AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MAY 1, 2023

2:30 PM, STATE CAPITOL, ROOM 127

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

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

The public may provide public comment after all witnesses on all panels and issues have concluded, and after the conclusion of member question by calling toll-free: ***877-692-8957, access code: 131 51 27***

ITEMS TO BE HEARD

NON-PRESENTATION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

HEALTH EQUITY

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY (CALHHS)
4120 EMERGENCY MEDICAL SERVICES AUTHORITY (EMSA)
4260 DEPARTMENT OF HEALTH CARE SERVICES (DHCS)
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH)
4800 HEALTH BENEFIT EXCHANGE (HBEX)

ISSUE 1: CALHHS/CDPH: EQUITY CENTERED PROGRAMS BUDGET CHANGE PROPOSAL (BCP)

PANEL

- **Rohan Radhakrishna**, Deputy Director, Office of Health Equity (OHE), CDPH
- **Nick Mills**, Finance Budget Analyst, Department of Finance (DOF)
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, Legislative Analyst's Office (LAO)

ISSUE 2: CDPH: PUBLIC HEALTH REGIONAL CLIMATE PLANNING REVERSION

PANEL

- **Linda Helland**, Climate Change & Health Equity Section Chief, OHE, CDPH (*Remote*)
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 3: CDPH: PROTECTING CHILDREN FROM THE DAMAGING EFFECTS OF LEAD EXPOSURE, SPRING FINANCE LETTER (SFL) ISSUE 315

PANEL

- **Maria Ochoa**, Deputy Director, Center for Healthy Communities, CDPH
- **Michelle Gibbons**, Executive Director, County Health Executives Association of California (CHEAC)
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 4: EMSA: DIVERSITY, EQUITY, AND INCLUSION STRATEGIC PLAN DEVELOPMENT BCP

PANEL

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

ISSUE 5: DHCS: CALIFORNIA CANCER EQUITY ACT (SB 987) BCP

PANEL

- **Lori Walker**, Deputy Director & Chief Financial Officer, Department of Health Care Services (DHCS)
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Andrew Duffy**, Principal Program Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

ISSUE 6: HBEX: $1 PREMIUM SUBSIDY AUGMENTATION, SFL ISSUE 20

PANEL

- **Joseph Donaldson**, Finance Budget Analyst, DOF
- **Matt Aguilera**, Principal Program Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

HEALTH CARE LICENSING AND SENIORS

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 7: FACILITATING PROJECTS TO BENEFIT NURSING HOME RESIDENTS BCP

PANEL

- **Michelle Bell**, Office of Internal Operation Chief, Center for Health Care Quality (CHCQ), CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 8: INTERNAL DEPARTMENTAL QUALITY IMPROVEMENT ACCOUNT PROVISIONAL LANGUAGE, SFL

PANEL

- **Michelle Bell**, Office of Internal Operation Chief, CHCQ, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 9: REMOVAL OF FEDERAL HEALTH FACILITIES CITATION PENALTIES ACCOUNT AWARD LIMIT TRAILER BILL

PANEL

- **Michelle Bell**, Office of Internal Operation Chief, CHCQ, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 10: RADIOLOGIC HEALTH BRANCH LICENSING AND CERTIFICATION TRAILER BILL, SFL

PANEL

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 11: MEDI-CAL: SHORT-TERM COMMUNITY TRANSITIONS (SB 281) BCP

PANEL

- **Lori Walker**, Deputy Director & Chief Financial Officer, DHCS
- **Tom Heinz**, Executive Director, East Bay Innovations (*Remote*)
- **Hersh Gupta**, Finance Budget Analyst, DOF
- **Andrew Duffy**, Principal Program Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 12: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) MONITORING AND PROGRAM OPERATIONS BCP

PANEL

- **Lori Walker**, Deputy Director & Chief Financial Officer, DHCS
- **Hersh Gupta**, Finance Budget Analyst, DOF
- **Andrew Duffy**, Principal Program Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 13: POST ELIGIBILITY TREATMENT OF INCOME TRAILER BILL

PANEL

- **Lori Walker**, Deputy Director & Chief Financial Officer, DHCS
- **Hersh Gupta**, Finance Budget Analyst, DOF
- **Andrew Duffy**, Principal Program Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 14: SKILLED NURSING FACILITIES (SNF) PAYMENT DELAYS

PANEL

- **Jennifer Snyder**, Legislative Advocate, California Association of Health Facilities
- **Michelle Baass**, Director, DHCS
- **Hersh Gupta**, Finance Budget Analyst, DOF
- **Andrew Duffy**, Principal Program Budget Analyst, DOF

MENTAL HEALTH MODERNIZATION

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 15: MENTAL HEALTH SERVICES ACT: HISTORY AND OVERVIEW

PANEL

- **Darrell Steinberg**, Mayor, City of Sacramento / Founder, Steinberg Institute
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission (OAC)

ISSUE 16: MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION: TRANSFER TO ADMINISTRATION

PANEL

- **Michelle Baass**, Director, DHCS
- **Andrea Wagner**, Executive Director, California Association of Mental Health Peer Run Organizations
- **Ivan Arellano**, Student, Imperial County High School
- **Carlos Gastelum**, Student, Imperial County High School
- **Aiyanna Hoffman**, Student, Imperial County High School
- **Dave Gordon**, Superintendent, Sacramento County Office of Education
- **Kelechi Ubozoh**, Author of *We've Been Too Patient: Voices from Radical Mental Health*, Lived Experience (*Remote*)
- **Bill Brown**, Sheriff, County of Santa Barbara
- **Robert Harris**, Legislative Advocate, SEIU California
- **Tyler Rinde**, Deputy Director of Child Welfare Policy, California Alliance of Child and Family Services
- **Toby Ewing**, Executive Director, OAC
- **Diana Vazquez-Luna**, Finance Budget Analyst, DOF
- **Iliana Ramos**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 17: MENTAL HEALTH SERVICES ACT REFORM

PANEL

- **Michelle Baass**, Director, DHCS
- **Robert Harris**, Legislative Advocate, SEIU California
- **Ahmadreza Bahrami**, Division Manager, Public Behavioral Health, Fresno County (*Remote*)
- **Lishaun Francis**, Senior Director, Behavioral Health, Children Now
- **Tyler Rinde**, Deputy Director of Child Welfare Policy, California Alliance of Child and Family Services
- **Dannie Ceseña**, Executive Director, California LGBTQ Health and Human Services Network (*Remote*)
- **Toby Ewing**, Executive Director, OAC
- **Michelle Cabrera**, Executive Director, County Behavioral Health Directors Association (CBHDA)
- **Diana Vazquez-Luna**, Finance Budget Analyst, DOF
- **Iliana Ramos**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 18: IMPROVE STATEWIDE ACCOUNTABILITY AND ACCESS TO BEHAVIORAL HEALTH SERVICES

PANEL

- **Michelle Baass**, Director, DHCS
- **Mary Watanabe**, Director, Department of Managed Health Care (DMHC)
- **Dan Southard**, Chief Deputy Director, DMHC
- **Michelle Cabrera**, Executive Director, CBHDA
- **Toby Ewing**, Executive Director, OAC
- **Kiran Savage-Sangwan**, MPA, Executive Director, California Pan Ethnic Health Network (CPEHN)
- **Diana Vazquez-Luna**, Finance Budget Analyst, DOF
- **Iliana Ramos**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 19: BOND MEASURE TO FUND BEHAVIORAL HEALTH RESIDENTIAL TREATMENT SETTINGS

