AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 9, 2020

2:30 PM, STATE CAPITOL, ROOM 4202

(Please note room change)

ITEMS TO BE HEARD

NON-DISCUSSION ITEMS

ATTACHMENT

LIST OF PANELISTS IN ORDER OF PRESENTATION

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 1: OFFICE OF THE SURGEON GENERAL: TRAUMA-INFORMED TRAINING DEVELOPMENT AND PUBLIC AWARENESS CAMPAIGN BUDGET CHANGE PROPOSAL

PANELISTS

- **Dr. Nadine Burke Harris**, California Surgeon General
- **Matt Schueller**, Chief of Staff, Office of the California Surgeon General
- **Sydney Tanimoto**, Principal Program Budget Analyst, Department of Finance
- **Mina Hanin**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 2: ALL CHILDREN THRIVE UPDATE

PANELISTS

- **Monica Morales**, Deputy Director of Center for Healthy Communities, Department of Public Health
- **Harold Goldstein, DrPH**., Executive Director, Public Health Advocates
- **Jack Zwald**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 3: MEMBER/STAKEHOLDER PROPOSAL: TRAUMA-INFORMED TRAINING FOR K-12 EDUCATORS – GARCIA, E.

PANELISTS

- **Assemblymember Eduardo Garcia**
- **Bea Gonzalez,** Coordinator, Expanded Learning Programs, ASES /21st CCLC/ ASSETs, Coachella Valley Unified School District

ISSUE 4: MEMBER/STAKEHOLDER PROPOSAL: TRAUMA-INFORMED PRIMARY CARE MEDICAL HOME MODEL FOR CHILD ABUSE VICTIMS - RAMOS, RUBIO

PANELISTS

- **Assemblymember Ramos**
- **Dr. Amy Young Snodgrass**, Child Abuse Pediatrician, Division Chief for Forensic Pediatrics at Loma Linda University Children's Hospital, and Medical Director of the San Bernardino County Children's Assessment Center

ISSUE 5: OFFICE OF HEALTH CARE AFFORDABILITY

PANELISTS

- **Alice Chen**, Deputy Director for Policy and Planning and Director of Clinical Affairs, California Health and Human Services Agency
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 6: DEPARTMENT AND BUDGET OVERVIEW

PANELISTS

- **Dr. Dave Duncan**, Director, Emergency Medical Services Authority
- **Rick Trussell**, Chief of Administration, Emergency Medical Services Authority
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 7: DEPARTMENT AND BUDGET OVERVIEW

PANELISTS

- **Mary Watanabe**, Acting Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director, Legislative Affairs, Department of Managed Health Care
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 8: OFFICE AND BUDGET OVERVIEW

PANELISTS

- **Marko Mijic**, Acting Director, Office of Statewide Health Planning and Development
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 9: HEALTH CARE WORKFORCE ISSUES AND PROPOSITION 56 OVERSIGHT

PANELISTS

- **Dr. Bradley Gilbert**, Director, Department of Health Care Services
- **Jacey Cooper**, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
- **Marko Mijic**, Acting Director, Office of Statewide Health Planning and Development
- **CJ Howard**, Deputy Director, Healthcare Workforce Development Division, Office of Statewide Health Planning and Development
- **Alek Klimek**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 10: MEMBER/STAKEHOLDER PROPOSAL: MEDICAL RESIDENCY TRAINING ON ABORTION CARE AND TRANSGENDER CARE – CHIU

PANELISTS

- **Assemblymember David Chiu**

ISSUE 11: MEMBER/STAKEHOLDER PROPOSAL: PRIMARY CARE PSYCHIATRIC FELLOWSHIP SCHOLARSHIPS - EGGMAN

PANELISTS

- **Assemblymember Susan Eggman**
- **Shannon Suo**, M.D., Director, Train New Trainers in Primary Care Psychiatry, U.C. Davis

- **Robert McCarron**, D.O., Director, Train New Trainers in Primary Care Psychiatry, U.C. Irvine

ISSUE 12: MEMBER/STAKEHOLDER PROPOSAL: PSYCHIATRIC RESIDENCY SUPPORT – FONG

PANELISTS

- **Assemblymember Vince Fong**
- **Barbara Glaser**, Senior Legislative Advocate, California Hospital Association

ISSUE 13: MEMBER/STAKEHOLDER PROPOSAL: RURAL MEDICAL RESIDENCY SUPPORT – GALLAGHER

PANELISTS

- **Assemblymember James Gallagher**
- **Dr. David Alonso**, Butte Glenn Medical Society

ISSUE 14: MEMBER/STAKEHOLDER PROPOSAL: TRAINING AND PRACTICE OF ADVANCE PRACTICE CLINICIANS AND DEBT RELIEF FOR HEALTH PROFESSIONALS - GRAY

PANELISTS

- **Assemblymember Adam Gray**
- **Beth Malinowski**, Director of Government Affairs, California Primary Care Association/California Health+ Advocates

ISSUE 15: MEMBER/STAKEHOLDER PROPOSAL: SUBSTANCE ABUSE DISORDER WORKFORCE EDUCATION AND TRAINING PLAN – NAZARIAN

PANELISTS

- **Assemblymember Adrin Nazarian**
- **Le Ondra Clark Harvey, Ph.D.**, Director of Policy and Legislative Affairs, California Council of Community Behavioral Health Agencies

ISSUE 16: STAKEHOLDER PROPOSAL: ECONSULT AND TELEHEALTH ASSISTANCE PROGRAM – RIVAS, R.

PANELISTS

- **Assemblymember Robert Rivas**
- **Jennifer Stoll,** Executive Vice President Government Relations, OCHIN

ISSUE 17: STAKEHOLDER PROPOSAL: PRIMARY CARE AND PSYCHIATRIC RESIDENCY SUPPORT - WOOD

PANELISTS

- **Assemblymember Jim Wood**
- **Beth Malinowski**, Director of Government Affairs, California Primary Care Association/California Health+ Advocates

ITEMS TO BE HEARD

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 1: OFFICE OF THE SURGEON GENERAL: TRAUMA-INFORMED TRAINING DEVELOPMENT AND PUBLIC AWARENESS CAMPAIGN BUDGET CHANGE PROPOSAL

PANELISTS

- **Dr. Nadine Burke Harris**, California Surgeon General
- **Matt Schueller**, Chief of Staff, Office of the California Surgeon General
- **Sydney Tanimoto**, Principal Program Budget Analyst, Department of Finance
- **Mina Hanin**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Office of the Surgeon General (OSG) requests $10 million one-time General Fund for the development of an Adverse Childhood Experiences (ACEs) cross-sector training program that will be accredited by the OSG, in addition to a statewide ACEs public awareness campaign.

BACKGROUND

The administration provided the following background:

As one of his firsts acts in office, Governor Gavin Newsom took strong and decisive action to address the public health crisis of Adverse Childhood Experiences (ACEs) and toxic stress by creating the position of California Surgeon General to marshal the insights and energy of medical professionals, scientists, public health experts, public servants and everyday Californians to drive solutions.

In his Executive Order establishing the role of California Surgeon General, Governor Newsom notes that: "some of the most pernicious, but least addressed health challenges are the upstream factors that eventually become chronic and acute conditions that are far more difficult and expensive to treat," and "the overwhelming scientific consensus is that these upstream factors, including toxic stress and the social determinants of health, are the root causes of many of the most harmful and persistent health challenges facing Californians".

In recognition of the fact that Adverse Childhood Experiences represent a major barrier to achieving the core principles of justice for all and affordability, the Newsom administration allocated over $100 million to develop a first-in-the-nation effort to implement routine screening for ACEs among Medi-Cal beneficiaries, to enable early detection and early intervention, by training California's 88,000 primary care Medi-Cal providers on trauma-informed care.

Additionally, in her first act as California Surgeon General, Dr. Nadine Burke Harris embarked on a statewide listening tour with the goal of understanding the experiences, concerns and priorities of local communities. Three key takeaways from the Surgeon General's listening tour were that:

- First, ACEs are a common thread among many of the most pressing issues our communities face. From healthcare to homelessness, the opioid crisis, disaster recovery and gun violence, communities all over California are pleading for assistance in addressing trauma.

- Second, California has an army of people eager to roll up their sleeves (e.g. educators, law enforcement, health providers, community organizers, etc.) and who are willing, or already are hard at work, on tackling the issues of ACEs and toxic stress in their communities. However, there is still much work to be done to raise awareness among the general public in order to support these community level efforts to be effective. Among lay audiences, there continues to be a lack of understanding of the short- and long-term consequences of ACEs.

- Third, while there are many individuals and organizations working on ACEs and trauma-informed care in various settings, there is a lack of coordination and standardization in how individuals are assessed and supported. There is a clear need for instruction, best practices, and support on how to implement trauma-informed care in order to capitalize on the economies of scale and drive towards a unified outcome.

The term Adverse Childhood Experiences comes from the landmark study published by the federal Centers for Disease Control and Prevention (CDC) and Kaiser Permanente over two decades ago, which specifically refers to 10 categories of stressful or traumatic events experienced in the first 18 years of life. These include:

- Physical, emotional, or sexual abuse;
- Physical or emotional neglect; and
- Parental incarceration, mental illness, substance dependence, separation/divorce, or intimate partner violence.

Since the publication of the study, a robust body of literature has been established which demonstrates that ACEs are highly prevalent, strongly associated with poor childhood and adult health, mental health, behavioral and social outcomes and demonstrate a pattern of high rates of intergenerational transmission.

The Office of the Surgeon General has identified two critical budget needs for Fiscal Year 2020-21:

1. The need for a public education campaign to raise awareness and understanding of ACEs and toxic stress. The campaign will aim to validate an individual's experience and encourage Californians to seek out or accept assistance and begin to heal, as well as equip Californians with a shared language to better navigate the needs they or a loved one may be needing to heal. Coalescing around this issue as a society is critical to our ability to make progress towards the Surgeon General's vision of cutting ACEs and toxic stress in half in a generation.

2. The need for a standardized and accredited cross-sector training materials to ensure that front-line providers such as educators and law enforcement officers can recognize the symptoms of an overactive stress response due to ACEs and respond with trauma-informed principles and refer to care, rather than escalating the encounter with harsh, punitive measures. Currently, there are "trauma-informed" trainings that occur on a limited basis throughout the state in numerous programs including the CDSS, CDPH, CDE, and POST. However, these trainings do not use standardized language or guidelines and are sometimes based on limited or outdated evidence.

According to the most recent data from the California Department of Public Health (CDPH), 63.5% of California adults have experienced at least one ACE, and 17.6% have experienced 4 or more. ACEs are associated, in a dose-response fashion, with significantly increased odds of negative health outcomes, including 9 out of 10 of the leading causes of death in the United States.

Research also demonstrates that the higher the ACE score, the more likely the individual is to struggle with mental health issues including depression, post-traumatic stress disorder, anxiety, sleep and eating disorders, and to engage in risky behaviors such as early and high-risk sexual behavior and substance abuse. Unpublished research by Dr. Burke Harris and colleagues indicate that costs to California attributable to ACEs from just 8 health conditions (asthma, arthritis, COPD, depression, cardiovascular disease, lifetime smoking, heavy drinking and obesity) total $126.5B per year. Stemming the tide of Adverse Childhood Experiences is critical to improving healthcare affordability.

In addition to these health and mental health outcomes, ACEs are also strongly associated with increased social risks as well. A national study of more than 35,000 adults found that even after adjusting for the impact of socio-demographics and substance use, ACEs are independently associated with as much as 4 times the risk of incarceration. Reducing ACEs is a fundamental component to addressing social challenges including homelessness and violence. The harmful effects of ACEs are possibly most evident on children's educational attainment. Children with 4 or more ACEs are as much as 32 times as likely to experience learning and behavior problems as compared to children with 0 ACEs. A recent national study looking at data from more than 65,000 children also found that as ACE scores increase, risk of repeating a grade increases and homework completion as well as school engagement declines. Raising awareness about the effect of ACEs on learning is vital to ensuring that vulnerable children have equal opportunity to learn and be successful in school.

STAFF COMMENTS/QUESTIONS

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

1. Should we be concerned that a public awareness campaign will generate a significant new demand on medical providers, many of whom may not be trained or educated yet on ACEs and therefore unhelpful to patients?

2. Should a public awareness campaign be implemented after, rather than before, the development of training curriculum, and widespread training of medical professionals, law enforcement, educators, etc.?

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

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 2: ALL CHILDREN THRIVE UPDATE

PANELISTS

- **Monica Morales**, Deputy Director of Center for Healthy Communities, Department of Public Health
- **Harold Goldstein, DrPH**., Executive Director, Public Health Advocates
- **Jack Zwald**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROGRAM UPDATE

The Budget Act of 2018 allocated $10 million on a one-time basis from the Mental Health Services Fund (Proposition 63 funds) to support the All Children Thrive California (ACT/CA) pilot project from January 1, 2019 to June 30, 2021. Of these funds, the Department of Public Health (CDPH) was allocated up to $1 million to administer the pilot program.

BACKGROUND

CDPH provided the following update:

CDPH awarded a 30-month contract to Community Partners as the fiscal agent for this project, with subcontracts to Public Health Advocates and the University of California (UCLA) Center for Healthier Children, Families, and Communities to implement the project.

