSUE

In light of where we are in the pandemic, with COVID rates declining and both the federal and state public health emergencies ending, it's an appropriate time to pause and begin reflecting on California's public health infrastructure, our ability to respond effectively to pandemics or other large-scale public health emergencies, and key lessons learned from the pandemic. The Subcommittee would like the panelists to share their thoughts and expertise on California's public health infrastructure and readiness to meet the challenges of the next public health crisis.

The 2022 Budget Act includes a $300 million ongoing General Fund investment in both state and local public health infrastructure. The administration provided the following update on the first year of implementation of this funding:

"In 2022-23, CDPH received support for critical public health infrastructure and transformation of statewide public health system as part of the Future of Public Health Initiative. This included $300 million in General Fund comprised of $200.4 million in local assistance and $99.6 million in state operations with authority for 404 positions.

This first year has been focused on filling critical state and local health positions with diverse, representative, and highly qualified staff.

State

- CDPH has prioritized hiring the 404 positions received in the Future of Public Health funding for State operations.
- To date, we have **hired 155 positions (38 percent) of the 404 positions**.
- We are on track to fill 80 percent of the positions by June 30, 2023.
- We have used LEAN process improvement to streamline our hiring processes.
- We have added resources within HR and are recruiting in new ways including advertising sites and pooled recruitment.
- We have contracted with an HR consulting firm to do large-scale, multi-channel recruitment campaigns by occupational area (3 campaigns have been implemented for Health Program series, Health Facilities Evaluator series, and the Research Scientists series).

Local

- Across the 61 LHJs, there are a total of 1223 proposed positions to be hired.
- To date, **576 positions (47 percent) of the 1223 positions** have been filled.
- At the local level, CDPH issued guidance and applications were received, reviewed, and approved by end of November.
- 60 of the 61 LHJs received a 25 percent advance payment and will be paid additional funds upon invoicing once the initial 25 percent is expended.

OPP/RPHO

- Established two new offices which were approved by CalHR in December including the Office of Policy & Planning and the Regional Public Health Office

Quality Improvement:

- Launched new structures and system improvement efforts
- CDPH released a Continuous Improvement Plan to boost the Department's agility and responsiveness in addressing complex public health challenges
- Launched lean improvement projects for hiring, contracting and regulation package development

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the administration and stakeholders provide:

- Assessments of California's strengths and weaknesses in public health infrastructure and emergency preparedness;
- Implementation updates on the new $300 million investment from 2022;
- Accountability measures associated with the new 2022 funding; and

- Key lessons learned from the pandemic.

Finally, please also respond to the following questions:

1. Are we, or will we be, more prepared for the next public health crisis than we were for the COVID pandemic?

2. How will the state measure progress? How will we know if we're better prepared for crises?

Staff Recommendation: This is an oversight issue and therefore no Subcommittee action is recommended at this time.

ISSUE 14: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE

PANEL

- **Sharisse Kemp**, ADAP Branch Chief, CDPH (*Virtual*)
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ESTIMATE

The 2023-24 ADAP November Estimate provides revised projections of 2022-23 and 2023-24 Local Assistance costs for medication, health insurance premiums, medical out-of-pocket costs, ADAP enrollment site payments, and administrative costs associated with pharmacy, insurance and medical benefits management services. Total estimated budget authority needs for 2022-23 and 2023-24, below, includes all assumptions.

Table 1 displays the estimated ADAP Local Assistance budget authority need for 2022-23 (column C) and 2023-24 (column G) and compares that need to the amount reflected in the Budget Act of 2022 (columns B and F). The Budget Act of 2018 authorized an ongoing $2 million in budget authority to modify and expand PrEP-AP which is also displayed in Table 1.

- 2022-23: Office of AIDS (OA) estimates the ADAP budget authority need will be $440.5 million ($333.4 million ADAP Rebate Fund (Fund 3080) and $107.1 million Federal Trust Fund (Fund 0890)), which is $14.5 million lower than reported in the Budget Act of 2022 (Table 1). The 3.2 percent decrease is driven primarily by lower medication expenditures and premiums for the insured client groups than previously estimated.

- 2023-24: OA estimates the ADAP budget authority need will be $440.1 million ($338.6 million ADAP Rebate Fund (Fund 3080) and $101.5 million Federal Trust Fund (Fund 0890)), which is $14.9 million lower than reported in the Budget Act of 2022 (Table 1). The 3.3 percent decrease is driven primarily by Medi-Cal Expansions, and the same factors listed above.

Table 2 displays the estimated ADAP revenue for 2022-23 (column C) and 2023-24 (column G) and compares them to the amount reflected in the Budget Act of 2022 (columns B and F).

- 2022-23: OA estimates ADAP revenue will be $335.1 million (Table 2), $22.1 million lower than reported in the Budget Act of 2022. The 6.2 percent decrease is driven primarily by lower medication expenditures than previously estimated.

- 2023-24: OA estimates ADAP revenue will be $380.2 million (Table 2), $23 million higher than reported in the Budget Act of 2022. The 6.4 percent increase is driven primarily by a delay in the collection of rebate from the prior year from one manufacturer.

California Department of Public Health
AIDS Drug Assistance Program and PrEP Assistance Program
2023-24 November Estimate
Table 1: Local Assistance Budget Authority
(In Thousands)

Local Assistance	2022 Budget Act	Current Year FY 2022-23			2022 Budget Act	Budget Year FY 2023-24		
		2023-24 November Estimate	$ Change from 2022 Budget Act	% Change from 2022 Budget Act		2023-24 November Estimate	$ Change from 2022 Budget Act	% Change from 2022 Budget Act
(A)	(B)	(C)	(D) =(C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Funds Requested	**$455,054**	**$440,521**	**-$14,533**	**-3.2%**	**$455,054**	**$440,128**	**-$14,926**	**-3.3%**
Federal Trust Fund - Fund 0890	$98,950	$107,076	$8,127	8.2%	$98,950	$101,519	$2,570	2.6%
ADAP Rebate Fund - Fund 3080	$354,105	$331,445	-$22,660	-6.4%	$354,105	$336,609	-$17,496	-4.9%
2018 Budget Act - PrEP-AP - Fund 3080	$2,000	$2,000	$0	0.0%	$2,000	$2,000	$0	0.0%
Caseload	35,873	35,801	-72	-0.2%	35,873	36,628	755	2.1%

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

2023-24 November Estimate
Table 2: ADAP Rebate Fund (Fund 3080) Revenues
(In Thousands)

Local Assistance	2022 Budget Act	Current Year FY 2022-23			2022 Budget Act	Budget Year FY 2023-24		
		2023-24 November Estimate	$ Change from 2022 Budget Act	% Change from 2022 Budget Act		2023-24 November Estimate	$ Change from 2022 Budget Act	% Change from 2022 Budget Act
(A)	(B)	(C)	(D) =(C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Revenue Requested	**$357,165**	**$335,082**	**-$22,083**	**-6.2%**	**$357,165**	**$380,191**	**$23,027**	**6.4%**
ADAP Rebate Fund - Fund 3080	$354,923	$332,840	-$22,083	-6.2%	$354,923	$377,949	$23,027	6.5%
Interest Income	$2,242	$2,242	$0	0.0%	$2,242	$2,242	$0	0.0%

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

TABLE 3: ESTIMATED VARIABLE EXPENDITURES BY CLIENT GROUP

CLIENT GROUP	EXPENDITURES	
	FY 2022-23	FY 2023-24
Medication-Only	$313,407,919	$299,195,054
Medi-Cal SOC	$670,664	$658,655
Private Insurance	$86,602,374	$91,529,534
Medicare	$26,476,046	$28,770,897
PrEP-AP	$10,171,767	$13,233,295
SUBTOTAL	**$437,328,771**	**$433,387,434**
Admin Costs: ADAP	$5,365,537	$5,825,091
Admin Costs: PrEP-AP	$4,480,015	$6,121,167
Admin Costs: Enrollment	$7,070,000	$6,945,000
Health Management Systems (HMS)	-$15,723,094	-$14,150,785
TOTAL	**$438,521,230**	**$438,127,908**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
Admin Costs are pharmacy, insurance and medical benefits management services.