PANEL

- **Michelle Baass**, Director, DHCS
- **Nicole Eberhart**, PhD, Senior Behavioral Scientist, RAND Corporation (*Remote*)
- **Diana Vazquez-Luna**, Finance Budget Analyst, DOF
- **Iliana Ramos**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ITEMS TO BE HEARD

HEALTH EQUITY

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ISSUE 1: CALHHS/CDPH: EQUITY CENTERED PROGRAMS BUDGET CHANGE PROPOSAL (BCP)

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- **Rohan Radhakrishna**, Deputy Director, Office of Health Equity (OHE), CDPH
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- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, Legislative Analyst's Office (LAO)

PROPOSAL

CalHHS requests to transfer $182,000 General Fund and1.0 permanent AGPA position to CDPH to perform a retrospective analysis of the intersection of the COVID-19 pandemic and health disparities and equity. The purpose of this analysis is to help the State better understand how health disparities fueled the pandemic and what can be done to mitigate such disparities during future crises. This position was approved as part of the 2021-22 Equity-Centered BCP for CHHS; this request is to shift the previously authorized work from CalHHS to CDPH.

BACKGROUND

The Administration provided the following background information:

The COVID-19 pandemic has highlighted systemic racism and discrimination that has created social, economic, and health inequities contributing to disproportionately higher infection and mortality rates for both chronic and infectious diseases; and COVID-19 incidence has been disproportionate in Black, Latino, and Pacific Islander populations. The higher prevalence of underlying health conditions such as diabetes, obesity, and hypertension among communities of color increases the likelihood of more severe outcomes.

California was the first state in the nation to implement a health equity metric as part of the Blueprint for a Safer Economy framework. The equity metric requires counties to demonstrate an improvement in COVID-19 test positivity rates in neighborhoods facing the most severe impacts. Addressing differential infection rates in disadvantaged communities is critical to safely reopening California's economy. Health equity has been a key focus of the Administration and the COVID-19 pandemic has accelerated the need for additional action. The Administration states that this proposal builds on these efforts to address the need for a more culturally and linguistically competent and responsive health and social services system.

Member Request:

Assemblymember Calderon has submitted a request to the Subcommittee for CDPH to include in this analysis the economic impact of Long COVID on California's women in the preliminary analysis. Assemblymember Calderon states the following:

> "CDPH defines Long COVID as new, returning, or lingering symptoms after infection from the virus. These symptoms can include fatigue, shortness of breath, and chronic muscle pain that persists after having COVID-19. A recent study by the PHOSP-COVID Collaborative Group tracked the recovery of COVID patients in the United Kingdom for over a year. It was found that women were less likely than men to make a full recovery. Women experienced symptoms associated with more severe ongoing health impairments, which affected their ability to work and provide for their families.
>
> The impact of experiencing Long COVID reaches beyond the additional strain on the medical system. It can further exacerbate gender wage gaps, increase household debt, and deplete retirement savings. Gaps in employment can be especially devastating for single mothers, single-income households, and communities of color. Acquiring Long COVID data is essential to including women in economic recovery efforts after the pandemic. Amending AB 128 to include this data will benefit the women of our state at no additional cost."

STAFF COMMENTS/QUESTIONS

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

1. What is the proposed or anticipated timeline for this analysis?
2. How will CDPH share the final analysis with the Legislature and public?
3. Please provide a response to Assemblymember Calderon's request (described above).

Staff Recommendation: Subcommittee staff recommends asking for a commitment from CDPH to incorporate the economic impacts of Long COVID on women into their analysis, per Assemblymember Calderon's request, and recommends approval of this proposal at a future hearing with this commitment.

ISSUE 2: CDPH: PUBLIC HEALTH REGIONAL CLIMATE PLANNING REVERSION

PANEL

- **Linda Hellland**, Climate Change & Health Equity Section Chief, OHE, CDPH (*Remote*)
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

The Governor's budget proposes to "revert" (i.e., cut from the budget) $25 million which was approved through a CDPH BCP in last year's budget on Public Health Regional Climate Planning. The Governor's budget makes restoration of this reduction contingent on a trigger which could restore the funding in January of 2024.

BACKGROUND

The Administration provided the following background information in the 2022 BCP:

Climate change is considered the greatest global public health threat of the 21st Century and is impacting human health now.

United Nations Secretary-General António Guterres has called climate change "a code red for humanity. The alarm bells are deafening, and the evidence is irrefutable." The UN chief said that despite the peril, solutions were clear: "Inclusive and green economies, prosperity, cleaner air and better health are possible for all, if we respond to this crisis with solidarity and courage."

In September 2021, more than 200 medical journals–including the New England Journal of Medicine and The Lancet–published an unprecedented joint statement warning that climate change is the "greatest threat" to global public health and urging world leaders to reduce heat-trapping emissions to avoid "catastrophic harm to health that will be impossible to reverse."

In October 2021, the World Health Organization released the "COP 26 Special Report on Climate Change and Health: The Health Argument for Climate Action." The report's ten recommendations propose a set of priority actions from the global health community to governments and policy makers, calling on them to act with urgency on the current climate and health crises. The recommendations were developed with over 150 organizations and 400 climate and health experts to inform governments and other stakeholders ahead

of the 26th Conference of the Parties (COP26) of the United Nations Framework Convention on Climate Change and to highlight opportunities for governments to prioritize health and equity in the international climate agenda. Simultaneously, more than 600 organizations representing 46 million health workers worldwide signed a "Healthy Climate Prescription" letter urging national leaders and country delegations to take rapid and strong action to address the health emergency of the climate crisis.

The Biden administration's Health and Human Services Agency has recently established an Office of Climate Change and Health Equity, with a vision similar to that of the CDPH Office of Health Equity's Climate Change and Health Equity Section (CCHES), and has reached out to collaborate with CDPH.

In California, communities across the State have responded to increasing, and sometimes devastating, health impacts associated with climate change in recent years, including injury, illness, and death from wildfires and wildfire smoke, extreme heat, drought, landslides, extreme weather events, vector-borne diseases, and associated mental health impacts (see Figure 1). Similar to the disproportionate impacts of COVID-19 on low-income populations and communities of color, climate change also harms those already facing inequities first and worst.

2020 was a historic year for California wildfires, seeing 9,917, including the largest wildfires in state history, which collectively destroyed a record 4.26 million acres, burned down towns and timberlands, and produced smoke that covered over 3,000 miles and turned day into darkness in parts of the state. According to California Department of Forestry and Fire Protection (CAL FIRE), the number of wildfires and square miles burned in 2021 has outpaced even the record year of 2020: from January 1 through December 17, 2021, 8,786 fires burned 4,014 square miles compared to 8,112 fires and 2,255 square miles burned during approximately the same period last year.