The All Children Thrive California pilot project will test a public health approach to prevent childhood trauma, counter its effects, and foster individual, family and community resilience. The pilot program will engage cities in strategies to reduce the prevalence of adverse childhood experiences, building on a national All Children Thrive Initiative that prioritizes children's health in more than a dozen U.S. cities.

Contractor activities include:

- Establishing an Equity Advisory Group (EAG)
    - The EAG meets on a quarterly basis with approximately 15 members who represent organizations who work on behalf of priority populations in California.

- Identifying evidence-based interventions and public health practices and developing model programs, policies, and practices for implementation by cities and counties
    - ACT/CA has submitted a literature review, compiled a list of model programs, and begun to identify model public health practices and interventions with the greatest likelihood for feasibility; scaling; and that elevate equity, community participation, and community leadership for implementation in the targeted jurisdictions.
- Developing and sharing an online Toolkit for cities and counties
    - The Toolkit describing model programs, policies, strategies and best practices for promoting equity and ensuring community participation is on track to be completed.
- Recruiting and providing coaching and technical assistance to help cities and counties establish strategies
    - ACT/CA is on track to begin recruitment, coaching, and technical assistance to support targeted jurisdictions in their efforts to improve child wellbeing.
- Establishing a peer-learning network, webinars, and educational seminars
    - ACT/CA is on track to begin activities to establish and support a peer-learning network, webinars, and educational seminars in the targeted jurisdictions.
- Evaluating the impact of activities and report findings
    - UCLA has selected the qualified subcontractor and is currently working in partnership with CDPH to complete the design of the Evaluation Plan.

CDPH provides administrative oversight and support with 1.8 Full Time Equivalent positions in the Center for Healthy Communities, Injury and Violence Prevention Branch. This includes a Staff Services Analyst to perform fiscal and contract management activities, and portions of a Program Manager and Epidemiologist to serve as subject matter experts, provide technical assistance, leverage other related department initiatives and projects for the benefit of the project, and ensure that required reports are submitted to the Mental Health Services Oversight and Accountability Commission and the Legislature. CDPH has convened multiple meetings among the All Children Thrive partners, which have included the participation of the CDPH Director, to ensure coordination and collaboration. CDPH will continue to support the implementation of this project which has promise for improving the lives of children in California.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH and Dr. Harold Goldstein present an update on the All Children Thrive project.

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

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 3: MEMBER/STAKEHOLDER PROPOSAL: TRAUMA-INFORMED TRAINING FOR K-12 EDUCATORS – GARCIA, E.

PANELISTS

- **Assemblymember Eduardo Garcia**
- **Bea Gonzalez,** Coordinator, Expanded Learning Programs, ASES /21st CCLC/ ASSETs, Coachella Valley Unified School District

Public Comment

PROPOSAL

The National Compadres Network (NCN) requests $2 million for trauma-informed care training of educators.

BACKGROUND

The NCN provided the following background information:

NCN partners with programs such as A.S.E.S to provide trauma-informed care with a cultural emphasis to educators, parents and children. Under this proposal, grant funds will be utilized to increase the number of trainings and technical support due to the overwhelming demand from school sites. Students have also asked for more opportunities to engage in the Rites of Passage Programs and this has required NCN to train more facilitators. The grants will also be used to expand peer-mentoring programs among other things.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Garcia and Bea Gonzalez present this proposal.

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

ISSUE 4: MEMBER/STAKEHOLDER PROPOSAL: TRAUMA-INFORMED PRIMARY CARE MEDICAL HOME MODEL FOR CHILD ABUSE VICTIMS - RAMOS

PANELISTS

- **Assemblymember James Ramos**
- **Dr. Amy Young Snodgrass**, Child Abuse Pediatrician, Division Chief for Forensic Pediatrics at Loma Linda University Children's Hospital, and Medical Director of the San Bernardino County Children's Assessment Center

Public Comment

PROPOSAL

Loma Linda University Children's Hospital requests $6 million over three years to implement a trauma-informed primary care medical home model for child abuse victims.

BACKGROUND

Loma Linda University Children's Hospital provided the following background information:

- The Trauma-Informed Medical Home Model seeks to apply our expertise gained from decades of treating children with disproportionately high ACE scores and apply this to a system of ongoing coordinated medical and mental health care for child victims. The goal is to adapt this experience to a larger population and build upon known resiliency factors to develop an effective evidence-based treatment and service approach for child abuse victims in the largest geographic county in the nation, San Bernardino County.

- This new expanded program will seek to provide a seamless continuum of multi-disciplinary, resiliency-informed medical care targeting the nearly 2,500 children placed into foster care each year. In addition, services will be offered to the larger current population of over 6,000 foster youth in the county, as well as additional victims of child abuse and neglect not placed into the system.

- The clinic model will incorporate additional multi-disciplinary providers into the current medical evaluation to deliver a more holistic approach to care including developmental assessment, nutritional assessments, dental evaluations, hearing and vision screening, vaccinations and routine care, as well as evaluations for needed allied healthcare such as speech and physical therapy. Evaluations will culminate into a multi-disciplinary evaluation summary to use for follow-up and referrals. Records will be stored in electronic health records (EHR) for ease of

information retrieval and sharing. Orders and referrals will be conducted in EHR to provide tracking and ensure completion.

- Experts working within this system of care will conduct county-wide training to regional care providers, multi-disciplinary partners and caregivers to create a network of trauma-informed care within the county. Under this model, training medical students, residents and fellows in Child Abuse Pediatrics will continue but with a broader trauma-informed primary care approach.

- Staff includes: (1) Child Abuse Pediatrician, (1) Pediatrician, (2) Therapists/MFTs/LCSWs; (1) Social Worker; 1 Clinical Manager RN; (3) Medical Assistants/Patient Service Representatives; and (1) Research Analyst

- Facility Costs include rent for a new location that is crucial in easing the transition of care for children and offers a co-location of nearby diagnostic and laboratory services, subspecialists for head injury and trauma, medical therapy, an education department, and scholarship program. The rented space will also include (7) exam rooms that will be fully equipped to provide both forensic evaluations and on-going primary care for children; a Sexual Abuse Exam Room that includes specialized equipment like a colposcope, mechanical bed for exams, screen to project images, leisegang (mobile screen); and (3) therapy rooms equipped with the necessary tools to deliver trauma-informed mental health interventions including evidenced based early intervention and Cognitive Behavioral Therapy as supported by the National Child Traumatic Stress Network and in collaboration with other centers supported by SAMHSA.

- Education and Outreach costs reflect that trained professionals within the clinic will provide ongoing training to a multitude of providers and caregivers both in the clinic classroom as well as in the regions. Trainings will include education regarding signs and symptoms of child abuse, child abuse reporting, findings from ACE research, understanding medical and mental health outcomes among children who have suffered abuse, understanding behaviors and needs, as well as educational needs and outcomes. Professionals will educate providers and caregivers on the multitude of services provided in the clinic and how to access these services. We will also engage the community in a public service campaign and partner with our community to create flyers. Work is being done with First 5 San Bernardino to train other providers in the region on recognizing signs of child abuse.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Ramos and Dr. Amy Young Snodgrass present this proposal.

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

ISSUE 5: OFFICE OF HEALTH CARE AFFORDABILITY

PANELISTS

- **Alice Chen**, Deputy Director for Policy and Planning and Director of Clinical Affairs, California Health and Human Services Agency
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Governor's proposed January budget includes a proposal to create an Office of Health Care Affordability. As stated in the Budget Summary: "This Office will be charged with increasing price and quality transparency, developing specific strategies and cost targets for the different sectors of the health care industry, and financial consequences for entities that fail to meet these targets. The ultimate goal is for savings to return to consumers who are directly impacted by increasing health care costs.

The Office will also create strategies to address hospital cost trends by region, with a particular focus on cost increases driven by delivery system consolidation. To improve health outcomes, the Office will also work to establish standards to advance evidence-based and value-based payments to physicians, physician groups, and hospitals, as well as to advance administrative simplification.

The administration has not yet provided proposed trailer bill or additional detail on this proposal.

BACKGROUND

The following background was included in the Background Paper prepared by the Assembly Health Committee for their informational hearing on cost containment on February 25, 2020:

"Health care spending in the United States (U.S.) has grown faster than the rest of the economy. According to the most recent data, U.S. health care spending reached $3.6 trillion in 2018 or $11,172 a year per capita, accounting for 17.7% of the nation's Gross Domestic Product (GDP), up from 13.3% of GDP in 1998 and 16.3% of GDP in 2008. In 2027, U.S. health spending is projected to grow to 19.4%, a total of $6 trillion, and will account for nearly one-fifth of GDP. Public health insurance, including Medicare and Medicaid (Medi-Cal in California), paid the largest share of spending (41%), followed by

private health insurance (34%), and consumers' out-of-pocket spending (10%). The most recent data available for California indicate that health care spending in the state totaled $292 billion in 2014. According to a California Health Care Foundation (CHCF) report entitled, "Getting to Affordability: Spending Trends and Waste in California's Health Care System (Getting to Affordability)," per capita spending has grown steadily over time for all sources of coverage – employer-sponsored insurance, Medi-Cal, Medicare and private health insurance. Private health insurance coverage faced the highest growth rates at 4% per year. The report points out that most of the spending comes from inpatient hospital stays and office-based medical provider services ($60 billion each), followed by prescription drugs ($45.6 billion).

According to the 2020 Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey, conducted by CHCF on how California residents view health care policy and their experiences with the health care system, eight out of 10 residents (84%) rate making health care more affordable as an "extremely important" or "very important" priority for the Governor and Legislature to address in 2020. This survey also paints a picture of Californians worried about many types of health care costs, including unexpected medical bills and out-of-pocket expenses. Due to these affordability issues, many residents reported delaying or skipping medical treatment or medications, including cutting pills in half or skipping doses.

Additionally, 24% of those surveyed reported that they or someone in their family, had problems paying for or were unable to pay medical bills within the past 12 months, and as a result, they have cut back on basic household needs like food and clothing, used up their savings, increased their credit card debt, taken on extra work, borrowed money from friends or relatives, or taken money out of their savings accounts. Although disturbing, the survey results are not surprising.

More than half of Californians and their families (58%) obtain their health coverage through their employer, but wages have not kept pace with health spending. According to the UC Berkeley Labor Center (UC Labor Center), since 2008, premiums for job-based family health coverage in California have grown by 49% on average; but real median wages have remained stagnant. For example, single coverage premiums averaged $8,712 per year in 2018, equivalent to $4 per hour for someone working 40 hours per week and for family coverage, the average annual premium was $20,843 which is equivalent to $10 per hour work for a full-time worker, which is $2 less per hour than the current $12 minimum wage for employers with more than 25 employees. In addition to premium costs, consumers are also facing higher out-of-pocket spending. The Getting to Affordability report points out that from 2000 to 2016, annual out-of-pocket patient spending increased by almost 36% for those with employer-sponsored coverage or an average annual increase of 2% per year while those with private, individual market coverage had an annual average growth rate of around 4%. The UC Labor Center states that these affordability challenges are causing financial difficulties for those struggling to

pay premium or medical bills, deter enrollment in and retention of coverage, and decrease access to care.

The growth in health care spending and affordability challenges are not unique to California; many states are exploring multiples ways to control spending, and one method is through the creation of cost containment commissions. According to a January 2020 CHCF report entitled Commissioning Change: How Four States Use Advisory Boards to Contain Health Spending, cost-containment commissions establish targets to make health care more affordable to consumers and improve the delivery of care. For example, the Maryland Health Services Cost Review Commission, established in 1972, is the oldest commission of its kind in the U.S. Maryland's commission was initially focused on setting payment rates for hospital services but its scope has been expanded to include total hospital budgets and targets for total statewide spending per capita. In 2012, the Massachusetts Health Policy Commission was established to monitor health care spending growth in Massachusetts and provides data-driven policy recommendations regarding health care delivery and payment system reform. Although the Oregon Health Authority is working on establishing a statewide growth benchmark for health care costs, since 2009, it has been focused on controlling costs for the state's Medicaid program and premium costs for state employee health plans, and in 2012 received a federal waiver to cap its Medicaid cost growth to 3.4% per year, which was eventually applied to state employee health plans.

According to the National Conference of State Legislatures, other options for containing or reducing health care costs and improving efficiency in health care include: administrative simplification; global or fixed prepayment to health providers; public health promotion; medical homes; combating health care fraud and abuse; prescription drug agreements and volume purchasing; use of generic prescription drugs and brand-name discounts; all-payer rate setting; performance-based health care provider payments; and establishing an all-payer claims database. The Getting to Affordability report explored six areas of cost containment that target unnecessary spending in California: overtreatment; failures of care delivery and inadequate prevention; failures of care coordination; administrative complexity; pricing and market inefficiencies; and, fraud and abuse."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Health and Human Services Agency present this proposal.

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

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 6: DEPARTMENT AND BUDGET OVERVIEW

PANELISTS

- **Dr. Dave Duncan**, Director, Emergency Medical Services Authority
- **Rick Trussell**, Chief of Administration, Emergency Medical Services Authority
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED BUDGET

For 2020-21, the Governor's Budget proposes $35.9 million for the support of EMSA, a 2 percent decrease from the 2019-20 current year budget. Of this amount, approximately $16.6 million is budgeted for State Operations, while the remaining is for Local Assistance.

The primary source of funding for this department is federal funds, which is included in the lines below labeled "Federal Trust Fund" and "Reimbursements," as those are federal funds that come through other departments first, namely the Departments of Health Care Services and Public Health.