New assumptions that affect the ADAP estimate include the following:

1. Expansion of Medi-Cal to All Income-Eligible Californians;
2. Restoration of the Covered California State Premium Subsidy;
3. Increase in Federal Funds: 2022 Ryan White Part B Supplemental Grant;
4. Increase in Federal Funds: 2021 Ryan White Part B Grant Carryover; and
5. Medi-Cal Expansion: Asset Limit Changes.

Caseload:

Overall ADAP caseload remains relatively stable, with a projected 2.1 percent increase in enrollment from the current year to the budget year. The following table displays the projections for 2023-24:

TABLE 10: 2022 Budget Act Caseload and Variable Expenditures; Budget Year 2023-24

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	10,393	29.0%	$302,785,103	$0	$0	$302,785,103
Medi-Cal SOC	103	0.3%	$1,187,709	$0	$0	$1,187,709
Private insurance*	10,900	30.4%	$24,135,323	$73,683,229	$1,812,749	$99,631,301
Medicare*	7,536	21.0%	$24,357,919	$6,925,619	$508,871	$31,792,410
PrEP-AP	6,941	19.3%	$10,826,716	$0	$1,452,073	$12,278,789
SUBTOTAL	**35,873**	**100.0%**	**$363,292,770**	**$80,608,848**	**$3,773,693**	**$447,675,311**
Admin Costs: ADAP	-	-	$2,188,318	$1,646,967	$945,476	$4,780,760
Admin Costs: PrEP-AP	-	-	$3,085,462	$0	$2,140,700	$5,226,161
Admin Costs: Enrollment	-	-	$0	$0	$0	$6,975,000
HMS	-	-	-$11,602,862	$0	$0	-$11,602,862
TOTAL	**35,873**	**100.0%**	**$356,963,687**	**$82,255,815**	**$6,859,869**	**$453,054,371**

* Subgroup of 13,839 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
Admin Costs are pharmacy, insurance and medical benefits management services.

BACKGROUND

The administration provided the following background information on ADAP and HIV/AIDS in California:

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) administers the Acquired Immunodeficiency Syndrome (AIDS) Drug Assistance Program (ADAP). ADAP provides access to life-saving medications for eligible California residents living with Human Immunodeficiency Virus (HIV), assistance with costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV, and post-exposure prophylaxis (PEP) for clients who may have been exposed to HIV. ADAP services, including support for medications, health insurance premiums, and medical out-of-pocket costs, areprovided to five groups of clients:

1. Medication-only clients are people with HIV (PWH) 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 PWH 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 PWH who have some form of health insurance, including insurance purchased through Covered California, privatelypurchased health insurance, or employer-based health insurance. This group is divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.

4. Medicare clients are PWH who are enrolled in a Medicare plan. This group is divided into three client sub-groups: Part B, Part C, and Part D. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.

5. PrEP Assistance Program (PrEP-AP) clients are HIV-negative individuals who are at risk of HIV infection and who have chosen to take PrEP as a way to prevent infection. For insured clients, the PrEP-AP pays for PrEP and PEP related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's copayment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP and PEP-related medical costs and medication costs for clients who are ineligible for a medication assistance program through a drug manufacture or other assistance programs.

As a covered entity in the Health Resources & Services Administration (HRSA) 340B Drug Pricing Program, ADAP collects rebates for most prescriptions purchased for ADAP clients. ADAP does not collect rebates for prescriptions purchased for Medi-Cal SOC or PrEP-AP clients. To prevent duplicate rebate discounts on the same claim, which is prohibited, ADAP does not invoice manufacturers for rebates on Medi-Cal SOC claims. As the primary payer, MediCal has the right to claim mandatory rebate on prescriptions for Medi-Cal SOCclients. ADAP also does not collect rebate on medication purchases for PrEP-AP clients because PrEP-AP is separate and distinct from ADAP and is not a 340B covered entity.

Historically, most ADAP clients were medication-only clients without health insurance because PWH were unable to purchase affordable health insurance in the private marketplace. With the implementation of the Affordable Care Act, 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 to safeguard ADAP as the payer of last resort. Clients who enroll in full-scope Medi-Cal are disenrolled from ADAP because these clients have no SOC, no drug copays 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 copays for medications on the ADAP formulary.

Eligible clients with health insurance can also co-enroll in ADAP's health insurance assistance programs for assistance with their insurance premiums and medical out-of-pocket costs, which can only be paid if ADAP pays the client's premium. Helping ADAP clients purchase and maintain comprehensive health insurance is more cost effective than paying the full cost of medications and improves health outcomes by providing access to the full spectrum of medical care beyond the HIV outpatient care and medications available through the Ryan White Program.

Current HIV Epidemiology in California

Approximately 139,700 people in California at the end of 2020 had been diagnosed with HIV and reported to OA. However, OA estimates that 12 percent of all PWH in California are unaware of their infection. Therefore, OA estimates that there were approximately 159,100 PWH in California as of the end of 2020. Since the epidemic began in 1981, approximately 105,000 Californians diagnosed with HIV have died, with over 1,800 dying in 2020 alone.

Of the approximately 139,700 people living with diagnosed HIV (PLWDH) in California, approximately 38.5 percent are Latinx; 36.3 percent are White; 16.9 percent are Black/African American; 4.3 percent are Asian; 3.5 percent are multi-racial; 0.2 percent are American Indian/Alaskan Native; and 0.2 percent are Native Hawaiian/Pacific Islander. While Latinx and Whites make up the largest percentage of PLWDH in California, the rate of HIV among Blacks/African Americans is substantially higher (987.7 per 100,000 population, versus 345.4 per 100,000 among Whites and 344.5 per 100,000 among Latinx).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.4 percent); 8.4 percent of living cases are attributable to high-risk heterosexual contact (defined as contact with a sex partner or partners of the opposite gender who are either known to be HIV infected or known to be someone who injects drugs, has hemophilia, or is a man who has sex with other men); 6.3 percent to men who have sex with men who also inject drugs; 5.5 percent to injection drug use; 1.5 percent to transgender sexual contact; 0.5 percent to perinatal exposure; and 11.4 percent to other or unknown sources including other heterosexual contact.

There are approximately 3,900 new HIV cases reported in California each year, which is a revision from the prior year of approximately 4,500 new HIV cases. One potential driver of the decrease may be the statewide stay-at-home order period during the COVID-19 pandemic. The number of PWH in the state is expected to grow by two to three percent each year for the foreseeable future until more progress is made in preventing new HIV infections. This increase is attributed to stable incidence rates and longer survival of those infected primarily due to the effectiveness and availability of treatment.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present a brief overview of the ADAP estimate and respond to the following questions:

1. Please explain the primary changes and dynamics in funding reflected in the estimate.

2. What explains the increases in federal funds?

3. What explains the ongoing over-estimates of drug costs?

4. Please explain the assumptions and conditions that are affecting caseload projections.

Staff Recommendation: Subcommittee staff recommends holding this item open until May Revision updates can be reviewed.

ISSUE 15: BABYBIG INFANT BOTULISM TREATMENT AND PREVENTION PROGRAM BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Katya Ledin**, Infectious Diseases Laboratories Division Chief, CDPH (*Virtual*)
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests additional expenditure authority of $7.4 million in 2023-24, $11.6 million in 2024-25, $7 million in 2025-26, $4.9 million in 2026-27, and $3.9 million in 2027-28 and ongoing from the Infant Botulism Treatment and Prevention Fund to enable CDPH to meet manufacturing costs associated with the production of Lot 8 of its licensed orphan drug BabyBIG® (Human Botulism Immune Globulin), used for the treatment of infant botulism.

BACKGROUND

The administration provided the following background information:

BabyBIG® is the drug used for the treatment of infant botulism, and CDPH is the only source of BabyBIG® in the world. BabyBIG® is the only licensed treatment for infant botulism in the United States. BabyBIG® is distributed statewide and nationwide, for a fee to patients with infant botulism, as required by the Federal Orphan Drug Act and State law, Health and Safety Code (HSC) sections 123700-123709. The U.S. Food and Drug Administration (FDA) licensed BabyBIG® to CDPH in October 2003.