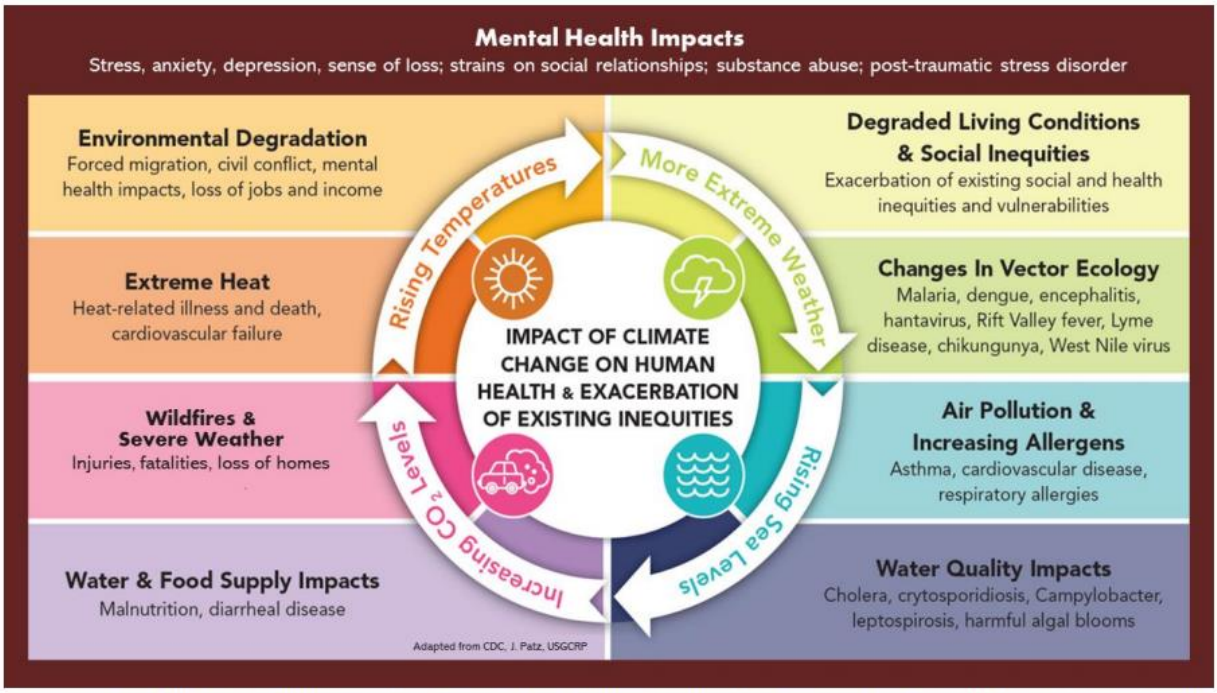

Figure 1. Impact of Climate Change on Human Health and Exacerbation of Existing Inequities (CDPH Climate Change and Health Equity Section; adapted from CDC, J. Patz, USGCRP).

Western wildfires are now about 44 percent more likely than they were prior to the 1980s due to the influence of climate change, which has increased temperatures and dried out forest fuels. More than 7 percent of Californians currently live in high-risk wildfires areas. If greenhouse gas emissions continue to rise, the frequency of large wildfires will increase by nearly 50 percent, and the average area burned statewide will increase by 77 percent by the end of the century. Nearly every Californian breathed severe wildfire smoke at some point in 2020, and 88 percent of the population was exposed in 2021. Exposure to wildfire smoke can exacerbate asthma and chronic obstructive pulmonary disease, respiratory infections, and some cardiovascular effects, and lead to low-birthweight babies, and deaths. Researchers estimate that wildfire smoke during August and September 2020 may have led to as many as 3,000 excess deaths among elderly Californians. Similarly, research concluded that in addition to the 106 deaths caused directly by the 2018 California wildfires, the associated wildfire smoke and air pollution led to an estimated 3,652 additional deaths.

In August 2020, and again in July 2021, the highest temperatures ever reliably recorded on Earth—130 degrees Fahrenheit—occurred in Southern California. As severe heat worsens over coming decades due to climate change, it is projected to result in up to 4,300 excess deaths per year in the state in 2025, increasing to up to 11,300 excess deaths per year by 2050. Exposure to high temperatures can cause heat-related illnesses, such as heat cramps, heat rashes, heatstroke, heat exhaustion, and even death. High heat has been associated with acute renal failure, stroke, diabetes, and suicide, and high heat during pregnancy increases risks of congenital heart disease, pre-term delivery, and stillbirth. Some outdoor workers and indoor workers not in climate-controlled environments are at higher risk from exertional heat stroke. In July 2021, a heat

dome over the Pacific Northwest (where many houses in the usually temperate region do not have air-conditioning and residents are thus more vulnerable to heat) resulted in a historic heat wave with hundreds of associated deaths. A devastating event like this could well happen to similar temperate regions of California, particularly coastal communities that have not historically needed air-conditioning. In addition, not all deaths that may be due to climate-related extreme heat are recorded as extreme heat deaths, resulting in an undercount of health impacts from heat. In fact, 599 deaths were reported as due to extreme heat in California from 2010 to 2019, but an analysis of excess deaths during heat waves by the Los Angeles Times estimated that the actual number of deaths may have been as high as 3,900.

As heat waves and droughts have been intensifying in California due to climate change, their effects impacted Californians in this past decade and their disease burdens are expected to increase further into the future resulting in many more cases and deaths. Major climate-sensitive infectious diseases include vector-borne diseases that are transmitted by mosquitoes, ticks, fleas, or other vectors; waterborne and foodborne diseases such as Legionnaires' disease, Salmonella and E.coli O157 and Vibrio infections; and soil- or dust-borne coccidioidomycosis (Valley Fever).

Psychological impacts from any disaster greatly exceed physical injury. Mental health impacts are increasing along with climate-related disasters. Extreme weather events can exacerbate existing mental health challenges. Estimates range from about 25 to 50 percent of survivors of extreme weather events having some kind of mental health issue following the event. Higher temperatures increase emergency room visits for mental health outcomes, homicide, and suicide in California, with females, Hispanics, and children 6 to 18 years old at highest risk.

In sum, climate change affects virtually all aspects of health and well-being, including access to basic needs of clean air, food, water, shelter, and physical safety. Catastrophic events like wildfires, droughts, and floods not only directly result in injuries, deaths, and displacement, but also loss of livelihoods, businesses, crops, and homes—contributing to unemployment, poverty, and the housing crisis. Direct impacts and subsequent cascading effects increase chronic diseases, infectious diseases, mental health challenges, and heat- and smoke-related illnesses. Climate change impacts are widespread and happening now. The economic impacts of climate change are significant as well: the greatest share of economic impacts of climate change on county economies are due to mortality, resulting in billions of dollars of losses each year in California.

Climate change affects every Californian, but some communities and individuals experience worse health impacts from the crisis than others. People with existing health conditions, people inadequately housed, outdoor workers, certain communities of color, immigrants, the very young or elderly, pregnant people, people with disabilities, those who have low incomes, and those who are socially isolated face disproportionate risk of harm from climate impacts. Without adequate financial resources, people are less likely

to have air conditioning or air filters to counter heat waves, worsening air quality, and wildfire smoke. The same people may not have reliable vehicles to escape when climate-related danger approaches. These communities are also more likely to live with higher levels of air pollution, which worsens on warmer days and during wildfire smoke events. Deep reductions in greenhouse gas emissions that also reduce air pollution would reduce air pollution mortality in California by about 55 percent by mid-century.