EMERGENCY MEDICAL SERVICES AUTHORITY *(Dollars In Thousands)*					
Fund Source	**2018-19 Actual**	**2019-20 Projected**	**2020-21 Proposed**	**CY to BY Change**	**% Change**
General Fund	**$9,510**	**$10,862**	**$10,679**	**($183)**	**-1.7%**
Emergency Medical Services Training Program Approval Fund	$217	$226	$226	$0	0%
Emergency Medical Services Personnel Fund	$2,622	$2,813	$2,618	($195)	-6.9%
Federal Trust Fund	$2,975	$4,393	$5,014	$621	14.1%
Reimbursements	$12,554	$15,708	$15,710	$2	0.01%
Emergency Medical Technician Certification Fund	$1,333	$1,757	$1,657	($100)	-5.7%
Total Expenditures	**$29,211**	**$35,759**	**$35,904**	**$145**	**0.4%**
Positions	71.5	69.8	70.8	1	1.4%

BACKGROUND

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

The EMSA is comprised of the following three divisions:

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

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

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

STAFF COMMENTS/QUESTIONS

The Subcommittee staff requests EMSA provide a brief overview of the department and budget and respond to the following:

1. Please describe EMSA’s roles and responsibilities with regard to responding to an infectious disease pandemic.

2. What activities has EMSA engaged in related to Covid19?

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

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 7: DEPARTMENT AND BUDGET OVERVIEW

PANELISTS

- **Mary Watanabe**, Acting Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director, Legislative Affairs, Department of Managed Health Care
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Governor's 2020-21 budget proposes $93.7 million, a decrease of approximately $716,000 (0.6%) from current year spending for DMHC's overall budget.

The DMHC receives no General Fund and is supported primarily by an annual assessment on each HMO. The annual assessment is based on the Department's budget expenditure authority plus a reserve rate of 5 percent. The assessment amount is prorated at 65 percent and 35 percent to full-service and specialized plans respectively. The amount per plan is based on its reported enrollment as of March 31st of each year. The Knox-Keene Act requires each licensed plan to reimburse the department for all its costs and expenses.

DEPARTMENT OF MANAGED HEALTH CARE *(Dollars In Thousands)*					
Fund Source	**2018-19 Actual**	**2019-20 Projected**	**2020-21 Proposed**	**CY to BY Change**	**% Change**
Managed Care Fund	$78,973	$94,294	$93,749	($545)	-0.6%
Reimbursements	$0	$171	$0	($171)	-100%
Total Expenditures	**$78,973**	**94,465**	**93,749**	**($716)**	**-0.8%**
Positions	429.9	417.3	425.8	8.5	2.0%

BACKGROUND

The mission of the Department of Managed Health Care (DMHC) is to regulate, and provide quality-of-care and fiscal oversight for health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

The Department achieves this mission by:

- Administering and enforcing the body of statutes collectively known as the Knox-Keene Health Care Service Plan Act of 1975, as amended.
- Operating the 24-hour-a-day Help Center to resolve consumer complaints and problems.
- Licensing and overseeing all HMOs and some PPOs in the state. Overall, the DMHC regulates approximately 90 percent of the commercial health care marketplace in California, including oversight of enrollees in Medi-Cal managed care health plans.
- Conducting medical surveys and financial examinations to ensure health care service plans are complying with the laws and are financially solvent to serve their enrollees.
- Convening the Financial Solvency Standards Board, comprised of people with expertise in the medical, financial, and health plan industries. The board advises DMHC on ways to keep the managed care industry financially healthy and available for the millions of Californians who are currently enrolled in these types of health plans.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to provide a brief overview of the department and its proposed budget.

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

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 8: OFFICE AND BUDGET OVERVIEW

PANELISTS

- **Marko Mijic**, Acting Director, Office of Statewide Health Planning and Development
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED BUDGET

For 2020-21, the Governor's Budget proposes $160.3 million for the support of OSHPD. The proposed budget reflects a 52.1 percent ($174.1 million) decrease from the current year budget, primarily reflecting one-time investments in the 2019 Budget Act including:

1. $50 million General Fund to support mental health workforce programs;

2. $35 million General Fund for the Workforce Education and Training (WET) plan; and

3. $25 million Mental Health Services Fund for the WET plan.

The significant reduction also reflects $62.6 million in carryovers from the 2017 and 2018 Budget Acts related to the following:

- $55,939,000: Health Care Payments Database carryover
- $6,919,000: Song-Brown Health Care Workforce Training carryover
- $2 million: Pediatric residency slots
- $35 million: Workforce Education and Training Implementation (WET)
- $47,350,000: Mental Health Workforce Development Programs (non-WET)
- $2,650,000: Primary Care Clinician Psychiatry Fellowships

OSHPD Budget *(Dollars in Thousands)*					
Fund Source	**2018-19 Actual**	**2019-20 Projected**	**2020-21 Proposed**	**CY to BY $ Change**	**% Change**
General Fund	42,793	183,191	33,333	($149,858)	-81.8%
Hospital Building Fund	65,750	68,269	68,319	$50	0.1%
Health Data & Planning Fund	36,734	34,396	35,365	$969	2.8%
Registered Nurse Education Fund	1,923	2,200	2,203	$3	0.1%
Health Facility Construction Loan Insurance Fund	5,078	5,212	5,215	$3	0.1%
Health Professions Education Fund	1,111	3,233	3,123	($110)	-3.4%
Federal Trust Fund	1,464	1,564	1,585	$21	1.3%
Reimbursements	873	3,116	3,116	$0	0%
Mental Health Practitioner Education Fund	366	827	827	$0	0%
Vocational Nurse Education Fund	219	226	226	$0	0%
Mental Health Services Fund	14,051	27,765	2,552	($25,213)	-90.8%
Medically Underserved Account For Physicians, Health Professions Education Fund	4,402	4,403	4,403	$0	0%
TOTAL EXPENDITURES	**$174,764**	**$334,402**	**$160,267**	**($174,135)**	**-52.1%**
Positions	428.6	423.9	428.9	5	1.2%

BACKGROUND

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

Cal-Mortgage Loan Insurance Division

This division administers the California Health Facility Construction Loan Insurance Program and provides credit enhancement for eligible nonprofit healthcare facilities when they borrow money for capital needs. Cal-Mortgage insured loans are guaranteed by the "full faith and credit" of the State of California. This guarantee permits borrowers to obtain lower interest rates, similar to the rates received by the State of California.

Eligible Health Facilities must be owned and operated by private nonprofit public benefit corporations or political subdivisions such as cities, counties, healthcare districts or joint powers authorities. Health facilities eligible for Cal-Mortgage Loan Insurance include:

- Hospitals, of any type
- Skilled nursing facilities
- Intermediate care facilities
- Public health centers
- Clinics and other outpatient facilities
- Multi-level facilities (which include a residential facility for the elderly operated in conjunction with an intermediate care facility, a skilled nursing facility, or a general acute care hospital)
- Laboratories
- Community mental health centers
- Facilities for the treatment of chemical dependency
- Child day care facilities in conjunction with a health facility
- Adult day health centers
- Group homes
- Facilities for the developmentally disabled or mentally disordered
- Offices and central service facilities operated in connection with a health facility

Loans may be insured to finance or refinance the construction of new facilities; to acquire existing buildings; to expand, modernize, or renovate existing buildings; and to finance fixed or moveable equipment needed to operate the facility.

The Facilities Development Division (FDD):

1. Reviews and inspects health facility construction projects.
2. Has projects, currently under plan review or construction, valued in excess of $20 billion.
3. Enforces building standards, per the California Building Standards Code, as they relate to health facilities construction.
4. Is one of the largest building departments in the State of California.

The Healthcare Workforce Development Division (HWDD)

This division supports healthcare accessibility through the promotion of a diverse and competent workforce while providing analysis of California's healthcare infrastructure and coordinating healthcare workforce issues. The division's programs, services and resources address, aid and define healthcare workforce issues throughout the state by:

1. Encouraging demographically underrepresented groups to pursue healthcare careers.
2. Identifying geographic areas of unmet need.
3. Encouraging primary care physicians and non-physician practitioners to provide healthcare in health professional shortage areas in California.

HWDD staff collect, analyze and publish data about California's healthcare workforce and health professional training, identify areas of the state in which there are shortages of health professionals and service capacity, and coordinate with other state departments in addressing the unique medical care issues facing California's rural areas.

Health Professions Education Foundation (HPEF)

A nonprofit 501(c)(3) corporation, HPEF improves access to healthcare in underserved areas of California by providing scholarships, loan repayments, and programs to health professional students and graduates who are dedicated to providing direct patient care in those areas.

The Healthcare Information Division (HID)

This division collects and disseminates healthcare quality, outcome, financial, and utilization data, and produces data analyses and other products. The Division collects and publicly discloses facility level data from more than 5,000 CDPH-licensed healthcare facilities - hospitals, long-term care facilities, clinics, home health agencies, and hospices. These data include financial, utilization, patient characteristics, and services information. The Division produces more than 100 data products, including maps and graphs, summarizing rates, trends, and the geographic distribution of services. Risk-adjusted hospital and physician quality (outcome) ratings for heart surgery and other procedures are also published. The Division provides assistance to the members of the public seeking to use OSHPD data and, upon request, can produce customized data sets or analyses for policymakers, news media, other state departments and stakeholders.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD provide an overview of the Office and its proposed budget.

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

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 9: HEALTH CARE WORKFORCE ISSUES AND PROPOSITION 56 OVERSIGHT

PANELISTS

- **Dr. Bradley Gilbert**, Director, Department of Health Care Services
- **Jacey Cooper**, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
- **Marko Mijic**, Acting Director, Office of Statewide Health Planning and Development
- **CJ Howard**, Deputy Director, Healthcare Workforce Development Division, Office of Statewide Health Planning and Development
- **Alek Klimek**, Finance Budget Analyst, Department of Finance
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

OVERSIGHT ISSUES

This issue is to explore the state's programs, efforts and activities that are devoted to increasing and improving the state's health care workforce, in order to provide the necessary context for reviewing and considering the myriad of health care workforce-related budget proposals that have been submitted to this Subcommittee by stakeholders, advocates and Members of the Assembly. These programs primarily reside in OSHPD, but also include Proposition 56 physician and dentist loan repayments through DHCS. Under the jurisdiction of the education Subcommittees, California's institutions of higher education also play a major role in addressing California's health care workforce shortage.

This issue also provides an overview of Proposition 56 revenue generally. The 2019 Budget Act includes a requirement on various health and human services programs, including Proposition 56 supplemental Medi-Cal provider payments, that the program or service be suspended on December 31, 2021 if certain fiscal conditions in the state are not met. The Governor's January 2020 budget proposes to extend these suspension until July 1, 2023.

BACKGROUND

As described in the previous issue on OSHPD, OSHPD operates a wide range of programs intended to: 1) increase the overall size of California's health care workforce; 2) increase access to health care professionals in medical-shortage areas of the state; and 3) increase cultural diversity within California's health care workforce. OSHPD also operates the Song Brown program which provides financial support for primary care residency programs throughout the state.

Medical Residency Funding

The Song Brown program has provided residency program subsidies for many years. In 2017, the budget included $100 million General Fund ($33 million per year for three years) for Song Brown to: 1) increase the amount of support to existing programs; 2) support the expansion of existing programs; 3) support teaching health centers; and 4) provide funding to incentivize the creation and addition of new medical residency slots in California. The 2019 Budget Act approves of making this $33 million per year ongoing. The Song Brown program has a total budget for awards of approximately $38 million each year. $31 million is General Fund, and $7 million is Data Fund. The actual amounts awarded may vary based on applications received.

FY	Primary Care Residencies		Family Nurse Practitioner Physician Assistants		Registered Nurse Education Programs		Total Awards
	Award Amount	Number of Awards	Award Amount	Number of Awards	Award Amount	Number of Awards	
2017-18	$ 30,575,971	78	$ 1,656,000	14	$ 2,784,659	18	$ 35,016,630
2018-19	$ 33,800,000	79	$ 1,920,000	17	$ 2,862,921	25	$ 38,582,921
2019-20	$ 40,835,000	97	$ 2,040,000	15	TBD	TBD	$ 42,875,000
Total	$ 105,210,971	254	$ 5,616,000	46	$ 5,647,580	43	$ 116,474,551

Mental Health Workforce Funding

- Awareness and attention to the particular workforce shortages in mental health care have been increasing over the past several years. In response to this new awareness, the Governor proposed, and the 2019 Budget Act includes, $50 million in one-time funds specifically for various mental health workforce programs at OSHPD.

- Workforce Education and Training (WET)
  As mandated by the Mental Health Services Act (MHSA), OSHPD oversees the development and implementation of 5-year WET plans. The first two 5-year plans were funded with county MHSA funds, however just ten years of that funding was committed for this purpose. The second 5-year plan ended in 2018. OSHPD oversaw the development of the third 5-year plan which received funding through the 2019

Budget Act, including: $25 million (MHSA) and $35 million (General Fund), with a required local match of 33 percent.

Health Professions Education Foundation Programs
For a full list OSHPD Health Professions Education Foundation Programs, including fiscal and participation details (please see attachment A at the end of the agenda).

Proposition 56 Overview
Proposition 56 was passed by voters in November 2016 and it instituted $2 excise tax on a pack of 20 cigarettes (increased from $0.87 to $2.87), and an equivalent tax on other tobacco products.