Under the oversight and at the direction of CDPH as Sponsor, BabyBIG® is made by contractors from plasma, the liquid part of the blood, donated by persons who receive a special botulism vaccine booster usually because they have an occupational risk of exposure to botulism. Immunized persons include laboratory workers at CDPH and other facilities. A new lot of BabyBIG® is made approximately every five years.

As established by HSC section 123702, CDPH collects a fee for BabyBIG® that is deposited in the Infant Botulism Treatment and Prevention Fund (Fund 0272). BabyBIG® fee revenue can only be used for making more BabyBIG® and other statutorily mandated activities. Fees accrue in the fund in non-production years to provide the funds needed in production years. The fee for BabyBIG® is $57,300 per patient. Approximately 185 BabyBIG® treatments are distributed each year, thereby generating a stable fee revenue income of approximately $10.6 million per year. Based on a five-year average, approximately 30 percent of the treatments are distributed in California. Hospitals, not

families, pay the fee for BabyBIG® and are reimbursed by either private or public insurance entities, including Medi-Cal.

One of CDPH's key roles in BabyBIG® production is obtaining the human plasma that contains antibodies that neutralize botulinum toxin. Also, as the Sponsor and licenseholder, CDPH is responsible to the FDA for all aspects of product safety, quality control, maintenance, distribution, and inventory tracking of BabyBIG®. CDPH fulfills these responsibilities through FDA-required external contracts with manufacturers and regulatory specialists who are designated in the BabyBIG® license to monitor product quality, safety, stability, pharmacovigilance/safety reporting, BabyBIG® release, and inventory tracking. Pharmaceutical industry manufacturing costs typically average four to six percent higher than the yearly general inflation rate because of additional manufacturing quality control, specialized supply chain, and regulatory compliance costs.

BabyBIG® is highly cost-effective. Use of BabyBIG® shortens average hospital stay by almost four weeks (from six weeks to two weeks) and reduces hospital costs by more than $97,000 per patient (2020 dollars). Following licensure of BabyBIG® in 2003, more than 2,500 infant botulism patients nationwide have been treated through June 2022, thereby avoiding more than 160 years of patient hospital stays and more than $240 million of hospital costs (2020 dollars).

Use of BabyBIG® in California saves Medi-Cal approximately $2 million per year. Use of BabyBIG® results in cost avoidance savings to California hospitals of approximately $5 million annually, and approximately $16 million nationwide annually. Estimates of hospital cost savings were obtained from ongoing program cost-tracking surveillance and were also published in the February 2018 peer-reviewed Journal of Pediatrics.

The 2014, 2015 and 2018 Budget Acts included increased ongoing appropriation authority to meet the increased manufacturing costs due to inflation, new FDA requirements that increased production costs, and collection of additional blood plasma from out-of-state donors to provide an adequate supply of BabyBIG®.

The license for BabyBIG® is contingent on using specified processes, facilities, and equipment. There is only one facility in the world approved by FDA for production of BabyBIG®, located in Los Angeles, California. CDPH's contract production facility in Los Angeles has affirmed its commitment to manufacture the next lot of BabyBIG® (Lot 8) for CDPH. This proposal will provide CDPH with the necessary increased expenditure authority to address manufacturing and other costs that will start in 2023-24 and carry on into 2027-28 and ongoing and includes post-production regulatory compliance activities and associated costs.

STAFF COMMENTS/QUESTIONS

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

1. Who pays the fees that support this program, and is there any reason to believe that the fee increase could be a hardship on anyone?

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 16: CALIFORNIA IMMUNIZATION REGISTRY (AB 1797) BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Robert Schechter**, Immunization Branch Chief, CDPH (*Virtual*)
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests 3 positions and $915,000 in 2023-24, and 3 positions and $453,000 in 2024-25 and ongoing General Fund to manage the increased workload related to the requirements of Assembly Bill AB 1797 (Akilah Weber, Chapter 582, Statues of 2022).

BACKGROUND

The administration provided the following background:

Starting January 1, 2023, AB 1797 requires health care providers and other agencies to report administered immunizations to the ongoing California Immunization Registry (CAIR) and allows schools, childcare facilities, and human services agencies to look up COVID-19 immunizations for program participation purposes.

Reporting of routine vaccines is largely voluntary under current state law. Only pharmacists, optometrists, dentists, podiatrists, and Medi-Cal Managed Care Plans are required to report immunizations given to patients into CAIR. In contrast, most providers of vaccines in California are not required to report their immunizations, leaving a significant gap in the immunization data captured in CAIR. The passage of AB 1797 closes that gap by requiring all health care providers to report immunizations administered into CAIR.

Recent analyses of COVID-19 vaccine providers indicate there are thousands of providers not currently reporting their other non-COVID-19 vaccine doses in CAIR. As most providers are now enrolling in data exchange with CAIR (i.e., submitting immunization data to CAIR from their electronic health record systems), additional staff will be needed for data exchange enrollment, support, and maintenance. Once data exchange has begun, ongoing errors and discrepancies in transmission require reconciliation by CAIR staff. As the number of providers enrolled in data exchange increases, staff support will be needed to review data quality and address discrepancies.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 17: RESTROOM ACCESS: MEDICAL CONDITIONS (AB 1632) BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH, Center for Healthy Communities (CHC), Chronic Disease Control Branch (CDCB) requests nine positions and $1.4 million General Fund expenditure authority in 2023-24 and ongoing to create a new program to implement and provide oversight for the Restroom Access Act as mandated by AB 1632 (Akilah Weber, Chapter 893, Statutes of 2022).

BACKGROUND

The administration provided the following background information:

People with certain medical conditions such as Crohn's disease or ulcerative colitis may experience symptoms that require immediate access to a restroom. Several organizations, such as the Crohn's and Colitis Foundation, offer cards that individuals with gastrointestinal disorders such as inflammatory bowel disease can carry to explain their symptoms to facility managers in case of an emergency. However, businesses in states without Restroom Access laws are not required to grant access to an individual, even if they have such a card.

AB 1632 requires CDPH to develop a standard electronic form to be shared on CDPH's website, in a printable format, that a health care provider may sign to serve as reasonable evidence of the existence of an eligible medical condition or use of an ostomy device.

AB 1632 requires a place of business open to the public for the sale of goods that has a restroom for its employees to allow any individual who has an eligible medical condition, is lawfully on the premises of that place of business, and requires immediate access to a toilet facility, to use the employee restroom. This is required even if the place of business does not normally make the employee restroom available to the general public.

AB 1632 enacts a civil liability penalty up to $100 for each violation on a business owner where the violation was due to willful or grossly negligent conduct. An employee of a place of business would not be subject to discharge or any other employment disciplinary action for failing to provide immediate access to the employee restroom unless the employee's

action is contrary to an expressed policy developed by their employer. AB 1632 does not create or imply a private right of action for violation of its terms.

AB 1632 requires CDPH to develop a new program with the ability to implement the enforcement requirements of AB 1632 for businesses violating the statute. Developing the new program will require time to hire new staff, train, and purchase equipment. The new staff will begin research and development of regulation packages and identify methods and metrics that will allow CDPH to monitor activities and gauge performance towards implementation.

STAFF COMMENTS/QUESTIONS

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

1. Will CDPH be educating the business community about their new legal obligations resulting from this bill?

2. Will local health departments monitor/enforce this?

3. Will there be monitoring or will the fines result only from investigations/complaints?

4. Will fine revenue ultimately pay the costs of the program?

5. Please explain why the costs of this program have exceeded the estimate shared with the Assembly Appropriations Committee when analyzing AB 1632.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 18: LEAD RENOVATION, REPAIR AND PAINTING PROGRAM (SB 1076) BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH, Center for Healthy Communities (CHC), Childhood Lead Poisoning Prevention Branch (CLPPB) requests 1 position and $615,000 in General Fund authority in 2023-24 and 2024-25, an additional 31 positions and $5.5 million in expenditure authority from the Lead-Related Construction Fund in 2025-26, and $5.2 million in 2026-27 and ongoing to implement the residential lead-based paint Renovation, Repair and Painting (RRP) program as mandated by SB 1076 (Archuleta, Chapter 507, Statutes of 2022).