Local health departments (LHDs) are on the front lines preparing for and responding to the health impacts of climate change, and also express the urgent need to address climate change. This is evidenced by the California Conference of Local Health Officers (CCLHO) adopting climate change as one of three priorities for 2019, 2020, and 2022. Seventy percent of California public health officers said they do not have adequate information to respond to climate change, although 94 percent perceived it to be a health threat." In 2018, the Bay Area Health Inequities Initiative (BARHII) conducted focus groups with staff from 20 LHDs and 6 subject matter expert stakeholders to assess LHD capacity and needs to take action to address climate change and health. BARHII found that respondents consistently reported a need for a State-administered climate change and health program that provides staffing resources to LHDs, support for community engagement, training, and technical assistance. LHDs are tasked by statute to lead health-related activities in their jurisdictions to detect health threats, reduce and prevent illnesses, injuries, and deaths. Only two LHDs currently have full-time staff dedicated to addressing the health impacts of climate change.

In addition to these LHD needs, tribal communities are one of the most vulnerable groups to the effects of climate change, since tribes do not have the same capacity to relocate or adapt to climate threats. Disproportionate adverse impacts resulting from climate change, including lack of representation in governmental planning efforts, are significant issues facing tribal governments. Tribal health programs are uniquely qualified to engage with tribes, and they express a need for dedicated public health resources to adequately address the health impacts of climate change on tribal communities.

STAFF COMMENTS/QUESTIONS

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

1. How did CDPH plan to distribute these funds ($25 million)?
2. Was this intended to be a grant program for local health jurisdictions and Tribal health programs?
3. Please explain the methodology proposed to be used for the trigger associate with this, and other, proposed budget cuts.

Staff Recommendation: Subcommittee staff recommends holding this item open to allow for additional time for consideration.

ISSUE 3: CDPH: PROTECTING CHILDREN FROM THE DAMAGING EFFECTS OF LEAD EXPOSURE, SPRING FINANCE LETTER (SFL) ISSUE 315

PANEL

- **Maria Ochoa**, Deputy Director, Center for Healthy Communities, CDPH
- **Michelle Gibbons**, Executive Director, County Health Executives Association of California (CHEAC)
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH is requesting 2 positions and $9.7 million from the Childhood Lead Poisoning Prevention (CLPP) Fund in 2023-24, 2024-25, and 2025-26 and $6.1 million CLPP Fund in 2026-27 and ongoing to provide services to children with blood lead levels that meet or exceed the Centers for Disease Control's (CDC) updated Blood Lead Reference Value (BLRV) and to support new lead poisoning prevention activities.

BACKGROUND

The Administration provided the following background information:

The Childhood Lead Poisoning Prevention Branch (CLPPB) is supported by fees assessed and collected annually from lead polluters. Most of these funds are distributed to 48 Local Health Jurisdictions (LHJs) that conduct lead poisoning prevention and case management services in their jurisdictions under a contract with CLPPB.

The State provides direct lead poisoning prevention and case management services to 13 LHJs and provides oversight to 48 contracted LHJs including:

- Training and supporting public health nurses and environmental professionals in local programs to provide appropriate services.
- Providing lead test results to local programs.
- Performing statewide surveillance.
- Performing statewide data analysis.
- Providing guidance on the provision of effective outreach.
- Providing technical assistance.

LHJ funding that is supported by the CLPP Fund is allocated proportional to the need. LHJ allocations are calculated based on the number of Medi-Cal eligible children under six years of age, the number of children living in older housing, and the number of children

with elevated Blood Lead Levels (BLLs) within each jurisdiction. Health and Safety Code Section 105301(b) defines elevated BLLs to be BLLs no higher than the BLRV specified by the CDC.

In 2019, the California State Auditor (CSA) recommended that the CLPP Program focus more on primary prevention, in alignment with the Legislature's intent granting CDPH broad statutory authority to implement a program to prevent childhood lead poisoning. The report recommended CDPH take steps to support LHJ activities that directly result in a reduction in the number of children with lead poisoning. CDPH instituted progress trackers and accountability measures for the 2020-2023 contract cycle to evaluate the work done by LHJs.

The 2020 Budget Act included $2.1 million ongoing CLPP Fund for LHJs to begin implementing CSA's recommendations to improve the prevention of childhood lead poisoning in California. CLPPB then underwent a strategic planning process with LHJ involvement and feedback in 2021 to more fully address the findings of the CSA audit to inform the LHJ Scope of Work (SOW) for the upcoming contract cycle.

Additionally, in October of 2021, CDC updated the BLRV from 5 µg/dL to 3.5 µg/dL. Implementation in California of the CDC's guidance of lower BLRV will begin with the 2023-2026 LHJ contracts. The lower BLRV will increase the number of children in need of lead poisoning basic case management services. It is anticipated that this will more than double the number of children requiring services beginning in 2023-24 based on the estimated number of children who fall within this lower threshold of blood lead level and the expected testing rates for these children.

This proposal will enable CLPPB to initiate implementation of the new workload for case management as a result of the lowered BLRV and for increased SOW activities based on the CSA recommendations.

This proposal will help provide early intervention for children with increased BLLs, reduce additional exposure, align lead poisoning prevention services with the guidance of CDC and American Academy of Pediatrics, provide services to the increased number of children that meet or exceed CDC's updated BLRV, and allow the CLPP Program to increase primary prevention efforts to align with the latest public health science and guidance from the CSA.

The CLPP Fund is intended to fund CDPH's efforts in preventing childhood lead poisoning and provide case management services to children with elevated BLLs. The proposed 2023-26 LHJ SOW includes detailed guidance to LHJs to improve primary prevention to further address the CSA recommendations. New SOW activities include:

- Implementing mechanisms to leverage funding for healthy housing.
- Tracking referrals made, and families provided short-term lodging during remediation according to local standard operating procedures (SOP).
- Documenting SOPs for connecting tenants with low-cost legal services.
- Tracking results of enforcement actions taken to improve lead-related construction work compliance.
- Implementing interventions based on criteria to lower cost of abatement and increased property owner compliance.
- Tracking the percentage of families referred to partner organizations who are provided successful interventions to address unsafe housing conditions.
- Additional funding in the upcoming 2023-26 contract cycle will allow LHJs to provide comprehensive lead poisoning prevention and direct case management services at the levels needed to effectively reduce childhood lead poisoning.

Of the $9.7 million, $5.9 million will be allocated for basic case management services to be performed by State and Local staff and $3.6 million will be allocated to develop and enhance local general prevention measures outlined in the 2023-2026 SOW proposed by contracted LHJs. CDPH will evaluate the effectiveness and actual costs of the selected lead prevention activities during the 2023-2026 contract period and submit a proposal in 2026-27 with an updated SOW for lead prevention activities that reflects findings from the first three years of implementation.

Of the $9.7 million requested, $214,000 will be allocated in State Operations to establish 2 positions. These positions will support direct services provided by State and Local Public Health Nurses, Community Health Workers and Environmental Professionals that perform case management, care coordination, and environmental investigations to identify and remove lead sources.

STAFF COMMENTS/QUESTIONS

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

1. Does CDPH have authority to increase the fees as necessary to cover the increasing costs of the program?

2. Does CDPH have any way to measure outcomes in order to evaluate the effectiveness of this program?

Staff Recommendation: Subcommittee staff recommends approval of this proposal at a future hearing.