Department of Finance (DOF) reports that, compared to the 2019 Budget Act, cigarette consumption has decreased more than expected and electronic cigarette consumption has grown less than expected.

2019 Budget Act	2020 Governor's Budget	
2019-20		2020-21
$1.411 Billion	$1.370 Billion	$1.338 Billion

Summary of Proposition 56 Allocations:
1. Backfills to tobacco and general taxes, based on fiscal effect on those funds calculated by the Department of Tax & Fee Administration (CDTFA).
2. Administrative Costs – CDTFA, up to 5% – State Auditor, up to $400,000
3. Defined Allocations
4. Percentage-Based Allocations

Proposition 56 provides backfills to various funds based on its fiscal effect on those funds, as calculated by the CDTFA. CDTFA has incorporated an additional year of data into their backfill estimate which more accurately reflects consumer behavior after the passage of Prop 56, according to DOF.

	2018-19 (Final)	2019-20 (Final)	2020-21 (Estimated)
Total Backfills	$69.7 million	$164.0 million	$160.1 million

Defined Allocations:

In 2018-19, Prop 56 made defined allocations of:

- $40 million to UC Graduate Medical Education,
- $30 million to the State Dental Program, and
- $48 million to Law Enforcement Efforts ($118 million total).

Beginning in 2019-20, Prop 56 requires these allocation to be reduced annually based on reduction in Prop 56 revenues. CDTFA has implemented this provision by comparing the decrease of total revenues for the last two years of actuals (2017-18 and 2018-19).

	Budget Act (Estimated)	Governor's Budget (Final)
2019-20 Reduction	-3.25%	-4.94%

Percentage-based Allocations:
After the defined allocations, the remainder of Proposition 56 revenue is allocated to:
• Medi-Cal 82%
• UC Medical Research 5%
• Tobacco Prevention and Control – Dept. of Public Health 11% – Dept. of Education 2%

Department of Finance
Proposition 56 Revenue Allocation
Forecast at Governor's Budget 2020
(Dollars in Millions)

	Forecast At Budget Act (BA)	Forecast At Governor's Budget (GB)		Difference	
Gross Revenue	**2019-20**	**2019-20**	**2020-21**	**BA 2019-20 vs GB 2019-20**	**GB 2019-20 vs GB 2020-21**
Proposition 56 Gross Revenue (3304)	$ 1,411.1	$ 1,369.5	$ 1,338	-$41.6	-$31.3
Revenue Backfills					
General Fund Backfill (0001)	$ 6.4	$ 17.2	$ 16.8	$10.8	-$0.4
Proposition 99 Backfill (0230)	$ 24.8	$ 52.2	$ 50.9	$27.3	-$1.2
Breast Cancer Fund Backfill (0004)	$ 1.3	$ 3.4	$ 3.4	$2.2	-$0.1
Proposition 10 Backfill (0623)	$ 37.2	$ 91.2	$ 89.0	$54.0	-$2.2
Administrative Costs					
CDTFA (3304)	$ 1.6	$ 1.5	$ 1.4	$0.0	-$0.1
State Auditor (0126)	$ 0.4	$ 0.4	$ 0.4	$0.0	$0.0
Defined Allocations					
UC Graduate Medical Education (3306)	$ 38.7	$ 38.0	$ 37.1	-$0.7	-$0.9
CDPH State Dental Program (3307)	$ 29.0	$ 28.5	$ 27.8	-$0.5	-$0.7
CDPH Law Enforcement (3318)	$ 5.8	$ 5.7	$ 5.6	-$0.1	-$0.1
CDTFA Law Enforcement (3319)	$ 5.8	$ 5.7	$ 5.6	-$0.1	-$0.1
DOJ Law Enforcement (3320)	$ 5.8	$ 5.7	$ 5.6	-$0.1	-$0.1
DOJ Local Grants (3320)	$ 29.0	$ 28.5	$ 27.8	-$0.5	-$0.7
Percentage-Based Allocations					
Medi-Cal Health Care Treatment Fund (3305)	$ 1,004.7	$ 895.0	$ 874.9	-$109.7	-$20.1
CDE Tobacco Prevention (3321)	$ 23.9	$ 21.3	$ 20.8	-$2.6	-$0.5
CDPH Tobacco Prevention (3322)	$ 135.4	$ 120.6	$ 117.9	-$14.8	-$2.7
UC Research (3310)	$ 60.7	$ 54.6	$ 53.3	-$6.1	-$1.2

CDTFA = Department of Tax & Fee Administration CDPH = Department of Public Health
UC = University of California DOJ = Department of Justice CDE = Department of Education

Proposition 56 Medi-Cal
(Dollars in Millions)

Category		2019-20	2020-21
Supplemental Payments and Rate Increases	Physician Services	$ 393.1	$ 406.8
	Dental Services	$ 210.9	$ 210.9
	Women's Health and Family Planning	$ 67.0	$ 67.6
	Intermediate Care Facilities for the Developmentally Disabled	$ 15.0	$ 15.1
	AIDS Waiver	$ 3.4	$ 3.4
	Community-Based Adult Services	$ 15.5	$ 15.5
	Non-Emergency Medical Transportation	$ 4.6	$ 4.6
	Free-Standing Pediatric Subacute Facilities	$ 4.0	$ 4.1
	Hospital-Based Pediatric Physicians Services	$ -	$ 2.0
	Trauma Screenings	$ 9.1	$ 13.1
	Developmental Screenings	$ 16.8	$ 23.7
	Home Health Providers	$ 46.8	$ 45.4
	Pediatric Day Health Care Facilities	$ 6.9	$ 7.0
Other	Physician and Dentist Loan Repayment [1/]	$ -	$ 13.5
	Value-Based Payments Program [2/]	$ 181.8	$ 178.6
	Provider Training for Trauma Screenings [3/]	$ 15.0	$ 30.0
	Administrative Costs [4/]	$ 3.2	$ 3.2
	Total	**$ 993.1**	**$ 1,044.5**

Loan Repayment Program

The physician/dentist loan repayment program was funded with one-time Proposition 56 funds. DHCS contracts with Physicians for a Healthy California, a nonprofit arm of the California Medical Association, to operate the loan program. The first round (cohort) of the loan program has been completed, and the second round is in progress. Loans will be awarded to one cohort per year each year for five years.

The loan repayment program funding includes:

- 2018 Budget Act: $220,000,000; funds are available through June 30, 2025.
- 2019 Budget Act: $120,000,000; funds are available through June 30, 2029.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD and DHCS provide an overview of their health care workforce efforts and respond to the following:

1. What evidence exists, or will exist, to determine if the Proposition 56 physician/dentist loan repayment program is resulting in increased provider participation in the Medi-Cal program, and/or in the state's medical shortage areas?

2. What evidence exists, or will exist, to determine if the Proposition 56 supplemental provider payments are increasing provider participation in Medi-Cal?

3. What evidence exists that support the effectiveness of the workforce programs at OSHPD?

4. How many new residency slots have been created as a result of the $100 million included in the 2017-2019 budgets?

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

ISSUE 10: MEMBER/STAKEHOLDER PROPOSAL: MEDICAL RESIDENCY TRAINING ON ABORTION CARE AND TRANSGENDER CARE – CHIU

PANELISTS

- **Assemblymember David Chiu**

Public Comment

PROPOSAL

Planned Parenthood Affiliates of California (PPAC) propose a one-time appropriation of $5 million to increase the number of medical residents who are trained in comprehensive reproductive health care, including abortion care and transgender health care services.

BACKGROUND

PPAC provided the following background information:

There are more than 400 residency programs in California, but many residents state that abortion care training and training to provide transgender health care services is not widely available to them as certain programs opt-out due to religious or moral objections or other restrictions related to federal funding. In addition, abortion training may not be readily available to residents in non-OB/GYN residency programs.

Similarly, many residency programs do not have transgender health care services as part of their training programs. For example, one of the Planned Parenthood physicians recently trained in a California family medicine residency interested in providing transgender care stated that there was no training available for transgender health care and that the residents had to take the initiative to receive that training.

This funding would flow to residency programs to enable them to expand training in academic centers and community partners like Planned Parenthood to provide abortion and transgender health care training as part of residency program rotations. Each residency program, including the secondary provider sites that host rotations, is a potential opportunity to offer additional training to residents who many want to learn how to provide this care.

This proposal would cost the state a total of $5 million in 2020/21, with a standard small portion of funding being diverted from the residency programs to cover fund administration overhead. It is the intent of this proposal to allocate the funds once but allow for the dollars to be expended over multiple fiscal years to allow for a gradual

increase in capacity awareness among residency programs who may be interested in utilizing the funds. Additionally, it may be ideal to appropriate the funding from a short term or one-time revenue source, such as those with residual funds or funds that are estimated to decline more rapidly, such as some newly proposed vaping revenue in the Governor's January budget.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Chiu present this proposal.

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

ISSUE 11: MEMBER/STAKEHOLDER PROPOSAL: PRIMARY CARE PSYCHIATRIC FELLOWSHIP SCHOLARSHIPS - EGGMAN

PANELISTS

- **Assemblymember Susan Eggman**
- **Shannon Suo**, M.D., Director, Train New Trainers in Primary Care Psychiatry, U.C. Davis
- **Robert McCarron**, D.O., Director, Train New Trainers in Primary Care Psychiatry, U.C. Irvine

Public Comment

PROPOSAL

The California Psychiatric Association requests $10.5 million (one-time General Fund) to OSHPD for scholarship support to enable primary care providers in underserved areas to pay the tuition to enroll in the one-year joint UC Davis, UC Irvine fellowship: Train New Trainers in Primary Care Psychiatry (TNT PCP).

BACKGROUND

The California Psychiatric Association provided the following background information:

A significant amount of mental health care is delivered in primary care settings, yet primary care providers receive little formal training to do this effectively. Strong growth in the number of applications for this program by primary care providers since the inaugural 2016 class demonstrate two things: 1) primary care providers strongly value the training (see accompanying document labeled “Graduate Testimonials”); and, 2) enrollment of fellows from underserved areas is trending strongly upwards. These combined factors demonstrate that the program, through its fellows, is able to deliver significantly increased access to psychiatric care in underserved areas of California.

The increased funding proposed in this 2020-2021 budget year request relative to prior years responds to surges in demand for and growth of the TNT PCP program, particularly among practitioners in underserved areas. For instance, prior budget year allocations of $1 million (2018-2019) and $2.65 million (2019-2020) were quickly and completely committed for scholarships within months of the availability of funds and translate into 40 and 179 scholarships awarded respectively.

TNT PCP program enrollment growth starting from a cohort of 35 (2016), then growing to 47 (2017), 57 (2018), 112 (2019), and finally to 235 (2020) primary care providers shows the growth of the program. Demand is expected to continue to rise with 2021 enrollment conservatively estimated at 250, 2022 enrollment of 275, and 2023 enrollment of 300.

These projections support this budget request of $10.5 million. This amount would cover the costs of scholarships for 2-4 future cohorts and obviate the need for a subsequent request in the next budget cycle. Broken down, the $10.5 million is comprised of two increments, $10 million for direct scholarship support with a set aside of $.5 million for OSHPD administration for those two years

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Eggman and the California Psychiatric Association present this proposal.

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

ISSUE 12: MEMBER/STAKEHOLDER PROPOSAL: PSYCHIATRIC RESIDENCY SUPPORT – FONG

PANELISTS

- **Assemblymember Vince Fong**
- **Barbara Glaser**, Senior Legislative Advocate, California Hospital Association

Public Comment

PROPOSAL

The California Hospital Association (CHA) is requesting a one-time budget augmentation of $22.2 million to be used to increase and maintain psychiatry graduate medical education slots through a grant program administered by OSHPD's Psychiatry Residency Grant Program.

BACKGROUND

The CHA provided the following background information:

California faces a severe and growing shortage of psychiatrists which will have a significant negative impact on access to mental health services. Over the next decade it is projected that California will have 41% fewer psychiatrists than it will need. A large segment of the psychiatrist workforce is aging and approaching retirement. The main reason that psychiatry residency programs in California are not growing to meet the demand is a lack of funding.

Two of the most effective strategies for increasing psychiatrists in California are expanding the size of existing psychiatry residency programs and establishing new psychiatry residency programs. The two strongest predictors of where physicians will practice are where they finish residency training and where they were raised. California ranks first in the nation for physician retention after training, with 70% of its physicians who complete residency training in California remaining in the state to practice.

In California, 22 hospitals provide graduate medical training in psychiatry and one Teaching Health Center. With additional funding these institutions would increase their existing programs. There may also be a number of hospitals and THCs that would consider establishing a new psychiatry residency program if they were able to obtain funding to help with start-up costs.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Fong and the California Hospital Association present this proposal.

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

ISSUE 13: MEMBER/STAKEHOLDER PROPOSAL: RURAL MEDICAL RESIDENCY SUPPORT – GALLAGHER

PANELISTS

- **Assemblymember James Gallagher**
- **Dr. David Alonso**, Butte Glenn Medical Society

Public Comment

PROPOSAL

This proposal is for $25 million General Fund ($5 million annually for 5 years) for the Office of Statewide Health Planning and Development (OSHPD), for the purpose of funding the creation of new residency programs in rural counties across Northern California. Specifically, the following clinical facilities have committed to creating medical residency programs:

Butte County: Enloe Medical Center in Chico (multiple specialties); Behavioral Health Butte County and Oroville Hospital (psychiatry, others possible); Northern Valley Indian Health (Family Medicine and Psychiatry, Woodland in Yolo County, Chico in Butte and Willows in Glenn); Feather River Tribal Health (Oroville, Butte); Dignity Health in Redding (several specialties, Shasta County); several facilities in Mendocino, Lake, and Humboldt counties (psychiatry and other specialties).