BACKGROUND

The administration provided the following background information:

SB 1076 requires CDPH to review and amend its regulations to adopt and comply with the federal Environmental Protection Agency's (EPA) RRP Rule. This would advance efforts to reduce lead poisoning by providing clarity on the training and certification requirements for lead safe work practices, as well as by improving oversight and enforcement of those requirements at the state level.

The RRP Rule helps prevent exposure to lead by regulating renovation of homes and child-occupied building constructed before the ban on the use of lead-based paint in 1978. Lead-based paint disturbed during renovation creates paint chips and dust. Ingestion of lead-contaminated house dust contributes almost 40 percent of the increase in blood lead levels in U.S. children and creates hazards for workers. In 2019, 6,913 children in California had such excessive levels of lead in their blood that it placed them in the top 2.5 percent of children nationwide. California has more homes built before 1978, and more residential remodeling contractors, than any other state.

SB 1076 requires CDPH to review and amend its regulations to comply with the RRP Rule. To meet this requirement, CDPH will seek authorization from the EPA to take over administration of the RRP Rule in California. Fourteen states are already authorized to implement the RRP Rule and successfully perform a higher rate of RRP certification, inspections, and enforcement than the federal program. SB 1076 gives CDPH the ability

to verify that those doing renovation and repair work on pre-1978 homes are certified in lead safe work practices.

Implementation of SB 1076 requires CDPH to adopt regulations and establish a new system of fees to replace that of the EPA. The increased oversight of the regulated community will result in an increase in staffing needs for the CLPPB and the Occupational Health Branch.

CDPH will seek authorization from US EPA to implement the RRP program. Once CDPH becomes an RRP authorized state, CLPPB will implement the RRP program to expand training opportunities to residential renovation contractors to learn about lead-safe work practices, create a lead-safe residential renovation workforce, increase awareness of the threat of lead poisoning and associated screening, and support compliance with and enforcement of RRP requirements.

STAFF COMMENTS/QUESTIONS

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

1. For what reasons is General Fund part of this request, and what is it for specifically?

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 19: CHILDHOOD DROWNING DATA COLLECTION PILOT PROGRAM (SB 855) BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH, Injury and Violence Prevention Branch (IVPB), requests General Fund expenditure authority of $260,000 in 2023-24, $632,000 in 2024-25 and 2025-26, and $316,000 in 2026-27 to establish and administer a three-year Childhood Drowning Data Collection Pilot Program per SB 855 (Newman, Chapter 817, Statutes of 2022).

BACKGROUND

SB 855 requires CDPH to establish a comprehensive, coordinated, and data-driven approach to childhood drowning prevention through a Childhood Drowning Data Collection Pilot Program. The Childhood Drowning Data Collection Pilot Program would leverage existing Fatal Child Abuse and Neglect Surveillance (FCANS) data infrastructure, but otherwise represents a completely novel approach to childhood drowning surveillance and prevention.

Existing data systems on childhood drownings either do not contain critical information on the drowning circumstances or are not consistently and completely used for data reporting across the state. Furthermore, there are no state-led coordinated efforts to prevent childhood drownings. SB 855 would help resolve these issues by requiring CDPH to develop standard childhood drowning data reporting protocols and facilitating the creation of a California Water Safety Action Plan for Children.

SB 855 requires CDPH to establish a pilot program, on or before January 1, 2024, to collect detailed data on childhood drownings in five to ten counties, report progress and findings to the Legislature, and publish a California Water Safety Action Plan for Children.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH to present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 20: *OVERSIGHT*: PROPOSITION 99 UPDATES

PANEL – PRESENTERS

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

OVERSIGHT ISSUE

The following adjustments to Proposition 99 (tobacco tax) expenditures within CDPH are included in the January Budget, reflecting Proposition 99 revenue projections:

Proposition 99 Health Education Account
$505,000 TF
$505,000 OF
The Governor's Budget reflects an increase of $505,000 in Proposition 99 Health Education Account (Fund 0231), including a decrease of $870,000 in State Operations and an increase of $1,375,000 in Local Assistance as a result of the updated Proposition 99 revenue projections. The increase includes $141,000 in State Administration, $1,375,000 in Competitive Grants (Local Assistance), and $826,000 in Evaluation, and decreases of $1,493,000 in Media Campaign and $344,000 in Competitive Grants (State Operations). The revenues support a comprehensive statewide tobacco control program and reducing illness and premature death attributable to the use of tobacco products. The funds are provided to state and local government agencies, tribes, universities, colleges, community-based organizations, and other qualified agencies for the implementation, evaluation, and dissemination of evidence-based health promotion and health communication activities.

Proposition 99 Research Account
$1,491,000 TF
$1,491,000 OF
The Governor's Budget reflects an increase of $1,491,000 in Proposition 99 Research Account (Fund 0234) State Operations as a result of updated Proposition 99 revenue projections. The increase includes $179,000 in State Administration and $1,312,000 in External Contracts. The revenues are used for tobacco-related disease research.

Proposition 99 Unallocated Account
-$60,000 TF
-$60,000 OF

The Governor's Budget reflects a decrease of $60,000 in Proposition 99 Unallocated Account (Fund 0236) State Operations as a result of updated Proposition 99 revenue projections. The decrease includes $43,000 in State Administration and $17,000 for the California Health Interview Survey. The revenues are used to support tobacco education, tobacco prevention efforts, tobacco-related programs, tobacco-related healthcare services, environmental protection, and recreational resources.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH provide an overview and explanation of the Prop 99 changes within CDPH's budget, as well as detail on any corresponding policy or programmatic changes.

Staff Recommendation: This is an oversight issue and therefore no Subcommittee action is recommended at this time.

ISSUE 21: *OVERSIGHT*: PROPOSITION 56 UPDATES

PANEL – PRESENTERS

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Miren Klein**, Deputy Director (A), Center for Environmental Health, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

OVERSIGHT ISSUE

The following adjustments to Proposition 56 (tobacco tax) expenditures within CDPH are included in the January Budget, reflecting Proposition 56 revenue projections:

Proposition 56 State Dental Program Account
$4,842,000 TF
$4,842,000 OF
The Governor's Budget reflects an increase of $4,842,000 in State Dental Program Account (Fund 3307), including a decrease of $1,547,000 in State Operations and an increase of $6,389,000 million in Local Assistance as a result of updated Proposition 56 revenue projections. The funds are used for the state dental program for the purpose and goal of educating about, preventing, and treating dental disease, including dental diseases caused by use of cigarettes and other tobacco products.

Proposition 56 Tobacco Prevention and Control Programs Account
-$2,250,000 TF
-$2,250,000 OF
The Governor's Budget reflects a decrease of $2,250,000 in Tobacco Prevention and Control Programs Account (Fund 3322), including an increase of $5,756,000 in State Operations and a decrease of $8,006,000 in Local Assistance as a result of updated Proposition 56 revenue projections. The decrease includes a decrease of $406,000 in Media Campaign, $4,744,600 in Competitive Grants (Local Assistance), and $3,261,400 in Local Lead Agencies, and an increase of $2,644,000 in State Administration, $1,174,000 in Evaluation, and $2,344,000 in Competitive Grants (State Operations). The revenues are used for a comprehensive statewide tobacco control program and reducing illness and premature death attributable to the use of tobacco products. The funds are provided to state and local government agencies, tribes, universities, colleges, community-based organizations, and other qualified agencies for the implementation, evaluation, and dissemination of evidence-based health promotion and health communication activities.

Proposition 56 Tobacco Law Enforcement Account
-$797,000 TF
-$797,000 OF
The Governor's Budget reflects a decrease of $797,000 in Tobacco Law Enforcement Account (Fund 3318) State Operations as a result of updated Proposition 56 revenue projections. This funding supports the enforcement of state and local laws related to the illegal sales of tobacco to minors.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH provide an overview and explanation of the Prop 56 changes within CDPH's budget, as well as detail on any corresponding policy or programmatic changes. Please also respond to the following:

1. What's the reason there's an increase in funding for the Dental Program?

Staff Recommendation: This is an oversight issue and therefore no Subcommittee action is recommended at this time.