ISSUE 4: EMSA: DIVERSITY, EQUITY, AND INCLUSION STRATEGIC PLAN DEVELOPMENT BCP

PANEL

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

PROPOSAL

EMSA requests $100,000 General Fund in 2023-24 to contract with a consultant to assist in the development of a Diversity, Equity, and Inclusion Strategic Plan that aligns with California Health and Human Services Agency (CalHHS) initiatives to reduce health inequities and disparities and to support EMSA's emergency medical service (EMS) System Strategic Priorities. The consultant will lead the development of an EMSA Equity Workgroup to develop and implement a Diversity, Equity, and Inclusion Strategic Plan, which will include the following:

- Maximize community partnerships and stakeholder collaboration;
- Incorporate health equity concepts and measures into EMSA programs and policies;
- A strengths, weaknesses, opportunities, and threats analysis;
- A mission, a vision, objectives, strategic goals, tasks, and action items;
- Key performance indicators and baseline metrics;
- Develop mechanisms to collect detailed EMS Personnel workforce data;
- Develop mechanisms to collect detailed patient demographic and health outcomes data;
- Secure training and host forums for EMSA staff on the impact of EMS workforce diversity and cultural competency training on patient health outcomes; and
- Establish key performance indicators and baseline metrics.

BACKGROUND

The Administration provided the following background information:

As a department within the CalHHS Agency, EMSA was tasked with achieving the following goals to address pre-hospital EMS patient and workforce inequities:

1. Participate in a newly-established Justice, Equity, Diversity, and Inclusion (JEDI) subcommittee within the CalHHS Interdepartmental Advisory Council by appointing an executive-level Chief Equity Officer for membership;

2. Join the Capitol Collaborative on Race & Equity (CCORE) 2024-2025 Learning Cohort Program of government officials to learn about, plan for, and implement activities that embed racial equity approaches into institutional culture, policies, and practices;

3. Incorporate equity priorities in department strategic planning for internal and external stakeholders; and

4. Contribute to the development of CalHHS's Equity dashboard and enhance EMS workforce equity training and inclusion in services.

As noted by CalHHS, "over the last several years, federal, state, and private entities have moved to recognize and respond to long-standing social, economic, and health inequities." On the federal level, President Biden issued Executive Order 13985, Executive Order (Order) on Advancing Racial Equity and Support for Underserved Communities through the Federal Government. The Order requires allocating federal resources to "advance fairness and opportunity, promotes the equitable delivery of government benefits and equitable opportunities, and requires engagement with members of underserved communities."

CalHHS's Guiding Principles include a focus on equity and emphasize that CalHHS must be a leader in the fight for equity and strive to create programs that address persistent and systemic inequities. To create a state where all citizens can have an opportunity to thrive, CalHHS must identify and remove barriers that impede certain groups and individuals from achieving optimal health and wellness because of the color of their skin, gender identity, sexual orientation, age, or disability.

Health equity has been a key focus of the Administration, and the COVID-19 Pandemic has accelerated the need for additional action. It is critical that Californians of all ages, abilities, and backgrounds have equitable access to the conditions that optimize health. This is especially critical for communities who have experienced socioeconomic disadvantage, historical injustice, and other avoidable systemic inequities. To do this, EMSA must coordinate with CalHHS so that its policies and programs are strategically aligned to further statewide equity goals.

As such, the EMSA, in collaboration with EMS and healthcare provider stakeholders, has drafted a California Emergency Medical Services system strategic plan to include the goal of creating an equitable and transparent EMS system for the state of California.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA present this proposal and respond to any questions raised by the members of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for more time to evaluate the proposal in light of the General Fund deficit.

ISSUE 5: DHCS: CALIFORNIA CANCER EQUITY ACT (SB 987) BCP

PANEL

- **Lori Walker**, Deputy Director & Chief Financial Officer, Department of Health Care Services (DHCS)
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Andrew Duffy**, Principal Program Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS, Managed Care Quality and Monitoring Division (MCQMD) and Quality and Population Health Management (QPHM), request 3.0 permanent positions, four-year limited term (LT) resources equivalent to 1.0 position, and expenditure authority of $1,062,000 ($458,000 General Fund (GF); $604,000 Federal Fund (FF)) in fiscal year (FY) 2023-24, $726,000 ($292,000 GF; $434,000 FF) in FY 2024-25 through FY 2026-27, and $581,000 ($219,000 GF; $362,000 FF) in FY 2027-28 and ongoing to implement the provisions of SB 987 (Portantino, Chapter 608, Statutes of 2022).

BACKGROUND

The Administration provided the following background information:

These resources are needed to implement and maintain the new workload resulting from the bill's requirements to verify that Medi-Cal managed care health plans (MCPs) make good faith efforts to contract with a National Cancer Institute (NCI)-Designated Cancer Center, a site affiliated with the NCI Community Oncology Research Program, or a qualifying academic cancer center (herein referred to as cancer centers) in their counties of operation. DHCS will need to develop a cancer center referral program for enrollees with a complex cancer diagnosis, as defined; provide technical assistance to MCPs; develop any necessary monitoring tools; conduct ongoing monitoring activities; take corrective action, when necessary; and develop a process, in consultation with stakeholders, to continually update and further define complex cancer diagnosis for the purposes of these cancer center referrals.

DHCS contracts with MCPs to provide medically necessary health care to MCP members under a per-member-per-month capitated rate. MCPs negotiate reimbursement rates with individual providers and determine which health care providers they choose to include within their contracting provider networks. MCP members must use plan-contracted health care providers, except in limited circumstances where out-of-network access is allowed (e.g., emergency services and family planning services).

Pursuant to Title 42 of the Code of Federal Regulations Sections 438.68, 438.206, and 438.207, and Welfare and Institutions Code Section 14197, MCPs are responsible for ensuring that their contracted provider networks are adequate to serve their member populations in a timely manner. MCPs must annually submit documentation to DHCS to demonstrate the adequacy of their networks for the upcoming calendar year. DHCS is required by federal and state law to certify each MCP's aggregate network annually for a prospective review of their networks. MCPs must also meet time or distance standards based on the population density of the county for designated provider types.

SB 987 requires MCPs to make good-faith efforts to include at least one cancer center within their contracted and subcontracted provider networks within each county in which they operate for the provision of medically necessary services to members diagnosed with a complex cancer diagnosis. Eligible members have the right to request a referral to these in-network cancer centers. In instances where an MCP is unsuccessful in its good faith contracting efforts, members can still request a referral to an out-of-network cancer center; however, this access is limited to when the MCP and the out-of-network cancer center are able to come to agreement in terms of payment. The bill also requires DHCS, in consultation with stakeholders, to develop a process for updating and further defining "complex cancer diagnosis" on a periodic basis.

DHCS is responsible for setting the policy for MCP implementation of the bill; contracting with an external consultant, with expertise on the topic(s), for the purposes of developing a process, in concert with appropriate stakeholders, to update and further define complex cancer diagnosis for purposes of the referral program; working with appropriate stakeholders to continually update and further define complex cancer diagnosis as recommended; and conducting ongoing monitoring activities to verify MCP compliance with the bill's contracting and referral requirements and taking corrective action, when necessary. DHCS states that the requested resources are needed to lead policy development and implementation related to the bill's addition of cancer centers to MCP networks and the right to request a referral to both in and out-of-network cancer centers for eligible members; provide technical assistance to MCPs; provide clinical support and expertise; perform initial and ongoing monitoring activities and take corrective action, when necessary; and contract and collaborate with an appropriate external consultant and work with stakeholders, as necessary, to update the definition of "complex cancer diagnosis" on a periodic basis.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to any questions raised by members of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends approval of this proposal at a future hearing.