This proposal is sponsored by the following organizations:

- Butte-Glenn Medical Society
- North Valley Medical Association
- Humboldt-Del Norte County Medical Society
- Mendocino Lake County Medical Society
- Placer Nevada County Medical and Yuba-Sutter-Colusa Medical Societies
- Enloe Medical Center
- Physicians for a Healthy California
- Dignity Health in Redding
- Northern Valley Indian Health
- California Health and Wellness/ Health Net/ Centene
- Anthem Blue Cross

BACKGROUND

The sponsors of this proposal provided the following background information:

Rural Northern California has a huge provider shortage, and funding is necessary to help train and recruit doctors in this area. Residency programs will bring much needed providers to practice in our local communities, while increasing the likelihood that these residents stay and practice medicine as a long-term effort to increase healthy outcomes and decrease chronic and growing access to care problems. We look to the future and see many currently practicing physicians will retire in the next 5 years and are desperate to change the course of this inevitable outcome. The specialties that are most needed are Internal and Family Medicine, Psychiatry and Pediatrics. A Surgery residency program has been identified as a need in Redding and Chico.

The need is especially great in the aftermath of the campfire, and we have been working closely with the Butte-Glenn Medical Society and its Residency Task Force. The destruction of healthcare infrastructure in Butte County was not limited to just physical plant; we estimate that 10 to 15% of physicians left the area after the fire, worsening our existing challenges with healthcare access.

The Task Force has been a priority of our offices, and is represented by the following organizations (with additional organizations joining the effort): UC Davis School of Medicine, CSU Chico, Enloe Medical Center, Butte County Behavioral Health, Oroville Hospital, Dignity Hospital in Redding, Anthem Blue Cross, California Health & Wellness/Centene, the North Valley Medical Association, Northern Valley Indian Health, Shasta Community Health, and Physicians for a Healthy California. Butte-Glenn Medical Society is forming the Northern California Medical Education Program to support these proposed residency programs to help recruit residents to the programs when launched. The Alliance incorporates medical societies and county behavioral health leaders from the following rural counties: Humboldt, Del Norte, Siskiyou, Shasta, Tehama, Mendocino, Lake, Yuba, Sutter, Colusa, Butte, Glenn, Yolo, Placer and Nevada.

The Butte-Glenn Medical Society Residency Task Force is developing affiliation agreements with GME programs at UC Davis School of Medicine and the California Northstate University College of Medicine, both in Sacramento. Additional rural track connections with new Psychiatry and Family Medicine GME programs at Kaiser and Sutter in Sacramento are also being explored.

While Song-Brown funds flowed through Physicians for a Healthy California in 2019 and early 2020, these funds were largely to expand existing residency programs. The smaller hospitals and other clinical facilities in most rural counties of Northern California did not have existing GME affiliation agreements and might be under-resourced to take the steps

needed to establish such agreements. 2019 was a year of disaster recovery for rural counties such as Butte, Glenn, Tehama and Shasta after the Camp and Carr Fires impacted providers in many ways. In addition, the Physicians for a Healthy California funds available were not for psychiatry residency programs, which have been identified as some of the region's greatest needs.

With advice and guidance from the Butte-Glenn Medical Society Residency Task Force, it has become clear that additional funds are needed for clinical facilities in rural counties to prepare for residents by participating in ACGME conferences, establishing new contracts with medical schools and/or creating "rural tracks" so residents can rotate. Furthermore, these new residency programs require time and effort of clinical facilities to connect with future residents for matching and ensuring that the medical providers at the facility have the resources to provide positive experiences to residents.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Gallagher and Dr. David Alonso present this proposal.

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

ISSUE 14: MEMBER/STAKEHOLDER PROPOSAL: TRAINING AND PRACTICE OF ADVANCE PRACTICE CLINICIANS AND DEBT RELIEF FOR HEALTH PROFESSIONALS - GRAY

PANELISTS

- **Assemblymember Adam Gray**
- **Beth Malinowski**, Director of Government Affairs, California Primary Care Association/California Health+ Advocates

Public Comment

PROPOSAL

The California Primary Care Association (CPCA) and Planned Parenthood request a one-time General Fund investment in health care workforce, totaling $126.7 million for:

- Training and practice of advance practice clinicians in underserved communities ($49.7 million); and

- Debt relief to reduce or eliminate the level of accrued educational debt for underrepresented physicians, behaviorists, and care team members ($77 million).

Building on the work of the California Future Health Workforce Commission (CFHWC), CPCA and Planned Parenthood are proposing these funds be distributed in the following ways:

- $21 million to increase the number and diversity of nurse practitioners through the **expansion** of CSU and UC nurse practitioner education programs committed to primary care in underserved communities. These funds would be administered by the existing Song-Brown Healthcare Workforce Training Programs (Song-Brown Program).

- $16.8 million to increase the number and diversity of nurse practitioners through funds to **establish** CSU and UC nurse practitioner education programs committed to primary care in underserved communities. These funds would be administered by the existing Song-Brown Healthcare Workforce Training Programs (Song-Brown Program).

- $1 million to stabilize, expand, and establish physician assistant (PA) postgraduate fellowship opportunities in primary care in underserved communities. These funds would be administered by the existing Song-Brown Healthcare Workforce Training Programs (Song-Brown Program).

- $10.9 million to stabilize, expand, and establish nurse practitioner (NP) postgraduate fellowship opportunities in primary care in underserved communities. These funds would be administered by the existing Song-Brown Healthcare Workforce Training Programs (Song-Brown Program).

- $40.6 million to launch and fund the initial cohort of CFHWC developed Emerging California Health Leaders Scholarship Program (ECHLSP). This program aims to annually cover tuition for 10% of all students enrolled in eligible California health professions to enable more Californians to pursue degrees in high-end professions and practice in underserved communities. Of these funds, $39.5 million will be disseminate to student scholarships, while the remaining $1.1 million will go to operational and start-up costs. This fund would be administered through the OSHPD housed Health Professions Education Fund (HPEF).

- $27.4 million to increase the funds to existing loan repayment programs that are currently underfunded and incentivize health professionals to provide direct patient services in medically underserved areas of California. To guarantee that a higher percentage of eligible behavioral health and primary care applicants are receiving funding, these funds should be distributed to Steven M. Thompson Physician Corps Loan Repayment Program, Licensed Vocational Nurse Loan Repayment Program, Licensed Mental Health Services Provider Education Loan Repayment Program, Bachelor of Science Nursing Loan Repayment Program, and Advanced Practice Healthcare Loan Repayment Program. These funds would be administered through the OSHPD housed Health Profession Education Fund (HPEF). Based on calculations from HPEF's most recent grant cycle that take into account the total number of eligible applicants who would have been awarded were the programs fully funded, stakeholders are recommending the funding is distributed in the following ways:

    - Steven M. Thompson Physician Corps Loan Repayment Program: Estimated Need $15,000,000
    - Licensed Vocational Nurse Loan Repayment Program: Estimated Need $384,000
    - Advanced Practice Health Care Loan Repayment Program: Estimated Need $5,000,000
    - Licensed Mental Health Services Provider Education Loan Repayment Program: Estimated Need $7,000,000

- $4 million funds to increase the State Loan Repayment Program to expand the number of primary care physicians, dentists, dental hygienists, physician assistants, nurse practitioners, certified nurse midwives, pharmacists, and mental/behavioral health providers practicing in federally designated California Health Professional Shortage Areas (HPSA). These funds would be administered through OSHPD.

- $5 million in one-time funds (to be allocated until they are exhausted) to expand the number of physician assistants and nurse practitioners who primarily provide comprehensive reproductive health care by practicing with a 501(c)3 Community Health Center that primarily serves low-income patients, yet is not within a federally designated California Health Professional Shortage Areas (HPSA). **PPAC is co-sponsoring this item.

BACKGROUND

The workforce shortage has gone on too long, and is far too complex, for anything short of a multipronged approach that supports those most proximal to practice while building the infrastructure and pathway for a diverse, future workforce. Among the investments needing priority attention are:

The need to expand access to quality and affordable health care is vital. The Health Resources and Services Administration (HRSA) recently reported that more than 7.7 million Californians live in Health Professions Shortage Areas, a federal designation for counties experiencing shortfalls of primary care, dental care, or mental health care providers. Only two regions in California (Greater Bay Area and Sacramento) have ratios of primary care physicians per population above the minimum ratio recommended by the council of Graduate Medical Education (60 physicians per 100,000) – leaving other areas of the state woefully underprepared to adequately serve their populations (California Physician Supply and Distribution: Headed for a Drought?, CHCF 2018). The growing demand for access to affordable health care is further compounded by the fact that California is projected to have a shortfall of more than 4,100 primary care clinicians by 2030 (California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030, Healthforce Center at UCSF, 2017).

California needs to work towards increasing the supply of a behavioral health workforce that is distributed equitably across the state and reflects the demographic characteristics of the state's population. According to a recent 2018 report, *California's Current and Future Behavioral Health* (Healthforce Center at UCSF), the number of psychiatrists is projected to decrease by 34% between 2016 and 2028 largely due to the current age demographics of practicing psychiatrists. Nearly half of all psychiatrists (45%) are over

the age of 60 and are expected to retire within the next decade. According to the California Future Health Workforce Commission (2019), over the next decade it is projected that California will have 41% fewer psychiatrists and 11% fewer psychologists, marriage and family therapists, clinical counselors and social workers. Additionally, there are no doctoral programs in psychology in the Central Coast and San Joaquin Valley Regions. Given California's projection to have a particularly severe shortage of psychiatrists, the state must invest in strategies that expand models of care that rely less heavily on Psychiatrists and incentivize behavioral health professionals to practice in underserved regions of the state.

The Healthforce Center at UCSF (2017) notes that the current ratio of primary care physicians participating in Medi-Cal is approximately two-thirds of the federal recommendation. While recent Proposition 56 investments in graduate medical education, state loan repayment, and supplemental payments aim to turn the tide, these investments are not sufficient. At a time when this administration is launching a commendable effort with the Medi-Cal Healthier California for All program - a multi-year initiative by DHCS to improve the quality of life and health outcomes by implementing broad delivery system, program and payment reform across the Medi-Cal program - a workforce investment of the same caliber is needed. To succeed at bettering the quality of life for all Medi-Cal beneficiaries and achieve long-term cost savings, a comprehensive spectrum of primary care and behavioral health workforce investments is critical.

The California Future Health Workforce Commission (2019) lays out a bold plan to guarantee that individuals and families, including the Medi-Cal population, are able to receive timely primary care and behavioral health services. To move the Commission's vision forward, a just released Healthforce Center report (October 2019, UCSF), "*Leveraging the State Budget to Implement California Future Health Workforce Commission Recommendations*," presses for immediate action for continued and new investments in this budget cycle. This budget augmentation seeks to address some of those recommendations:

ADVANCED PRACTICE

California health centers are committed to using a care team approach to guarantee timely access to care. Health centers have seen firsthand the value of advanced practice clinicians – in particular, nurse practitioners and physician assistants, as part of these teams. Increasing the number of nurse practitioners and physician assistants delivering culturally competent care in underserved rural and urban communities is key to addressing the state's primary care workforce crisis. Nurse practitioners are also seen as part of the solution in expanding timely access to behavioral health services. For this reason the CFHWC (2019) recommends increase the number of persons training to become nurse practitioners. This proposal goes one-step further suggesting that

postgraduate fellowship opportunities should also be funded by the state to support the sustainability and growth of these programs.

DEBT RELIEF
Many health care professionals with student loans are less inclined to take jobs in California's underserved communities such as the central valley and rural/remote areas. A recent UCSF Report (2019) – Reducing Educational Debt Among Underrepresented Physicians and Dentists- strongly suggests that the rising cost of higher education raises concerns about equitable access to professional education for underrepresented minorities (URMs) and could be playing a significant role in holding the state back in diversifying its health care workforce. However, it is well documented that both scholarships and loan repayment programs influence the type of health career, graduate education, and post training practice locations an aspiring health professional chooses. This proposal aims to prevent and reduce/eliminate the level of accrued educational debt for underrepresented health care professionals – at all levels- not just physicians. This proposal suggests state investment in a new scholarship program, designed by the CFHWC, in addition to expanding funding to existing state programs that incentivize health professionals to practice in medically underserved regions.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Gray and the California Primary Care Association present this proposal.

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

ISSUE 15: MEMBER/STAKEHOLDER PROPOSAL: SUBSTANCE ABUSE DISORDER WORKFORCE EDUCATION AND TRAINING PLAN - NAZARIAN

PANELISTS

- **Assemblymember Adrin Nazarian**
- **Le Ondra Clark Harvey, Ph.D.**, Director of Policy and Legislative Affairs, California Council of Community Behavioral Health Agencies

Public Comment

PROPOSAL

The California Council of Community Behavioral Health Agencies (CBHA), California Consortium of Addiction Programs and Professionals (CCAPP), and the California Association of Alcohol and Drug Program Executives (CAADPE) request an allocation of $4,720,000 for 2020-21 for the development and implementation of a three-year workforce, education, and training plan to expand the substance use disorder (SUD) workforce. The funding request covers three distinct areas:

- Tuition assistance for vocational, community college, and university education, and improve the pipeline for potential new entrants via tuition reimbursement and fee waivers for tests and certification.