ISSUE 22: *OVERSIGHT*: CALIFORNIA CANCER REGISTRY BUDGET

PANEL – PRESENTERS

- **Dr. Allison Kurian**, M.D., M.Sc., Professor of Medicine, Epidemiology, and Population Health, Stanford University School of Medicine (*Virtual*)
- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

OVERSIGHT ISSUE

Established in 1985, the California Cancer Registry (CCR) is the largest registry in the nation and is recognized as one of the leading cancer registries in the world. The CCR is a vast repository of cancer data that provides vital information to public health officers and researchers. With this data, it is possible to determine cancer risk factors and study groupings of cancers in communities.

The CCR has several funding sources, primarily from tobacco tax revenue which inevitably declines over time. As a result, CDPH has indicated that there are insufficient funds to maintain a stable budget for the program. According to advocates, if state funding drops below the level required for federal matching funds, the CCR will lose considerable funding which will significantly diminish the CCR's capacity.

Public health advocates provided the following background information on the CCR budget:

"The CCR is funded through the General Fund, Proposition 99, and federal dollars for which it must provide matching dollars. Upon creation, the Legislature promised to provide ongoing funding of the CCR through each Budget Act1. The CCR funding has been on a steady decline due to the declining Proposition 99 funding and lean Budget years, leaving the CCR without sustainable funding. By cutting their budget further, we put them at risk of losing millions of federal matching funds and the ability to continue their critical work.

The CCR also works directly with our three regional registries which provide critical support on local instances of disease. They are the first line in collecting the data that is used for research and clinical trials. This has been largely a manual process that has taken many years to upload. In 2016, the Legislature passed, and Governor signed AB 2325 to update the cancer registry to ensure real time reporting. Since then, the CCR has worked diligently to implement this unfunded mandate and update the CCR to bring their reporting into the modern era.

Provided the appropriate funding, they will be able to achieve that goal in the next two years. What this means is that the registry will have data in real time, allowing researchers to utilize current data, as opposed to relying on old data. Additionally, the implication for clinical trials is immense. Currently only 3% of adults diagnosed with cancer participate in clinical trials, those numbers are much lower for those of racial and ethnic minorities. With real time reporting, we will be able to connect cancer patients to clinical trials and researchers while they are still able to make a difference.

The CCR is critically important to cancer research and eliminating gaps in health equity. With the appropriate, ongoing funding, the registry has the opportunity to implement changes that would provide real time data for researchers and clinical trials."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Dr. Kurian to present an overview of the CCR and the potential impacts on the CCR of budget shortfalls.

The Subcommittee requests CDPH to provide an explanation of the situation, reactions to Dr. Kurian's testimony and respond to the following questions:

1. According to the advocates, the CCR needs an ongoing augmentation of $6.6 million; is that the accurate amount of the shortfall in the CCR budget?

2. What will be the impacts on the operations and activities of the CCR if the shortfall is not addressed successfully?

3. Can we expect to see a proposed solution in the May Revise?

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this point in time.

ISSUE 23: WOMEN, INFANTS, CHILDREN (WIC) PROGRAM ESTIMATE

PANEL – PRESENTERS

- **Christine Sullivan**, WIC Division Chief, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ESTIMATE

This issue provides an overview of the WIC program estimate, and details the changes reflected in the January budget.

Current Year (2022-23) Changes

$218,828,000 TF
$218,828,000 OF

The Governor's Budget reflects an increase of $218.8 million in Local Assistance. This includes an increase of $195 million in the Federal Trust Fund and an increase of $23.8 million in the WIC Manufacturer Rebate Fund. Higher expenditure levels are due to the extension of the fruits and vegetables benefit increase for the full year, an increase in participation projections compared to the 2022 Budget Act, and an increase in food inflation. Rebate expenditure increases are attributed to a higher number of infants projected to be served in current year.

Budget Year 2023-24 Changes

$241,695,000 TF
$241,695,000 OF

The Governor's Budget reflects an increase of $241.7 million in Local Assistance. This includes an increase of $209.8 million in the Federal Trust Fund and an increase of $31.9 million in the WIC Manufacturer Rebate Fund. The increase in food expenditures is driven by the extension of the fruits and vegetables benefit increase, an increase in current and budget year participation projections compared to the 2022 Budget Act, and a food inflation rate of 1.88 percent. The increase in rebate expenditures is due to a higher number of infants projected to be served.

TABLE 4: EXPENDITURE COMPARISON (federal funds)
All figures in dollars, rounded to the nearest thousand

Fund 0890 Federal Trust Fund	2022 Budget Act	2022-23 November Estimate	2022-23 Change from 2022 Budget Act	2022-23 % Change from 2022 Budget Act	2023-24 November Estimate	2023-24 Change from 2022 Budget Act	2023-24 % Change from 2022 Budget Act
Local Assistance Expenditures	834,520,000	1,029,551,000	195,031,000	23.37%	1,044,309,000	209,789,000	25.14%
Food Expenditures (Food Grant)	512,520,000	707,551,000	195,031,000	38.05%	722,309,000	209,789,000	40.93%
Other Local Assistance (NSA Grant)	322,000,000	322,000,000	0	0.00%	322,000,000	0	0.00%
State Operations (NSA Grant)	63,145,000	64,502,000	1,357,000	2.15%	64,475,000	1,330,000	2.11%

TABLE 5: REVENUE COMPARISON (federal funds)
All figures in dollars, rounded to the nearest thousand

Fund 0890 Federal Trust Fund	2022 Budget Act	2022-23 November Estimate	2022-23 Change from 2022 Budget Act	2022-23 % Change from 2022 Budget Act	2023-24 November Estimate	2023-24 Change from 2022 Budget Act	2023-24 % Change from 2022 Budget Act
Total Available Resources	966,850,000	1,119,991,000	153,141,000	15.84%	1,122,790,000	155,940,000	16.13%
Food Grant	581,598,000	732,491,000	150,893,000	25.94%	734,590,000	152,992,000	26.31%
NSA Grant	385,252,000	387,500,000	2,248,000	0.58%	388,200,000	2,948,000	0.77%

TABLE 7: REVENUE COMPARISON (rebate funds)
All figures in dollars, rounded to the nearest thousand

Fund 3023 Manufacturer Rebate	2022 Budget Act	2022-23 November Estimate	2022-23 Change from 2022 Budget Act	2022-23 % Change from 2022 Budget Act	2023-24 November Estimate	2023-24 Change from 2022 Budget Act	2023-24 % Change from 2022 Budget Act
Projected Rebate Revenue	182,704,000	205,586,000	22,882,000	12.52%	213,383,000	30,679,000	16.79%
4% Reserve for Additional Revenue	7,308,000	8,223,000	915,000	12.52%	8,535,000	1,227,000	16.79%
Total Available Resources	190,012,000	213,809,000	23,797,000	12.52%	221,918,000	31,906,000	16.79%

WIC Participation in California

The largest participant category served in WIC is children due to the length of children's eligibility (first to fifth birthday). Other participant categories are limited to one year of eligibility or less. The table below displays the distribution of California WIC participants by category for 2021-22.

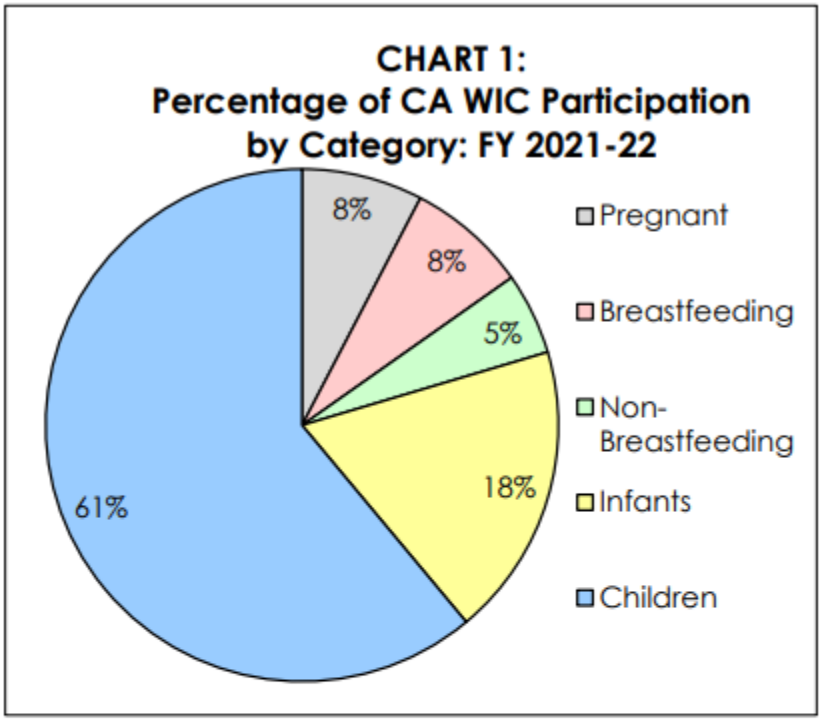

TABLE 1: ACTUAL CA WIC PARTICIPATION BY CATEGORY: FY 2021-22

Participant Category	Annual Average Monthly Participation FY 2021-22
Pregnant	71,383
Breastfeeding	70,784
Non-Breastfeeding	48,190
Infants	173,159
Children	570,139

BACKGROUND

The administration provided the following background on the WIC program:

CDPH, Women, Infants and Children Division (WIC) operates a $1.1 billion program that served approximately 934,000 low-to-medium income California residents per month in 2021-22.