ISSUE 6: HBEX: $1 PREMIUM SUBSIDY AUGMENTATION, SFL ISSUE 20

PANEL

- **Joseph Donaldson**, Finance Budget Analyst, DOF
- **Matt Aguilera**, Principal Program Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

PROPOSAL

The Administration requests that Item 4800-101-0001 be increased by $350,000 General Fund in fiscal year 2023-24 and annually thereafter to support the One-Dollar Premium Subsidy Program. This increase is necessitated by increased enrollment, causing the current appropriation of $20 million to be insufficient. This program provides payments to qualified health plan issuers for providing access to reproductive health services for beneficiaries and supporting a woman's right to choose. These funds will serve an estimated 29,000 additional enrollees.

BACKGROUND

The Administration proposed the following, which was approved, in 2021:

It is requested that Item 4800-101-0001 be increased by $20 million ongoing, and corresponding statutory changes made, to provide payments, on or after January 1, 2022, of no less than one dollar to qualified health plan issuers on behalf of qualified individuals enrolled in a qualified health plan through the exchange in the individual market that equal the cost of providing abortion services for which federal funding is prohibited.

The Legislature supported this 2021 proposal in order to make health coverage as affordable and accessible as possible through Covered California, California's Health Benefit Exchange. Prior to the 2021 budget, Covered California enrollees were billed a $1 premium separately from their other monthly premium, creating confusion and in some cases being the only premium billed to the enrollee.

STAFF COMMENTS/QUESTIONS

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

1. Is there a way to fund this based on enrollment estimates, rather than with a flat amount, as proposed, which may be too much funding, or too little funding, depending on fluctuations in enrollment?

Staff Recommendation: Subcommittee staff recommends approval of this proposal at a future hearing.

HEALTH CARE LICENSING AND SENIORS

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 7: FACILITATING PROJECTS TO BENEFIT NURSING HOME RESIDENTS BCP

PANEL

- **Michelle Bell**, Office of Internal Operation Chief, Center for Health Care Quality (CHCQ), CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests $5 million in 2023-24, $5 million in 2024-25, and $3 million in 2025-26 from the Federal Health Facilities Citation Penalties Account (Account) to support projects benefitting nursing home residents. CDPH also requests corresponding provisional language allowing for encumbrance or expenditure through June 30, 2027.

BACKGROUND

The Administration provided the following background information:

The Code of Federal Regulations (CFR) 42 Part 488.430 allows CMS to impose monetary penalties against skilled nursing facilities (SNFs), nursing facilities (NFs), and dually certified SNF/NFs that are not in substantial compliance with one or more Medicare and Medicaid participation requirements for Long-Term Care Facilities. A portion of these Civil Money Penalty (CMP) Funds collected from nursing homes are returned to the states in which CMPs are imposed. State CMP funds may be reinvested to support CMS approved activities that protect or improve the quality of life of nursing home residents. Health and Safety Code Section 1417.2 (a) establishes the Federal Health Facilities Citation Penalties Account (Account) into which moneys derived from CMPs for violations of federal law shall be deposited. CDPH provides contract management and oversight on behalf of CMS for all approved projects in California.

All states must submit to CMS an acceptable plan for the use of CMP funds for the upcoming calendar year. This plan must include available fund balances, current obligations, and plans for solicitation and review of future projects. CMS uses the data from California's CMP state plan to verify that federal CMPs are being properly distributed. If states are unable to adequately plan for the use of their CMP funds, then

CMS may withhold future disbursements of CMP funds to the state until the state has submitted an acceptable plan to comply with this section.

To date, State CMP funds have supported projects to provide staff training, improve mental health, and build relationships to improve quality of life for residents of SNFs. For example, LifeBio's Improving Person Centered Care through Engagement, Reminiscence Therapy, and Life Stories produces personalized story books about nursing home residents to strengthen their connections with facility staff. Tobin's Life Bridge program applies concepts of person-centered care and introduces coping mechanisms to better approach residents with behavioral outbursts and other challenging behaviors. Vohra Wound Physicians Management, LLC's California Wound Care Excellence Program enables participating nurses to receive online training and obtain wound care certification.

In the winter of 2020-21, the State of California experienced a surge in the number of people infected by and hospitalized with COVID-19. As a result, facilities imposed limitations on all in-person activities. Not only were residents unable to participate in in-person activities, but CMP grantees were also unable to enter to facilitate projects. As a result, grantees did not have expenditures for 2019-20, 2020-21, and 2021-22. As the COVID-19 pandemic begins to dissipate, CDPH projects that grantees will again be able to enter facilities and perform activities related to their projects.

Since 2015-16, CHCQ has been actively soliciting CMP projects within the available resources. For any potential CMS-approved project that may exceed the Account's existing expenditure authority, provisional language in the Annual Budget Act allows the Department of Finance to increase the expenditure authority from the Account after review of a request submitted by CDPH that demonstrates a need for additional authority.

The 2020 Budget Act included a $6 million augmentation in local assistance expenditure authority from the Account in 2020-21, 2021-22, and 2022-23. In 2023-24, the local assistance appropriation decreases to $575,000. This proposal will restore expenditure authority and allow DPH to award CMP project grants.

CDPH has seen a marked increase in the number of CMP applications submitted since 2017-18, and anticipates that the number of applications received and approved in the future will be similar to the volume observed in recent years. Currently there are two projects pending CDPH and CMS approval totaling $2. 2 million in 2023-24 and 2024-25, and $1.9 million in 2025-26 that can potentially affect the Account budget in those fiscal years. CDPH is requesting an augmentation of $5 million in 2023-24 and 2024-25 and $3 million in 2025-26, allowing CDPH to execute more multi-year contracts for current and future CMS-approved projects in a timely manner. As previously mentioned, the local assistance authority in the Account is scheduled to drop to $575,000 in 2023-24, which would prevent CDPH from timely awarding funds for CMS-approved projects.

Existing provisional language which authorizes the Department of Finance to increase the expenditure authority from the Account for approved CMP projects, after review of a request submitted by CDPH that demonstrates a need for additional authority, will be maintained. Based on current trends, CDPH anticipates a continued significant number of applications received, thus necessitating timely contract development and a need for expenditure authority to award funds to CMS approved projects to benefit nursing home residents. Furthermore, CHCQ requests provisional language allowing encumbrance or expenditure through June 30, 2027. This will allow CHCQ more flexibility to fund and execute multi-year agreements without having to complete a budget revision.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by members of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends approval of this proposal at a future hearing.

ISSUE 8: INTERNAL DEPARTMENTAL QUALITY IMPROVEMENT ACCOUNT PROVISIONAL LANGUAGE, SFL

PANEL

- **Michelle Bell**, Office of Internal Operation Chief, CHCQ, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH requests that provisional language be added to Item 4265-004-0942 that authorizes the Department of Finance to augment expenditure authority to support quality improvement activities, upon review of a request from CDPH, from the Internal Departmental Quality Improvement Account (IDQIA), which collects revenue from penalties assessed on facilities. The following is the proposed provisional language:

Add Provision 1 to Item 4265-004-0942 as follows:

1. The Department of Finance may augment this item, after review of a request submitted by the State Department of Public Health that demonstrates a need for additional expenditure authority to support quality improvement activities. Any augmentation shall be authorized not sooner than 30 days after notification in writing to the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or the chairperson's designee, may determine.