- Recruitment of a diverse workforce and creation of English learner education and examination materials.

- Development of a statewide substance use disorder workforce needs assessment report to evaluate the current state of the substance use disorder workforce; determine barriers to entry; and evaluate the state's systems for regulating and supporting this workforce.

BACKGROUND

The organizations sponsoring this request provided the following background information:

Although the addiction treatment field is growing due to increases in insurance coverage for mental health and substance use services and the rising rate of military veterans seeking behavioral health services, serious workforce shortages exist for addiction health professionals and paraprofessionals in California.

About 8% of Californians, or 2.7 million people, met the criteria for substance use disorder (SUD) in the past year; of those, only 1 in 10 received treatment. Despite these statistics, California lags the nation in its percentage of qualified counselors and other addiction treatment providers. There are less than 20,000 alcoholism and drug abuse counselors currently certified in California, and fewer than 700 of the nearly 140,000 physicians who hold a California license maintain an addiction specialty certification. Addiction programs have cited the "lack of qualified staff" as a primary reason that they are unable to expand provision of services to clients.

The California Mental Health and Substance Use Needs Assessment (2012) reports that, "Nationally approximately 8.9 million adults have a co-occurring disorder, but only 7.4% receive treatment for both conditions and almost 56% receive no treatment at all. This treatment disparity is due in part to the vastly different financial resources for the treatment of mental health versus substance use disorders in the state." Accordingly, last year's budget included $50 million in additional funding for OSHPD workforce development for mental health with no specific allotment for the SUD workforce.

There are a multitude of factors contributing to workforce shortages. Examples are:

- Retirement: Workforce in the addiction recovery field is older on average than in other healthcare areas.
- Compassion fatigue: Exhaustion is common, so workers move on.
- Salary: The average salary for social workers in the addiction field is $38,600 compared with $47,230 in the rest of the healthcare fields (Bureau of Labor Statistic).
- Overall need for myriad behavioral health professionals: Psychiatrists, psychologists, social workers, advanced practice nurses, marriage and family therapists, certified prevention specialists, addiction counselors, mental health counselors, psychiatric rehabilitation specialists, psychiatric aides, para-professionals, peer support specialists, recovery coaches and certified medical assistants.

Cultural Disparities Within the Workforce

The Department of Health Care Services, White Paper on California Substance Use Disorder Treatment Workforce Development, set workforce goals for the substance use disorder profession, including: "DHCS and providers of SUD services across California should make a concerted effort to recruit young individuals, males, and racial/ethnic minorities into the SUD workforce. Fewer members of these groups are involved, and generally it is preferable for clients to receive treatment from individuals who are of similar age, gender, and racial/ethnic background."

In addition, there are other vulnerable populations that could benefit from support in order to bolster their presence in the workforce. Namely, people who identify as lesbian, gay, bisexual, or transgender (LGBT), people who have been diagnosed with Hepatitis C or HIV, and those who have been involved in the criminal justice system often face social stigma, discrimination, harassment and other challenges not encountered by people who identify opposite of these categories. Dedicated funding to assist these individuals in attaining the training needed to join the SUD workforce is needed.

The mental health and substance use workforce in California is comprised of predominately English-only speakers. According to the 2010 US Census almost 38% of the population of California is of Hispanic/Latino origin. In Los Angeles County alone, it is reported that 36% of residents are foreign born and 57% speak a language other than English. A lack of curriculum in multiple languages discourages non-English speakers from entering the profession and an inability to encourage English language development for counselors who are unable to successfully pass competency examinations contributes to inadequate levels of culturally diverse addiction counselors. A structured English learner/counselor development career path that takes into account the need to effectively communicate clinically during the education process could foster greater participation from a wide variety of cultures. Development of a variety of alternate language curriculum for nonclinical professionals (peers, navigators, community health workers) could widen these resources.

Access to workforce development funding would improve access to addiction treatment by providing education opportunities for future SUD counselors and providers, and by evaluating SUD workforce shortage.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Nazarian and the California Council of Community Behavioral Health Agencies present this proposal.

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

ISSUE 16: MEMBER/STAKEHOLDER PROPOSAL: ECONSULT AND TELEHEALTH ASSISTANCE PROGRAM – RIVAS, R.

PANELISTS

- **Assemblymember Robert Rivas**
- **Jennifer Stoll,** Executive Vice President Government Relations, OCHIN

Public Comment

PROPOSAL

OCHIN requests $7.5 million for five years to establish the eConsult Services and Telehealth Assistance Program within the Department of Health Care Services. The grants funded through this budget proposal are limited to a 5-year term and shall be used for the following:

- Conduct infrastructure assessments, clinical objectives, and staffing plans
- Procuring technology and software and implementing eConsult services
- Staff and workflow training

BACKGROUND

OCHIN provided the following background information:

This funding will help FQHC's and RHC's establish an eConsult program to deliver coordinated virtual care and support California's community health centers, serving the state's most vulnerable population, so they may integrate new innovations and technology into their clinical workflows and receive assistance with staff education and training.

The adoption and use of telehealth and virtual care services across the California healthcare system is a rapidly growing and evolving modality for healthcare delivery. Remote electronic consultations, or eConsults, are a subset of virtual care that allows providers to "electronically" consult with another health care provider in a particular specialty where there may be a critical shortage.

eConsult services have the potential to dramatically impact healthcare delivery within primary care by allowing primary care providers to access specialty care in a timely manner and virtually consult with a specialty provider, prior to, or even avoiding an unnecessary referral. This allows for greater collaboration and improved communications, resulting in better care coordination. The populations served by FQHCs and RHCs are especially vulnerable to gaps in care when referrals to specialists require additional appointments, time off work, travel, or other challenges that can prove to be a barrier to

care with Medicaid or underinsured patients. If health centers are provided the technical support, eConsult services could offer the State of California's sensitive population numerous benefits.

RHCs and FQHCs that demonstrate a lack of sufficient access to care provided by medical specialists, that have not already implemented a program of eConsult or related telehealth services, and that demonstrate the ability to implement such a program effectively would be eligible funding recipients. Funds may also be administered by Health Care Coordinated Network (HCCNs) that demonstrate sufficient expertise and experience providing technical and other e-Consult assistance to CHCs and RHCs, sufficient participation commitments from eligible facilities, and a likelihood of successfully implementing eConsult programs.

Grants funded through this program would be eligible to HCCNs and rural health clinics for eConsult programs and related telehealth services with the goal of:

- Increasing specialty care access
- Avoiding unnecessary referrals
- Reducing patient travel
- Increasing primary care provider support
- Improving patient satisfaction
- Saving in health costs

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Rivas and OCHIN present this proposal.

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

ISSUE 17: MEMBER/STAKEHOLDER PROPOSAL: PRIMARY CARE AND PSYCHIATRIC RESIDENCY SUPPORT - WOOD

PANELISTS

- **Assemblymember Jim Wood**
- **Beth Malinowski**, Director of Government Affairs, California Primary Care Association/California Health+ Advocates

Public Comment

PROPOSAL

The California Primary Care Association requests $42.6 million one-time General Fund to expand primary care and psychiatry residency programs. Consistent with the California Future Health Workforce Commission, this request includes:

- $20.4 million to OSHPD for new primary care residency programs – These funds would be administered by the existing Song-Brown Healthcare Workforce Training Programs (Song-Brown Program). All funds should be disseminate to eligible primary care residency programs. And no new funds should be utilized for Song-Brown Program administration.

- $22.2 million to OSHPD for psychiatry residency programs – As the Song-Brown Program authority, established through the California Health and Safety Code, Section 128200-128241 is solely to increase primary care in California, these funds cannot be disseminated through the Song-Brown Program. These funds would be administered through the OSHPD Psychiatry Residency Grant Program established in the FY 2019-20 budget.

Additionally, this proposal includes the maintenance of current residency investments:

- $35 million (general fund) to OSHPD for Song-Brown Health Care Workforce Training Act; and

- $40 million (Proposition 56) in CalMedForce residency funds.

BACKGROUND

The California Primary Care Association provided the following background information:

The need to expand access to quality and affordable health care is vital. The Health Resources and Services Administration (HRSA) recently reported that more than 7.7 million Californians live in Health Professions Shortage Areas, a federal designation for counties experiencing shortfalls of primary care, dental care, or mental health care providers. Only two regions in California (Greater Bay Area and Sacramento) have ratios of primary care physicians per population above the minimum ratio recommended by the council of Graduate Medical Education (60 physicians per 100,000) – leaving other areas of the state woefully underprepared to adequately serve their populations (California Physician Supply and Distribution: Headed for a Drought?, CHCF 2018). The growing demand for access to affordable health care is further compounded by the fact that California is projected to have a shortfall of more than 4,100 primary care clinicians by 2030 (California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030, Healthforce Center at UCSF, 2017).

According to a recent 2018 report, *California's Current and Future Behavioral Health* (Healthforce Center at UCSF), the behavioral health profession shortages are also concerning. According to the California Future Health Workforce Commission (2019), over the next decade it is projected that California will have 41% fewer psychiatrists and 11% fewer psychologists, marriage and family therapists, clinical counselors and social workers.

The Healthforce Center at UCSF (2017) notes that the current ratio of primary care physicians participating in Medi-Cal is approximately two-thirds of the federal recommendation. While recent Proposition 56 investments in graduate medical education, state loan repayment, and supplemental payments aim to turn the tide, these investments are not sufficient. At a time when this administration is launching a commendable effort with the Medi-Cal Healthier California for All program - a multi-year initiative by DHCS to improve the quality of life and health outcomes by implementing broad delivery system, program and payment reform across the Medi-Cal program - a workforce investment of the same caliber is needed. To succeed at bettering the quality of life for all Medi-Cal beneficiaries and achieve long-term cost savings, a comprehensive spectrum of primary care and behavioral health workforce investments is critical.

The California Future Health Workforce Commission (2019) lays out a bold plan to guarantee that individuals and families, including our Medi-Cal population, are able to receive timely primary care and behavioral health services. To move the Commission's vision forward, a just released Healthforce Center report (October 2019, UCSF), "*Leveraging the State Budget to Implement California Future Health Workforce*

Commission Recommendations," presses for immediate action for continued and new investments in this budget cycle, including continued and new investments in primary care and psychiatry residency.

California health centers are leading the charge in expanding primary care residency in underserved communities. While federal funding supported this, these funds are far too unstable, and state investments have become critical to further stability and expansion of this model. The HRSA Teaching Health Center Graduate Medical Education (THC GME) program provides grants to CHCs that supervise the training of new physicians; over 1/3 of THCGME participants choose to practice primary care to underserved populations when their residencies are complete. California is home to eight existing and two new THC grants that fund primary care and psychiatry training programs. These programs are proud to be training over 100 residents. Two additional CA CHC residency programs became newly-accredited in 2019, but the funding was not sufficient to support their new resident cohorts. Many other CHCs are also interested in developing GME programs, but the lack of long-term funding makes for a risky undertaking.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Wood and the California Primary Care Association present this proposal.

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

NON-DISCUSSION ITEMS

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

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 18: EMERGENCY MEDICAL DISPATCH (SB 438) BUDGET CHANGE PROPOSAL

PROPOSAL

The Emergency Medical Services Authority requests 1 permanent position and $356,000 General Fund in 2020-21, $342,000 in 2021-22, and $171,000 annually thereafter to implement and meet the ongoing workload associated with the passage of SB 438 (Chapter 389, Statutes of 2019). SB 438 prohibits a public agency from delegating, assigning, or entering into a contract for "911" call processing services regarding the dispatch of emergency response resources unless the delegation or assignment is to, or the contract is with, another public agency.

BACKGROUND

The administration provided the following background information:

In 1980, the Legislature enacted the Emergency Medical Services (EMS) Act to create the modern-day EMS system (Chapter 1260, Statutes of 1980). The EMS Act established the California Emergency Medical Services Authority to coordinate and integrate all state activities concerning EMS, as well as to establish minimum standards, policies, and procedures that local agencies must meet and follow when delivering EMS. The EMS Act permitted counties to develop an EMS system and designate a Local Emergency Medical Services Authority (LEMSA) to implement state standards and develop medical protocols. Currently, 7 regional EMS systems covering multiple counties and 26 single county agencies make up the 33 LEMSAs within the state. The LEMSAs have the responsibility for developing protocols and standards for EMS response and care under the direction of its medical director.

Under the EMS Act, a LEMSA medical director adopts policies and procedures for dispatch, patient destination policies, patient care guidelines, and quality assurance requirements to ensure compliance with state standards. Currently, LEMSAs may contract with private entities for dispatch services, have agreements with fire departments

or other public agencies, or use both private agencies and public entities jointly for dispatch services.

Specific to communications and dispatch, the Warren-911-Emergency Assistance Act requires every local public agency to establish and operate, or be part of, an emergency telephone system using the digits "911". The purpose of the Act is to ensure an efficient statewide system for delivery of emergency 911 calls to the appropriate local agency public safety answering point (PSAP) that answer and respond to requests for emergency assistance. The Act also authorizes the state to oversee the development and operation of the 911 system. Under the Act, every 911 system must include police, fire, and emergency medical and ambulance services. These systems may include private ambulance services as part of the emergency response resource.