WIC receives federal funding to administer the WIC program through 84 local agencies (WIC Local Agencies) and approximately 3,800 authorized grocers (including military commissaries) and 53 authorized farmers at farmers' markets. Select authorized grocers in bordering states also accept California WIC benefits.

The funding through the United States Department of Agriculture (USDA) is based on a discretionary grant appropriated by Congress, plus subsequent reallocations of prior year unspent funds. The WIC program does not require any state general funds and is not an entitlement program; the number of participants served is limited by the discretionary federal grant. It is California's third largest federally funded food and nutrition assistance program after CalFresh, otherwise known as Supplemental Nutrition Assistance Program (SNAP) in most states, and thesubsidized school meal programs.

The WIC program provides nutrition services and food assistance for pregnant, breastfeeding, and non-breastfeeding women, infants, and children up to age five who are at nutritional risk. In addition to the categorical eligibility requirement, applicants can become income-eligible by providing documentation of income below 185 percent of the federal poverty level, which is equivalent to an annual income of $42,606 for a family size of three in 2022. Applicants can also be deemed income-eligible (adjunctive eligibility) based on participation in certain means-tested programs. Applicants who currently receive or are certified as eligible to receive Medi-Cal, California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, or Food Distribution on Indian Reservations benefits are adjunctively eligible.

WIC program services include nutrition education, breastfeeding support, assistance with finding health care and other community services, and benefits for specific supplemental foods redeemable at authorized grocers. The WIC program is federally funded by the USDA under the Federal Child Nutrition Act of 1966 and the Healthy, Hunger-Free Kids Act of 2010, as amended. Specific uses of the WIC program funds are required under federal laws and regulations, and WIC must report funds and expenditures monthly.

According to the most recent data (National- and State- Level Estimates of WIC Eligibility and WIC Program Reach in 2019, by USDA/Food and Nutrition Service (FNS) released in February 2022), the WIC program serves 68.9 percent of eligible Californians, the third highest coverage of eligible persons of all state WIC programs and fourth nationally behind Puerto Rico, Vermont, and Oregon, while the national average is 57.4 percent. A separate analysis showed that nearly half of all California resident infants born in 2018 were enrolled in WIC during their first year of life.

WIC revenues are comprised of the federal grants and retained manufacturer rebates. The maximum number of participants served by WIC depends largely on food package costs, of which infant formula is a large percentage. Purchase of infant formula represents approximately 35 percent of gross food expenditures. WIC program federal regulations 7 CFR 246.16a require all states to obtain infant formula manufacturer rebates through a competitive bidding process to offset this cost and maximize the number of participants that can be served. The California state budget authorizes WIC to retain infant formula rebate revenue and use it to offset the cost of food for WIC participants. Rebate revenue accounts for approximately 22 percent of WIC revenue for food.

In addition to funding food expenditures, the Local Assistance budget authority includes other federal funds, such as the Nutrition Services and Administration (NSA) grant, which are used by WIC Local Agencies to provide services directly to WIC families and support the statewide management information system (MIS) used in the provision of those services. The NSA grant also funds WIC State Operations for administering the program.

This Estimate projects food expenditures based on statewide participation, historical expenditures, any regulatory changes that affect costs, and inflation. WIC estimates cost per participant at the overall participation level. For program management purposes, participation is still projected at the categorical level. These categories are pregnant women, breastfeeding women, non-breastfeeding women, infants, and children under five years old. The Estimate also includes other Local Assistance and State Operations expenditures.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present a brief overview of the WIC estimate, and respond to the following questions:

1. What is known about the increase in participation, particularly in the context of decreasing participation for many years prior to the pandemic? Is this just in California or a new national trend?

2. What impact did federal pandemic flexibilities have on the program? Will any of the flexibilities continue permanently?

Staff Recommendation: Subcommittee staff recommends holding this item open in order to review and consider May Revise updates to the estimate.

ISSUE 24: GENETIC DISEASE SCREENING PROGRAM (GDSP) ESTIMATE

PANEL – PRESENTERS

- **Richard Olney**, GDSP Division Chief, CDPH (*Virtual*)
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

This issue provides an overview of the Genetic Disease Screening Program (GDSP) estimate, and details the changes reflected in the January budget.

Current Year (2022-23) Changes

-$177,000 TF
-$177,000 OF

The 2022 Budget Act appropriation for CDPH/GDSP's Local Assistance is $137.3 million in 2022-23. The CDPH/GDSP estimates 2022-23 Local Assistance expenditures will total $137 million, which is a slight decrease of $177,000 or 0.1 percent compared to the 2022 Budget Act. The decrease in Local Assistance is attributed to an overall decrease in the DRU's projection of live births compared to the 2022 Budget Act.

The Governor's Budget reflects a $177,000 decrease in Genetic Disease Testing Fund in Local Assistance attributed to a slight decrease in the Department of Finance Demographic Research Unit's projection of live births compared to the 2022 Budget Act.

Budget Year (2023-24) Changes

$7,903,000 TF
$7,903,000 OF

For 2023-24, CDPH/GDSP estimates Local Assistance expenditures will total $146 million, which is an increase of $9.1 million or 6.6 percent compared to the 2022 Budget Act amount of $137.3 million. The net increase in Local Assistance can be attributed to the New Assumption - 2023-24 Budget Change Proposal: California Newborn Screening Program Expansion that adds MPS II and GAMT deficiency to its screening panel, a full fiscal year of cfDNA screening (cfDNA screening started September 19, 2022), and inflationary contract rates increases

The Governor's Budget reflects an increase of $7.9 million in Genetic Disease Testing Fund. The increase of $1.0 million in State Operations can be attributed to baseline adjustments and $6.9 million in Local Assistance can be attributed to a full fiscal year of cfDNA screening (cfDNA screening started September 19, 2022), inflationary contract rate increases, and slight increases in caseload projections compared to the 2022 Budget Act.

Table 1. Genetic Disease Screening Program: Current Year and Budget Year Budget Summaries Compared to 2022 Budget Act

Fund 0203 Genetic Disease Testing Fund	2022 Budget Act	November Estimate	Change from Budget Act	Percent Change from Budget Act
Fiscal Year 2022-2023 Total	$173,046,000	$173,940,000	$894,000	0.5%
Fiscal Year 2022-2023 State Operations	$35,780,000	$36,851,000	$1,071,000	3.0%
Fiscal Year 2022-2023 Local Assistance	$137,266,000	$137,089,000	$(177,000)	-0.1%
Fiscal Year 2023-2024 Total	$173,046,000	$184,388,000	$11,342,000	6.6%
Fiscal Year 2023-2024 State Operations	$35,780,000	$38,066,000	$2,286,000	6.4%
Fiscal Year 2023-2024 Local Assistance	$137,266,000	$146,322,000	$9,056,000	6.6%

BACKGROUND

The CDPH/GDSP Local Assistance budget funds two distinct programs: The Newborn Screening Program (NBS) and the Prenatal Screening Program (PNS). NBS is a mandatory program that screens all infants born in California for genetic diseases. Parents may opt their newborns out of the program by claiming religious exemptions. PNS is an opt-in program for women who desire to participate. The screening test provides the pregnant woman with a risk profile. Screenings that meet or exceed a specified risk threshold are identified and further testing and genetic counseling/diagnostic services are offered at no additional expense to the participant.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH provide a brief overview of the GDSP estimate, highlighting any significant changes to the programs' budgets.