BACKGROUND

The Administration provided the following background information:

Since 2010-11, the Legislature has appropriated moneys in the IDQIA to be expended for internal CHCQ improvement activities as follows:

Fiscal Year	BCP Description
2010-11	BCP 002/HQ-03: 2010-11 $18,000; 2011-12 $393,811 and 2012-13 $299,677 for the partial costs of 1.5 positions for the Health Facility Self-Reporting Web Portal. BCP 058/HQ-05 for contracts for quality improvements within L&C.
2012-13	BCP 002/HQ-06: 2012-13 $333,000; 2013-14 $333,000; and 2014-15 $334,000 for implementation of quality improvement activity in the L&C Program. This activity will initiate and support ongoing efforts aimed at reducing preventable medical and medication errors and their associated health care costs in licensed health care facilities.
2013-14	November Estimate: $1.2 million; and 2014-15 $1.2 million to prevent infections in California's acute care hospitals, to improve the quality of data used by customers for making health care decisions, and to continue funding eight contractor positions in the Healthcare Associated Infections (HAI) Program's Infection Preventionist (IP)Liaison Unit.
2014-15	BCP 000/HQ-01: $1.4 million to expand the work related to the L&C Program Evaluation project. In order to meet CMS benchmarks, CHCQ used a contractor, Hubbert Systems Consulting, to evaluate ways to improve internal business practices and quality improvement efforts to achieve timely fulfillment of the L&C Program's state licensing and federal certification workload. BCP 000/HQ-04: $201,000 for a contract with UC Davis for an independent research analysis and report that describes the extent to which the federal certification standards are or are not sufficient as a basis for state licensing standards as required by SB 543 (Chapter 722, Statutes of 2013).

Fiscal Year	BCP Description
2015-16	BCP 004/HQ-03: $2 million to implement projects recommended by Hubbert report. These funds were used to purchase hardware and software to develop internal and external performance dashboards, automate key business practices, and streamline data collection from regulated entities. Further, CHCQ executed contracts to improve hiring, onboarding, and retention practices. CHCQ also used the funds to contract with a project manager/change consultant.
2016-17	4265-015-BCP-DP-2016-GB: $2 million to execute two contracts to implement recommendations from the Hubbert report. These funds were used to enhance the Centralized Applications Branch's Information Technology (IT) systems, replace the Health Facilities Consumer Information System with Cal Health Find, and complete contracted services for project and change management, recruitment, and onboarding and retention.
2017-18 – 2019-20	4265-007-BCP-2017-GB: $2 million to execute quality improvement projects and contracts ($2 million in 2017-18, $2 million in 2018-19, and $2 million in 2019-20). These funds were used for contracted services for leadership training programs, facilitation of stakeholder forums, project and change management, recruitment, and onboarding and retention. Further, CHCQ executed several multi-year purchase orders for IT service contracts, such as Adobe Experience Manager maintenance and enhancements, and data architecture consulting services. Additionally, CHCQ is using these funds to complete an automated licensing application system as required by Assembly Bill (AB) 2798 (Chapter 922, Statutes of 2018), as well as a Program Flex online application portal. CHCQ will continue to use these funds to contract for innovative recruitment and retention services and technological enhancements in the coming years.
2020-21 – 2022-23	4265-202-BCP-2020-MR: $3 million to execute quality improvement projects and contracts ($3 million in 2020-21, 2021-22, and 2022-23). These funds have been used to obtain expert level IT consulting assistance in support of business services and technical operations, including the development of the Risk and Safety Solutions mobile survey app for COVID mitigation surveys, Complaint and FRI investigations, and state licensing surveys. The consulting firm will provide skilled resources to aid with solution development and platform operations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by members of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends approval of this proposal at a future hearing.

ISSUE 9: REMOVAL OF FEDERAL HEALTH FACILITIES CITATION PENALTIES ACCOUNT AWARD LIMIT TRAILER BILL

PANEL

- **Michelle Bell**, Office of Internal Operation Chief, CHCQ, CDPH
- **Nick Mills**, Finance Budget Analyst, DOF
- **Sonal Patel**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

CDPH proposes trailer bill to remove the cap on penalty funds from the Federal Health Facilities Citation Penalties (FHFCP) account that may be used to improve the quality of care and life for long-term care (LTC) facility residents.

The full language can be found here:
https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/805

BACKGROUND

The Administration provided the following background information:

Per Health and Safety Code (HSC) sections 1424(c)(1), 1424(d)(1) and 1424(e)(1), and Title 42 of the Code of Federal Regulations (CFR) 488.438(a)(1), violations of state and federal law can result in LTC facilities paying civil penalties ranging from $100 to $25,000 per incident for a violation of state law and from $50 to $10,000 per day for a violation of federal law, depending on the severity of the violation.

Per 42 CFR 488.433(a), a portion of federal penalties collected from LTC facilities are returned to the states in which they are imposed. HSC 1417.2(a) and 1417.2(c) require these penalty funds to be deposited in the FHFCP account and may be reinvested to support Centers for Medicare & Medicaid Services (CMS) approved activities that protect or improve the quality of life of LTC facility residents. In accordance with 42 CFR 488.433(c) and 488.433(e)(1), CDPH provides contract management and oversight on behalf of CMS for all approved projects in California.

AB 1397 (Soto, Chapter 545, Statutes of 2007) created separate penalty accounts for state and federal civil penalties and established a $130,000 annual cap on the amount of money from the FHFCP account that the California Department of Public Health (CDPH) may spend each year. This amount has not increased in the 15 years since the passage of AB 1397.

Although CMS does prohibit costs that appear excessive or unreasonable, CMS does not specify a ceiling amount for project costs. Additionally, CMS has already approved multiple projects exceeding the current state limit. This proposal would align state law with Federal guidelines.

CDPH states that removing the spending cap is necessary to allow CDPH to fund projects that improve the lives of LTC facility residents and satisfy CMS guidance regarding the use of these penalty funds.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and provide some examples of projects that have been supported with these funds.

Staff Recommendation: Subcommittee staff recommends approval of this trailer bill at a future hearing.

ISSUE 10: RADIOLOGIC HEALTH BRANCH LICENSING AND CERTIFICATION TRAILER BILL, SFL

PANEL

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

PROPOSAL

CDPH proposes trailer bill to revise the denial, suspension, and revocation procedures associated with certain licenses and certifications authorized by CDPH's Radiologic Health Branch so that they are in alignment with the criteria used by the California Podiatric Medicine Board, Pharmacy Board, Physical Therapy Board, and CDPH's Clinical Laboratory Technologist and Nursing Assistant certification programs. The proposed amendments will also expand the civil penalty authority included in the Radiologic Technology Act to cover all statutory and regulatory violations related to medical radioactive material and X-ray machine use.

The full language can be found here:
https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/867

BACKGROUND

The Administration provided the following background information:

Current law prevents CDPH from taking disciplinary actions against applicants and authorized individuals who have been convicted of crimes substantially related to their duties. This limitation prevents CDPH from taking licensing action to deny, limit or condition, suspend, or revoke a certificate or permit against a certificate or permit holder when that person has committed a crime that increases the public's risk of future, similar criminal conduct.