A call to 911 initially routes to the primary PSAP, a law enforcement agency. The dispatcher determines the nature of the call for appropriate routing to the secondary PSAP, which may include law enforcement personnel, local government with fire protection responsibility, or the local EMS provider.

SB 438 prohibits a public agency from delegating, assigning, or contracting for "911" emergency call processing or notification duties regarding the dispatch of emergency response resources unless the delegation or assignment is to, or the contract or agreement is with, another public agency.

To comply with the bill, the EMS Authority would be required to establish one new section of regulations and amend one existing regulation as follows:

- Develop 911 call processing regulations for dispatch centers and develop an implementation tool kit to assist LEMSAs in altering their EMS systems.
- Amend the paramedic regulations for the provision of advanced life support provider approvals, denials, and appeals. The following amendments would need to be made to Section 100168 of the paramedic regulations:
    - Add the application process for public agencies requesting approval from the local EMS agency for a paramedic program.
    - Add the 90-day timeline for the LEMSA to approve or deny the request. If the application is incomplete, the 90-day clock restarts when the LEMSA receives the modifications.
    - Add the appeal process before an Administrative Law Judge for denials or exceeding the 90- day review timeline. The process should specify there is no reimbursement from the EMS Authority for costs associated with the appeal.

The EMS Authority will also have additional costs for the management of staff and administrative and legal costs associated with the review of EMS plans and potential appeals of determinations made on LEMSA dispatch systems and advanced life support providers.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this request at this time.

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

ISSUE 19: REGIONAL DISASTER MEDICAL HEALTH RESPONSE LOCAL ASSISTANCE BUDGET CHANGE PROPOSAL

PROPOSAL

The Emergency Medical Services Authority requests ongoing $365,000 General Fund to improve regional disaster medical and health mitigation, preparedness, response and recovery by funding three additional Regional Disaster Medical Health Specialists (RDMHS).

BACKGROUND

The administration provided the following background information:

The California statewide medical disaster program is one of the eight basic components of an emergency medical system as defined in Health and Safety Code, Division 2.5, section 1797.151. The requirement for the department to support disaster medical response operations is contained in the Emergency Services Act and the State Master Mutual Aid Agreement. The Emergency Services Act further delineates that the disaster response program at the state level is primarily designed to assist local communities. The specific planning, coordination and response requirements are detailed in the EMS Authority's Administrative Orders and the State Disaster Medical Response Plan.

The California State Emergency Plan, the Standardized Emergency Management System and the California Public Health and Medical Emergency Operations Manual identifies regional coordination as a critical component in California disaster response.

The California disaster medical and health system has long relied on the mutual aid regional structure linking together the Operational Areas, Regions, and the State during disaster mitigation, preparedness, response, and recovery activities before, during and after a disaster. Since 1989, California Health and Safety Code section 1797.152 has required the establishment of a Regional Disaster Medical and Health Coordination Program in each California Mutual Aid Region which includes the voluntary position of Regional Disaster Medical Health Coordinator (RDMHC). The RDMHC "shall be either a county health officer, a county coordinator of emergency services, an administrator of a local EMS agency, or a medical director of a local EMS agency" and in the event of a major disaster the RDMHC may coordinate the acquisition of medical, public, environmental and behavioral health mutual aid resources. The RDMHC also coordinates the development of plans for the provision of medical and public health mutual aid among the counties in the region. Currently, all of the RDMHC positions within the State of

California are filled by appointed volunteers who hold other full-time local government positions. For this reason, the RDMHC position is not able to address planning and development of a regional mutual aid system while still addressing day-to-day and emergent needs within the region and outside of the region. The voluntary program ultimately is not adequate to meet the disaster medical and health mutual aid planning and development needs of California.

Currently, using local assistance funds, the EMS Authority contracts with Local EMS Agencies to provide the RDMHS functions in support of the Regional Disaster Medical and Health Coordination Program, the RDMHC, and the Medical Health Operational Area Coordinator, who is responsible for the coordination of medical and health resources within a County. Ongoing funding for the RDMHS program is provided jointly by the EMS Authority and the California Department of Public Health.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this request at this time.

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

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 20: COUNTY MEDICAL SERVICES PROGRAM LOAN REPAYMENT ADMINISTRATION BUDGET CHANGE PROPOSAL

PROPOSAL

The Office of Statewide Health Planning and Development (OSHPD) requests three-year reimbursement authority to reflect a service agreement extension with the County Medical Services Program (CMSP) Governing Board to administer the CMSP Loan Repayment Program. This includes $2.24 million in Fiscal Year (FY) 2020-21, $180,000 in FY 2021-22, and $60,000 in FY 2022-23.

BACKGROUND

The administration provided the following background information:

Healthcare Workforce Development Division
OSHPD's Healthcare Workforce Development Division (HWDD) conducts healthcare workforce research to identify areas of unmet need, educates decision makers on the healthcare workforce, and administers programs that provide financial incentives to individuals and organizations to encourage under-represented groups to pursue healthcare careers and provide services in areas of unmet need. HWDD administers a number of scholarship and loan forgiveness programs that provide financial assistance to qualified healthcare professionals in exchange for working in underserved areas of California.

CMSP Loan Repayment Program
The CMSP Loan Repayment Program supports healthcare professionals (primary care physicians, psychiatrists, physician assistants, nurse practitioners, and dentists) working in one of 35 CMSP counties. CMSP's Governing Board sponsors the educational debt relief programs in exchange for a two-year service obligation providing direct patient care at a contracted provider site.

The initial service agreement between OSHPD and CMSP to administer the CMSP Loan Repayment Program totaled $3.4 million and began October 2016 for the period between FY 2016-17 and 2019-20. In May 2019, OSHPD and CMSP executed an amended service agreement to extend the termination date from FY 2019-20 to 2022- 23 and increase total reimbursement funding to $4.72 million. In August 2019, a Budget Act of 2019 Control Section 28.00 was approved for FY 2019-20 for $2.24 million. This proposal requests reimbursement authority between FY 2020-21 and the service termination date

in FY 2022-23 as follows: $2.24 million in FY 2020-21 ($2 million in loan funding and $240,000 in administrative costs), and continuing administrative costs of $180,000 in FY 2021-22 and $60,000 in FY 2022-23.

The $2.48 million over three years increased reimbursement authority will enable OSHPD to continue to administer the CMSP Loan Repayment Program through June 30, 2023, in order to increase the number of healthcare providers working in rural and underserved CMSP counties, and improve access to care for Californians living in these areas.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this request at this time.

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

ISSUE 21: HEALTHCARE DATA DISCLOSURE (SB 343) BUDGET CHANGE PROPOSAL

PROPOSAL

The Office of Statewide Health Planning and Development (OSHPD) requests 1.0 position and $119,000 in Fiscal Year (FY) 2020-21 and $107,000 in FY 2021-22 and annually thereafter from the California Health Data and Planning Fund to implement new healthcare data reporting requirements due to Chapter 247, Statutes of 2019 (SB 343).

BACKGROUND

The administration provided the following background information:

OSHPD is the primary repository for healthcare data in California. OSHPD collects facility-level financial, utilization, and services inventory data reported by over 6,000 licensed healthcare facilities including hospitals, long-term care facilities, clinics (primary care and specialty), home health agencies and hospices. OSHPD also collects approximately 16 million individual confidential patient records annually regarding hospital inpatient discharges, emergency department encounters, ambulatory surgery encounters, and coronary artery bypass graft surgeries.

OSHPD is required to develop and maintain uniform systems of accounting and data reporting for all acute care hospitals. Licensed hospitals in California must submit a Hospital Annual Disclosure Report and four Quarterly Financial and Utilization Reports each year based on these system requirements, which are routinely reviewed and revised to ensure that they provide guidance to hospitals and to meet the needs of data users.

OSHPD performs desk audits on these reports for compliance, accuracy, and reasonableness, and makes them available to the public to provide greater transparency. Data from OSHPD reports are used extensively by purchasers and providers of healthcare services, healthcare policy makers, patient advocates, and various media outlets.

SB 343 removes certain statutory alternative reporting requirements for health facilities that receive a preponderance of their revenue from associated comprehensive group practice prepayment health care service plans. Kaiser Permanente (Kaiser) is the only plan with health facilities that qualified for these exemptions. This results in the inability to compare the performance of Kaiser hospitals to other facilities, and in local communities not being able to evaluate the performance of their local hospital.

SB 343 requires OSHPD to conduct independent desk audits on all 33 Kaiser facilities rather than just the Kaiser Permanente southern California and Kaiser Permanente northern California groups as done in the past. For the increased workload, 1.0 Health Program Auditor II is required to conduct a desk audit of each of the four Quarterly Financial and Utilization Reports and each Annual Financial Disclosure Report for the 33 Kaiser facilities to ensure compliance with OSHPD's uniform system of accounting and reporting and Generally Accepted Accounting Principles. The requested position will process 33 annual reports and 132 quarterly reports each year as well as provide technical assistance to reporting hospitals and public data users. The workload associated with this rulemaking process will be absorbed by current staff.

SB 343 requires Kaiser to report financial and utilization information to OSHPD on a facility basis, rather than on a consolidated basis between two regions. Specifically, Kaiser will be required to file complete quarterly financial reports on a facility basis, and to report to OSHPD annual statements of income, expenses, and operating surplus or deficit, statements of ancillary utilization and patient census, and statements detailing patient revenue by payer and revenue center on a facility basis. Kaiser will continue to be exempt from annually reporting facility level Balance Sheets and Cash Flow Statements, and report these on a consolidated group level.

With this new requirement, Kaiser reports will be desk audited in the same manner as all other hospital reports and will be included in the statewide baseline information that establishes audit parameters that will affect the standards for which all other hospitals are compared. Regulations are needed to specify the annual reporting requirements as prescribed by SB 343.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this request at this time.

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

ISSUE 22: HOSPITAL COMMUNITY BENEFITS PLAN REPORTING (AB 204) BUDGET CHANGE PROPOSAL

PROPOSAL

The Office of Statewide Health Planning and Development (OSHPD) requests 2.0 positions and $519,000 in Fiscal Year (FY) 2020-21 and $245,000 in FY 2021-22 and annually thereafter from the California Health Data and Planning Fund to implement changes to the Hospital Community Benefit Program pursuant to Chapter 535, Statutes of 2019 (Assembly Bill [AB] 204).

BACKGROUND

The administration provided the following background information:

OSHPD is the primary repository for healthcare data in California. OSHPD collects facility-level financial, utilization, and services inventory data reported by over 6,000 licensed healthcare facilities including hospitals, long-term care facilities, clinics (primary care and specialty), home health agencies and hospices. OSHPD also collects approximately 16 million individual confidential patient records annually regarding hospital inpatient discharges, emergency department encounters, ambulatory surgery encounters, and coronary artery bypass graft surgeries.

The Hospital Community Benefit Program began in 1995. Each non-rural, private nonprofit hospital is required to conduct a community needs assessment every three years and to annually submit its community benefit plan to OSHPD. Currently, 223 hospitals are required to comply. Additionally, 12 of the 28 rural hospitals that are exempt voluntarily submit community benefit plans. Because the law does not require a standard format, comparative data analysis is not performed and standard data are not produced. There is no standardized calculation of the economic value or standardized reporting of defined categories of community benefits. This results in difficulty comparing what different hospitals spend or summarizing what is spent overall for certain types of community benefits in exchange for tax-exempt status.

AB 204 requires private nonprofit acute care hospitals to follow a specific methodology in valuing benefits they provide to their communities, and for that amount to be consistent with charity care cost as reported to OSHPD. Currently, hospitals report the amount of charity care accounts written off and their total operating costs on their annual financial disclosure report and their quarterly financial and utilization report (Health and Safety Code Sections 128735 and 128740). These reports identify the portion of patient bills written off for government-sponsored healthcare programs, which also must be reported as part of the hospital's community benefits.

In addition, a new annual report published by OSHPD will include a list of hospitals that failed to comply with community benefit reporting requirements.

AB 204 authorizes OSHPD to impose a fine up to $5,000 on hospitals for failure to adopt, update, or submit a community benefit plan consistent with the requirements. Potential revenue to the California Health Data and Planning Fund is indeterminate and would depend on the level of hospital compliance with the provisions of this bill.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this request at this time.

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

ISSUE 23: HOSPITAL PROCUREMENT CONTRACTS REPORTING (AB 962) BUDGET CHANGE PROPOSAL

PROPOSAL

The Office of Statewide Health Planning and Development (OSHPD) requests 2.0 positions and $790,000 in Fiscal Year (FY) 2020-21, and $290,000 in FY 2021-22 and annually thereafter from the California Health Data and Planning Fund to implement new hospital procurement contract reporting requirements and administer a hospital diversity commission pursuant to Chapter 815, Statutes of 2019 (Assembly Bill [AB] 962).

BACKGROUND

The administration provided the following background information:

OSHPD is the primary repository for healthcare data in California. OSHPD collects facility-level financial, utilization, and services inventory data reported by over 6,000 licensed healthcare facilities including hospitals, long-term care facilities, clinics (primary care and specialty), home health agencies, and hospices. OSHPD also collects approximately 16 million individual confidential patient records annually regarding hospital inpatient discharges, emergency department encounters, ambulatory surgery encounters, and coronary artery bypass graft surgeries.