Staff Recommendation: Subcommittee staff recommends holding this item open in order to review and consider May Revise updates to the estimate.

ISSUE 25: CALIFORNIA NEWBORN SCREENING PROGRAM EXPANSION BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Richard Olney**, GDSP Division Chief, CDPH (*Virtual*)
- **Nick Mills**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests 4 positions and $3.5 million in 2023-24, $3.3 million in 2024-25 and 2025-26, and $2.7 million in 2026-27 and ongoing from the Genetic Disease Testing Fund to comply with Health and Safety Code (HSC) Section 125001(d) and expand newborn screening to include mucopolysaccharidosis type II (MPS II) and guanidinoacetate methyltransferase (GAMT) deficiency.

BACKGROUND

The administration provided the following background:

Each year, the Newborn Screening (NBS) Program screens nearly 435,000 newborns for 80 disorders, leading to a diagnosis for about 1,000 babies annually. Early detection and treatment of inborn genetic and metabolic disorders can prevent life-threatening complications, improve health and quality of life for many families, and reduce the high cost of care for these conditions.

Health and Safety Code Section 125001 (d) specifically requires the CDPH NBS Program to continuously expand what is included in the statewide screening of newborns. Diseases that are detectable in blood samples and have been adopted by the federal Recommended Uniform Screening Panel (RUSP) must be included in the screening within two years of adoption. On August 2, 2022, newborn screening (NBS) for mucopolysaccharidosis type II (MPS II) was added to the RUSP; moreover, guanidinoacetate methyltransferase (GAMT) deficiency was recommended to be added by the Federal Advisory Committee in May 2022 and the official addition to the federal RUSP is expected later in 2022. The deadline for including MPS II on the California NBS panel is August 2024, and GAMT deficiency is likely to be mandated later in 2024. A budget augmentation is necessary to implement and begin screening within the two-year requirement outlined in statute.

MPS II is a genetic condition that can lead to intellectual disabilities and life-threatening cardiac and pulmonary complications due to a metabolic disorder that impairs the processing of complex sugars, causing the molecules to build up in various parts of the body. The condition can be treated by enzyme replacement through periodic intravenous infusions to help prevent storage complications, thereby improving health outcomes.

GAMT deficiency is a genetic condition that can lead to seizures, intellectual disabilities, behavioral manifestations such as autism, and movement disorders. It is possible to improve the health outcomes of this condition by treating with supplements and dietary restrictions, helping prevent neurological complications.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 26: CALIFORNIA INTEGRATED VITAL RECORDS SYSTEM UPGRADES FOR DEATH CERTIFICATE CONTENT (AB 2436) BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Dana Moore**, Deputy Director, Center for Health Statistic and Informatics, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests one-time expenditure authority of $563,000 General Fund in 2023-24 to fulfill the requirements set forth in AB 2436 (Bauer-Kahan, Cervantes, Chapter 966, Statutes of 2022). The statute requires the State Registrar to implement the changes made by the bill no later than July 1, 2024.

BACKGROUND

The administration provided the following background information:

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

The California Integrated Vital Records System (Cal-IVRS) includes the Electronic Birth Registration System (EBRS), the Electronic Death Registration System (EDRS), and the Vital Records Business Intelligence System (VRBIS). EBRS and EDRS are secure, web-based electronic birth and death registration databases that enable record preparers to enter certificate data into the registration database and electronically submit completed records to the local registrar to be registered. Once records are registered in EBRS and EDRS, record data are transmitted to VRBIS. VRBIS is a secure, web-based electronic solution for the SR to store California's vital records data and to permit local health departments and others to access such data for purposes allowed under California statute, such as epidemiologic analysis, surveillance, and program evaluation.

AB 2436 requires changes to the death certificate template and changes to the user interface to enable electronic capture of information on the parents' relationship to the decedent and additional last names used by the parents. Implementation of AB 2436 will require the removal of the fixed position of the birth mother (where applicable) eliminating the direct link between parent fields on the death certificate and standardized data files

such as the California Comprehensive Death File and the Inter-Jurisdictional Exchange Mortality File. This change also makes linking death certificates to birth certificates more difficult, an activity essential to infant mortality research and surveillance, and marking birth certificates as “deceased” to reduce fraud as mandated in Health and Safety Code sections 102245 and 103540. Coding changes are needed to reconcile these new inconsistencies.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 27: LIMITED PODIATRIC RADIOGRAPHY PERMIT (AB 1704) BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **John Roussel**, Deputy Director, Information Technology Services Department, CDPH
- **Miren Klein**, Deputy Director (A), Center for Environmental Health, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests $425,000 General Fund in 2023-24 to implement the provisions of AB 1704 (Chen, Chapter 580, Statutes of 2022), which requires CDPH to implement a new limited podiatric radiography permit.

BACKGROUND

The administration provided the following background information:

The Radiologic Technology (RT) Act, enacted in 1969, makes it unlawful for a person to administer or use diagnostic or therapeutic X-rays unless certified or permitted, is acting within the scope of that certification or permit, and is under the supervision of a person who holds a Supervisor and Operator (S&O) certificate or permit issued by CDPH. Pursuant to the RT Act, a certified individual is called a Certified Radiologic Technologist (CRT) and can take X-rays of all body parts. A permitted individual is called a Limited Permit X-ray Technician (XT) and can take X-rays of most body parts including the lower extremities.

CDPH has established radiation safety courses to include theory and clinical application in radiographic technique, determined the qualifications for instructors, and approved the examinations that must be passed to become a CRT or an XT. There is an exemption provision that provides for the training of non-certified, and/or non-permitted individuals to become a CRT or an XT. This training must occur in CDPH-approved X-ray schools so individuals can, through education, training, and experience, become competent taking X-rays.

The process that currently allows individuals to obtain a limited permit specific to podiatry has become unsustainable because there are no schools in California offering courses specific to podiatry. This has resulted in a shortage of podiatric medical assistants certified to take X-rays. This statute will create an alternate pathway for trained Podiatric

medical assistants to take a comprehensive, CDPH-approved course/exam which will allow them to perform X-rays on the foot, ankle, tibia, and fibula only in a podiatric office.

The statute establishes the criteria for who supervises the individual's training, addresses how a licensed podiatrist applies for approval and determines the standards for an approved program. AB 1704 limits the training course completion time to a maximum of one year for each student, and one student per licensed doctor of podiatric medicine.

AB 1704 authorizes CDPH to issue a limited podiatric radiography permits if the individual meets the following requirements:

- Completes existing eligibility requirements as defined in regulations;
- Passes CDPH-approved examinations in radiation protection, safety, and podiatric radiologic technology;
- Completes a CDPH-approved course, 60 hours of education, that shall include instruction in radiation protection, safety, principles of radiographic exposure, quality control, image processing, anatomy and physiology, digital radiography, positioning, and the performance of at least 50 X-ray procedures under supervision;
- Is under the supervision of a certified supervisor and operator who is a licensed doctor of podiatric medicine; and
- Operates leg-podiatric X-ray equipment in a podiatry office.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 28: RECREATIONAL WATER USE: REGULATION OF WAVE BASINS (AB 2298) BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Miren Klein**, Deputy Director (A), Center for Environmental Health, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests 1 position and expenditure authority of $193,000 in 2023-24, $290,000 in 2024-25 and 2025-26, $380,000 in 2026-27, and $193,000 in 2027-28 and ongoing General Fund to implement the provisions of AB 2298 (Mayes, Chapter 461, Statutes of 2022), which requires CDPH to adopt regulations on the sanitation and safety of wave basins.

BACKGROUND

The administration provided the following background information:

There are inherent risks of illness posed to surfers who recreate in water that could support the existence of microbial pathogens. For this reason, minimal sanitation requirements regarding the operational aspect of wave basins are necessary to be protective of public health. Promulgating science-based and health-protective regulatory standards for wave basins, such as water clarity, circulation, and microbial pathogen control, by incorporating the CDC guidance, when available, and utilizing existing state swimming pool regulations, where applicable, will protect the health and safety of wave basin users.

AB 2298 directs CDPH to adopt new regulations for wave basin sanitation and safety that may be based on existing public swimming pool regulatory requirements but shall consider the unique characteristics of a wave basin, including size, volume of water, and the chemical dispersion caused by wave action. The bill also states that CDPH may consider Centers for Disease Control and Prevention (CDC) guidance. CDC works with the Council for the Model Aquatic Health Code (Council) to maintain compliance with current Model Aquatic Health Code (MAHC). Every three years, the Council collects, assesses, and relays national input on needed MAHC revisions to CDC for final consideration.

AB 2298 provides authority to local health jurisdictions to enforce the regulations and requires the wave basin operator to comply with existing standards until wave basin regulations are adopted.

AB 2298 also subjects the newly defined wave basin to the permanent amusement ride regulations under the Permanent Amusement Ride Safety Inspection Program and allows the California Division of Occupational Safety and Health (CalOSHA), within the Department of Industrial Relations (DIR) to inspect and otherwise oversee the operation of a wave basin to ensure compliance with those standards and requirements. It also requires CDPH to consult with CalOSHA during the adoption of the wave basin regulations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 29: REDUCTION OF HUMAN REMAINS AND THE DISPOSITION OF REDUCED HUMAN REMAINS (AB 351) BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Miren Klein**, Deputy Director (A), Center for Environmental Health, CDPH
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests 1 position and expenditure authority of $357,000 in 2023-24, $403,000 in 2024-25, $335,000 in 2025-26 and $193,000 in 2026-27 and ongoing General Fund to implement the provisions of AB 351 (Christina Garcia, Robert Rivas, Chapter 399, Statutes of 2022), which requires CDPH to adopt rules and regulations prescribing the standards for human reduction chambers.

BACKGROUND

The administration provided the following background information:

The process of composting human remains, and the associated testing to verify the treatment process, including human remains decomposition and the destruction of pathogenic micro-organisms are relatively new. CDPH will need time to acquire knowledge of both the processes and efficacy of reduction chambers; and to solicit the services of subject-matter experts to develop efficacy testing for human reduction chambers in the areas of microbiology, composting, soil science, hazardous materials, radiological sciences, and chemical interactions with microbials. The collaborative effort with subject-matter experts will allow CDPH to develop standards and testing protocols to determine that the use of reduction chamber technology will be protective of public health and safety.

Current California law limits the disposition of human remains to traditional burial, cremation, and alkaline hydrolysis. Reduction chambers are used to compost human remains into soil using natural decomposition accelerated by the addition of organic materials and warm air, which is an alternative to traditional burial, cremation, and alkaline hydrolysis. Natural organic reduction is legal in four states: Colorado, Oregon, Washington, and Vermont. In 2019, Washington became the first state to legalize this practice and offer natural organic reduction for the disposition of the human remains.

AB 351 requires CDPH to adopt rules and regulations prescribing the standards for reduction chambers regarding the destruction of pathogenic micro-organisms and help preserve public health and safety. The statute requires reduction chamber manufacturers apply to CDPH for licensure of a reduction chamber for sale and use in the state. AB 351 will require a local registrar of births or deaths to issue permits for the disposition of reduced human remains commencing on January 1, 2027.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 30: LICENSURE OF CLINICAL LABORATORY GENETICISTS AND CLINICAL REPRODUCTIVE BIOLOGISTS (SB 1267) BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Robert Thomas**, Lab Field Services Branch Chief, CDPH (*Virtual*)
- **Shelina Noorali**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests 1 position and $210,000 from the Clinical Laboratory Improvement Fund in 2023-24 and $176,000 in 2024-25 and ongoing to implement licensure of Clinical Laboratory Geneticists and Clinical Reproductive Biologists as required by SB 1267 (Pan, Chapter 473, Statutes of 2022).

BACKGROUND

The administration provided the following background information:

SB 1267 makes several critical changes to existing law impacting the CDPH Laboratory Field Service (LFS) laboratory licensure program:

New License for Clinical Laboratory Geneticists

SB 1267 addresses CDPH's urgent need for a new clinical laboratory license category for clinical laboratory geneticists. Current law authorizes CDPH to license trainees, scientists, and specialists authorized to direct laboratories in the genetics subspecialties of clinical cytogenetics and clinical genetic molecular biology, and to apply fees for application and license renewal.

The national certifying organization for clinical laboratory personnel in the specialty of genetics, the American Board of Medical Genetics and Genomics (ABMGG), has recently consolidated two existing training and certification categories, cytogenetics, and genetic molecular biology, into a single category, laboratory genetics and genomics. Completion of an AMBGG training program and ABMGG certification is required by CDPH for California licensure for specialists authorized to direct laboratories in the existing subspecialties of clinical cytogenetics and clinical genetic molecular biology.

Because ABMGG is no longer issuing certification in the categories of cytogenetics and genetic molecular biology, CDPH cannot issue new licenses to applicants in those categories, as they are not able to obtain ABMGG certification in the discontinued separate categories. SB 1267 resolves this problem by creating a new genetics subspecialty, clinical laboratory genetics, and authorizing CDPH to issue licenses in the

new subspecialty and apply application and renewal fees to the newly created licenses. In addition to the subspecialties of cytogenetics and genetic molecular biology, the new laboratory genetics subspecialty includes the subspecialty of biochemical genetics, which is not currently licensed by the department. This will benefit persons trained in this important testing specialty, who direct and perform state-mandated prenatal and newborn genetic testing and will benefit the people of California by increasing the numbers of genetics specialists in this field available for employment in California laboratories.

Licensure of Clinical Laboratorians in Assisted-Reproductive Technology

SB 1267 also addresses a need for licensure of clinical laboratorians who provide clinical testing used in assisted reproductive technology (ART) techniques. This bill creates a new licensure category in the specialty of clinical reproductive biology, the laboratory discipline that provides diagnostic testing used in the management of primary and secondary infertility, fertility assessment, and fertility preservation. Results from reproductive biology tests and examinations are used to treat patients in assisted reproduction. The analyses performed in the reproductive laboratory are highly complex, require substantial clinical laboratory training and expertise in combination with training in ART techniques and procedures. These tests are an integral part of correctly diagnosing and treating infertility.

CDPH does not currently license specialists in the discipline of reproductive biology. As a result, ART facilities currently engage clinical laboratory personnel licensed to perform and direct laboratory tests in addition to personnel trained in ART practices. SB 1267 provides licensure for clinical reproductive biologists qualified to perform and direct both clinical testing used in ART procedures and ART technology and procedures. This will enable California training programs to train and ART facilities to recruit personnel specialized and licensed in both areas.

To implement licensure in the new specialty of clinical reproductive biology, CDPH will set standards for training programs that offer training in the full range of testing and techniques required for ART. This will support the development of a workforce qualified to perform and direct the full range of laboratory testing and techniques required to perform ART, expand the number of laboratory personnel trained in ART-related testing, and attract highly qualified individuals to work in California ART facilities, so that Californians receive the best possible care when seeking treatment for infertility.

As a result of SB 1267, starting on January 1, 2023, CDPH must oversee six new licensure types: Clinical Laboratory Geneticist Director, Clinical Laboratory Geneticist Scientist, Clinical Laboratory Geneticist Trainee, Clinical Reproductive Biologist Laboratory Director, Clinical Reproductive Biologist Scientist, and Clinical Reproductive Biologist Trainee.

The new subspecialty of Laboratory Genetics will combine the current license categories of cytogenetics and genetic molecular biology. The new category will also add licensure for biochemical geneticists, who are not currently licensed by CDPH, resulting in an increase in applications for licensure in Laboratory Genetics.

CDPH estimates that there are approximately 300 clinical reproductive biologists who work in approximately 70 assisted reproductive technology facilities in California. Of these persons, CDPH estimates that approximately 115 additional persons would qualify for licensure as directors or scientists annually, after an initial period of 270 persons qualifying in the first year.

As a result of the addition of these new license types, CDPH estimates that approximately 660 persons will qualify for licensure in 2023-24, and 435 persons will qualify for licensure in each year thereafter.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.