In addition to data, OSHPD collects additional documents as part of health facility disclosures. Since 1995, each non-rural, private nonprofit hospital is required to submit a community benefit plan to OSHPD. Additionally, OSHPD collects Hospital Fair Pricing Policies, procedures, and application forms, which began in 2008. Each document is submitted to OSHPD electronically or through a web-based application and is reviewed for compliance with statutory and regulatory requirements. Final reports are released to the public via OSHPD's web-based applications internet page.

AB 962 requires a similar document disclosure for hospital supplier diversity reports, which will be collected, reviewed for compliance, and released to the public via OSHPD's internet website. AB 962 requires OSHPD to establish and support an 11-member hospital diversity commission to meet quarterly with the initial meeting to occur on or before July 1, 2020. The commission will advise the Director of OSHPD and the hospital industry and make recommendations on best methods to increase procurement with diverse suppliers within the hospital industry. AB 962 also requires hospitals over $50 million in operating expenses or licensed hospitals with operating expenses over $25 million that are part of a hospital system to annually report to OSHPD a report on its procurement efforts towards minority, women, LGBT, and disabled veteran business enterprises. Failure to report will be subject to a fine of $100 per day. Potential revenue

to the California Health Data and Planning Fund is indeterminate and would depend on the level of hospital compliance with the provisions of this bill.

AB 962 creates additional workload and requires OSHPD to establish new program requirements and modify current data collection systems. Ongoing workload related to establishing a new data reporting program, receiving and managing data, making the data available on the website, and establishing and staffing a commission requires additional resources. There will be minor and absorbable costs to update regulations and develop and implement an appeals process related to the imposed civil penalties. Noncompliance issues will be documented and reported to the hospital, and fines assessed as provided under AB 962.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this request at this time.

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

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 24: HEALTH CARE COVERAGE: TELEHEALTH (AB 744) BUDGET CHANGE PROPOSAL

PROPOSAL

The Department of Managed Health Care (DMHC) requests 1.5 positions and $331,000 in FY 2020-21 and $379,000 in FY 2021-22 and ongoing from the Managed Care Fund to review health care service plan contracts, documents, and claims coverage of telehealth services as specified pursuant to Chapter 867, Statutes of 2019 (AB 744).

This proposal includes consultant services funding of $60,000 in FY 2020-21 and $120,000 in FY 2021-22 and ongoing from the Manage Care Fund to review the cost-sharing portion of telehealth contracts required by AB 744.

The remaining $271,000 in FY 2020-21, $259,000 in FY 2021-22 and ongoing from the Managed Care Fund is to support 1.5 positions

BACKGROUND

The administration provided the following background information:

The DMHC regulates health plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act). Under existing law, a health plan cannot require that in-person contact occur between a health care provider and an enrollee before payment is made for the services appropriately provided through telehealth, subject to contractual terms with the enrollees or providers. Additionally, a health plan cannot limit the type of setting where services are provided prior to payment for services appropriately provided through telehealth, subject to contractual terms. AB 744 expands the use of telehealth by establishing payment parity between telehealth and in-person health care services.

AB 744 requires the DMHC to review:

1. Health care service plan documents for compliance with reimbursement requirements for telehealth services;
2. Plan records regarding payments for telehealth services; and
3. Telehealth claim samples when conducting financial examinations.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this request at this time.

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

ISSUE 25: HEALTH PLANS AND HEALTH INSURANCE: THIRD-PARTY PAYMENTS (AB 290) BUDGET CHANGE PROPOSAL

PROPOSAL

The Department of Managed Health Care (DMHC) requests two-year limited-term expenditure authority of $1,163,000 in FY 2020-21 and $775,000 in FY 2021-22 from the Managed Care Fund to meet the requirements of Chapter 862, Statutes of 2019, [Assembly Bill (AB) 290]. AB 290 requires the DMHC to establish an Independent Dispute Resolution Process (IDRP) through which providers and health plans can seek rates above the Medicare rates, promulgate regulations, receive plan data regarding cost savings, and review health plan Evidence of Coverage (EOC) documents to verify plan compliance with the bill's provisions.

This request includes one-time consultant funding of $470,000 in FY 2020-21 to assist in developing the Provider Complaint System (PCS) platform to allow the receipt and processing of the IDRPs from providers and health plans. This consultant funding is contingent upon approval of Project Approval Lifecycle documents related to the development of the PCS platform. Additionally, one-time consultant funding of $31,000 in FY 2021-22 is requested to review cost saving schedules submitted by health care service plans.

This request also includes limited-term resources of $693,000 (equivalent to 3.5 positions) in FY 2020-21 and $744,000 (equivalent to 4.5 positions) in FY 2021-22 to address the increased workload resulting from AB 290 implementation.

Given the uncertainty regarding workload required to implement AB 290 beyond FY 2022-23, resources for FY 2022-23 and ongoing are not requested in this budget change proposal.

BACKGROUND

The administration provided the following background information:

DMHC regulates health plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act). Under existing law, health plans may not discriminate against enrollees and must provide coverage to enrollees regardless of health status. Third parties, such as the American Kidney Fund (AKF), provide financial assistance to enrollees to help individuals purchase commercial health plan coverage.

AB 290 requires the DMHC to do the following:

- Review EOCs and other plan documents for compliance with the requirements of the bill, such as notification of consumer protections and special enrollment triggering events.
- Review health plan policies and procedures for compliance with the bill's requirements on financially interested entities and health plans.
- Establish an IDRP, including written procedures and guidelines, by October 1, 2021 for determining if the amount required to be reimbursed is appropriate.
- Review annual health plan submissions related to financially interested entities and payments to financially interested providers.
- Process health plan recoupments submitted to the DMHC.
- Review health plan submissions regarding cost savings associated with Health and Safety Code Section 1367.016 and the impact on rates.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this request at this time.

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

ISSUE 26: INFORMATION SECURITY RESOURCES BUDGET CHANGE PROPOSAL

PROPOSAL

The Department of Managed Health Care (DMHC) requests 2.0 positions and $384,000 in FY 2020-21, $368,000 in FYs 2021-22 and 2022-23, and $328,000 in FY 2023-24 and ongoing from the Managed Care Fund to address the Department's highest information security and cybersecurity vulnerabilities.

This request includes $40,000 for Information Technology (IT) consultant services in FYs 2020-21, 2021-22 and 2022-23.

The remaining funding of $344,000 in FY 2020-21, $328,000 in FY 2021-22 and ongoing to support 2.0 positions. The below table displays the DMHC program for the 2.0 positions.

BACKGROUND

The administration provided the following background information:

The DMHC created its information security program more than 10 years ago to address the Department's information security needs. The DMHC's technology environment currently consists of several mission critical systems, most containing sensitive data, and over 500 end-devices. Information and cybersecurity threats have increased exponentially in frequency and sophistication and the DMHC has limited resources to address these growing threats.

California regulations and statutes place a responsibility on state agencies to protect the information contained in varied networks, databases and applications. According to the State Administrative Manual (SAM) Section 5300, each state entity is responsible for establishing an information security program to effectively manage risk, provide protection of information assets and prevent illegal activity, fraud, waste and abuse. Safeguarding against these threats requires a robust and sophisticated information security program and consistent improvements to cybersecurity defenses.

In FY 2017-18, a workload Budget Change Proposal (BCP) was submitted and approved to provide the DMHC's Office of Technology and Innovation (OTI) 2.0 permanent positions and $290,000 in limited term consultant funding to assist with security monitoring and enhancing the Department's security measures as well as consolidating and replacing legacy applications. The limited term funding is set to expire on June 30, 2020. The table below outlines the resource history for the OTI.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this request at this time.

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

ISSUE 27: LARGE GROUP RATE REVIEW (AB 731) BUDGET CHANGE PROPOSAL

PROPOSAL

The Department of Managed Health Care (DMHC) requests 5.0 positions and $1,747,000 in FY 2020-21 and $2,617,000 in FY 2021-22 and ongoing from the Managed Care Fund to meet the requirements of AB 731, which requires the department to create a new process for review of rates in the large group market and modify existing reporting requirements in the individual and small group markets.

This request includes one-time consultant funding of $50,000 in FY 2020-21 to assist with the development of reporting templates and procedures, ongoing consultant funding of $567,000 beginning in FY 2020-21 to review 80 percent of community-rated and experience/blended-rated filings, and additional ongoing consulting funding of $960,000 beginning in FY 2021-22 to assist in conducting the ongoing review of large group rate filings required by AB 731.

The following table notes the requested positions by program and classification:

Program/Classification	FY 20-21 and ongoing
OFFICE OF FINANCIAL REVIEW	
Senior Life Actuary	3.0
OFFICE OF TECHNOLOGY AND INNOVATION	
Information Technology Specialist II	1.0
OFFICE OF LEGAL SERVICES	
Attorney	1.0
Total	**5.0**

BACKGROUND

The administration provided the following background information:

The DMHC regulates health plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act). In 2018, 24 California health plans issued large group contracts covering over 7.8 million enrollees in approximately 13,600 renewing groups.

Existing law requires a health plan or health insurer offering a contract or policy in the individual and small group markets to submit rate information to the DMHC prior to any rate change. The DMHC currently reviews quarterly small group rate filings and annual

individual rate filings for the 12 health plans participating in these markets, for a total of 60 filings per year. A health plan's rate filing for its individual or small group market consists of a single filing that covers all of the plan's benefit designs for that market, and the DMHC's finding whether a rate is unreasonable or not justified applies to all of the benefit designs covered by the plan's filing. There are no provisions in current law requiring health plans to submit large group rate filings to the DMHC in order to determine whether rate increases are unreasonable or not justified.

Effective July 1, 2020, AB 731 requires a health care service plan offering a contract or policy in the large group market to file specified rate information with the DMHC annually and at least 120 days before implementing a rate change. Unlike the DMHC's individual and small group rate review program, AB 731 does not require the DMHC to review every specific contract holder rate in the large group market. Instead, the bill authorizes the DMHC to determine whether the methodology, factors and assumptions used to develop rates are unreasonable or not justified.

In addition, beginning July 1, 2021, specific contract holders that meet the criteria set out in the bill may seek DMHC review of a health plan's proposed rate before the health plans can move forward with a rate increase. In addition to establishing a rate program for the large group products, AB 731 also makes changes to the rate information reported by health plans in all market types, effective July 1, 2020.

As a result of AB 731, effective July 1, 2020, DMHC will be required to (1) develop forms and reporting templates to obtain the large group market data for its review of the large group rate methodology; (2) conduct the review of the large group rate methodology to determine whether it is unreasonable or not justified; and (3) modify existing reporting forms and templates in the individual and small group to account for the new rate information.

As a result of AB 731, effective July 1, 2021, DMHC will be required to (1) develop forms and templates to review a specific rate in the large group market; and (2) conduct a review of these specific rates to determine whether they are unreasonable or not justified.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this request at this time.

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

Attachment A:

Health Professions Education Foundation Programs FY 18-19						
Program Name	**Total Amount Allocated**	**# of Applications Received**	**# Awarded**	**Amount Awarded**	**Service Commitment**	**Location**
Vocational Nurse Scholarship Program (VNSP)	$12,000	5	3	$12,000	1 Years	San Diego, Stanislaus
Licensed Vocational Nurse to Associate Degree Nursing (LVN to ADN)	$16,000	21	2	$16,000	1 Years	Fresno, Merced
Associate Degree Nursing Scholarship Program (ADNSP)	$36,592	111	5	$36,592	1 Years	Los Angeles, Tulare, Yuba
Bachelor of Science Nursing Scholarship Program (BSNSP)	$98,874	87	10	$98,874	1 Years	Fresno, Imperial, Los Angeles, Orange, San Bernardino, Shasta
Allied Healthcare Loan Repayment Program (AHLRP)	$631,630	119	26	$301,946	1 Years	Colusa, El Dorado, Humboldt, Imperial, Mono, Napa, San Benito, Shasta, Sonoma, Yolo
Licensed Vocational Nurse Loan Repayment Program (LVNLRP)	$137,895	92	20	$118,658	1 Years	Alameda, Los Angeles, Madera, Riverside, San Bernardino, San Diego, San Joaquin, Stanislaus
Bachelor of Science Nursing Loan Repayment Program (BSNLRP)	$1,175,802	651	118	$1,149,494	1 Years	Alameda, Butte, Contra Costa, Fresno, Imperial, Kern, Kings, Lassen, Los Angeles, Madera, Mendocino, Merced, Monterey, Orange, Plumas, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Cruz, Stanislaus, Tulare
Licensed Mental Health Services Provider Education Program (LMHSPEP)	$269,526	759	27	$270,000	2 Years	Alameda, Los Angeles, Marin, Monterey, Orange, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Clara

Health Professions Education Foundation Programs FY 18-19						
Program Name	**Total Amount Allocated**	**# of Applications Received**	**# Awarded**	**Amount Awarded**	**Service Commitment**	**Location**
Steven M. Thompson Physicians Corps Loan Repayment Program (STLRP)	$4,470,536	198	45	$4,410,000	3 Years	Alameda, Calaveras, Contra Costa, Fresno, Imperial, Inyo, Kern, Lake, Los Angeles, Madera, Merced, Mono, Orange, Riverside, San Bernardino, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Sonoma, Tulare, Ventura

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