At present, the civil penalty is limited only to violations related to mammography procedures, which impedes CDPH's ability to enforce violations associated with medical X-ray and medical radioactive material procedures. With no penalty provision, even for repeat violations, CDPH's options for bringing authorized individuals into compliance are constrained to license suspension and revocation actions.

By revising CDPH's denial, suspension, or revocation procedures and aligning CDPH's existing radiation certification program authority with other similar licensing programs in the State, such as those overseen by the California Medical Board, the Pharmacy Board, the Physical Therapy Board, and CDPH, the state will be able to take actions necessary to protect patient care and the integrity of professional practice. Updating provisions in both the Radiologic Technology Act and the Nuclear Medicine Technologist certification law will provide the same level of patient protection as other existing California licensing programs. The civil penalty authority will be applicable to all health care radioactive drug use and X-ray machines procedures.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by members of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends approval of this proposal at a future hearing.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 11: MEDI-CAL: SHORT-TERM COMMUNITY TRANSITIONS (SB 281) BCP

PANEL

- **Lori Walker**, Deputy Director & Chief Financial Officer, DHCS
- **Tom Heinz**, Executive Director, East Bay Innovations (*Remote*)
- **Hersh Gupta**, Finance Budget Analyst, DOF
- **Andrew Duffy**, Principal Program Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS, Integrated Systems of Care Division (ISCD), Home and Community-Based Services (HCBS) Policy Branch, and HCBS Operations Branch, requests a three-year extension of 2.0 limited-term (LT) resources and expenditure authority of $286,000 General Fund (GF) in fiscal year (FY) 2024-25 through FY 2026-27 to continue to implement and maintain the workload of the temporary, state-funded California Community Transitions (CCT) Program created by the passage of SB 214 (Dodd, Chapter 300, Statutes of 2020) and extended by the passage of SB 281 (Dodd, Chapter 898, Statutes of 2022).

BACKGROUND

The Administration provided the following background information:

Individuals who have received care in an institution for an extended period of time face an array of challenges when looking to transition back into the community, including a lack of understanding about the availability of, and access to, HCBS, and a significant statewide lack of accessible and affordable housing. The temporary, state-funded CCT program provides the opportunity for eligible beneficiaries to transition earlier than the 60-day period required to be eligible for the MFP Rebalancing Demonstration, before they have lost community supports and/or resources and find themselves “stuck” in the facility.

In January 2007, the Centers for Medicare and Medicaid Services (CMS) awarded DHCS the Money Follows the Person (MFP) Rebalancing Demonstration Grant. The MFP Rebalancing Demonstration (also known as the CCT Program in California) is authorized under Section 6071 of the Federal Deficit Reduction Act of 2005 and extended by the Affordable Care Act (ACA) of 2010 and a series of short-term federal amendments and appropriations in 2019 and 2020.

Under the MFP Rebalancing Demonstration (which is also a part of the California Olmstead Plan), eligible individuals of all ages with disabilities have the opportunity to receive transition coordination services to assist them with the transition process from an institution to the community, and to connect them with the Long-Term Services and Supports (LTSS) they require to remain at home or in the community. Prior to the passage of the federal Consolidated Appropriations Act (CAA) of 2021, the MFP Rebalancing Demonstration authorized DHCS to draw down enhanced match funding to transition eligible individuals who had resided in an in-patient facility for at least 90 days (the CAA of 2021 amended the eligibility criteria to 60 days, as noted below) to the community setting of their choice. To be eligible to receive MFP Rebalancing Demonstration services, a person had to have continuously resided in a state-licensed health care facility for a period of 90 consecutive days or longer, with at least 1 day paid by Medi-Cal (facility stays for short-term rehabilitation services reimbursed by Medicare are not counted toward the residency period). DHCS contracts with CCT Lead Organizations (LOs) that employ or contract with transition coordinators who work directly with willing and eligible individuals, support networks, and providers, to facilitate transitions and monitor individuals for 365 days after they have transitioned to the community.

During the demonstration period, which begins on the day of discharge and lasts 365 days, CCT participants live in their own homes, apartments, or in approved community care facilities, and receive LTSS that are included in the person-centered, comprehensive, transition and care plans they develop with the assistance of their transition coordinator. After the demonstration period, individuals who remain eligible for Medi-Cal continue to receive Medi-Cal and other home and community-based services where they live.

The COVID-19 public health emergency (PHE) has had a significant impact on long-term care institutions, given that they house older adults and people with disabilities with underlying chronic conditions who are more susceptible to serious complications from COVID-19 illness. In an effort to reduce the risk of transmission of COVID-19, in September 2020, the Governor signed SB 214, which required DHCS to establish a temporary, state-funded CCT program and provide services consistent with the MFP Rebalancing Demonstration for transitioning eligible Medi-Cal beneficiaries out of an inpatient facility who have resided in that setting for fewer than 90 days.

Shortly after SB 214 was signed, the federal CAA of 2021 extended funding for the MFP Rebalancing Demonstration through 2023. It also amended the MFP eligibility criteria by reducing the minimum length of time required in an inpatient facility before an individual can qualify for the MFP Rebalancing Demonstration from 90 days to 60 days.

SB 214 policies took effect immediately as an urgency statute. Under the temporary program, new enrollments into the program would end on January 1, 2023, services would end on January 1, 2024, and the bill’s provisions would sunset on January 1, 2025.

SB 281 amends the articles that SB 214 added to the Welfare and Institutions Code (WIC), effectively extending SB 214 by authorizing DHCS to continue the temporary, state-funded CCT program for three years past the dates established by SB 214; DHCS is now required to cease enrollment of beneficiaries commencing January 1, 2026, cease providing services on January 1, 2027, and the bill's provisions will sunset on January 1, 2028.

SB 281 extends the goals of SB 214 and aligns with the MFP Rebalancing Demonstration provisions of the CAA of 2021 by reducing the minimum length of time required in an inpatient facility before an individual can qualify for the temporary, state-funded CCT program, from fewer than 90 days to fewer than 60 days.

This program is intended to both reduce the risk of COVID-19 transmission during the current pandemic and further the objectives of the MFP Rebalancing Demonstration for an additional three years.

SB 281 also authorizes DHCS to implement, interpret, or make specific the bill's provisions by means of letters, bulletins, or similar instructions without taking regulatory action.

Stakeholder Concerns

Stakeholders have shared concerns with the Subcommittee stating that the reimbursement rates for CCT have been flat since the program was created in 2007, pointing out that there has been no increase in 16 years to account for inflation and increases in labor costs.

Advocates state that: "California used to have a robust group of providers doing nursing facility transitions through the CCT Program. However, due to challenges with the low rates, difficulty getting reimbursed, and high turnover in the department – mainly due to the temporary nature of the pilot program - the number of CCT providers has dwindled down to less than 20."

Stakeholders point out that HCBS like CCT ultimately save the state millions of dollars by avoiding unnecessary institutionalization. According to an Assembly Appropriations analysis from August 2022, these transition services resulted in a projected savings of $34.4 million for 2022-2023 ($19.4 million General Funds).

Stakeholders believe that the CCT program is a critical program that should be made permanent, with the infrastructure and rates needed to ensure adults with disabilities and seniors have an opportunity to transition back to the community with the least number of barriers. Given these concerns, East Bay Innovations requests:

1. Adoption of reporting requirements for DHCS on the following:

    - CCT reimbursement rates, methodology, reviews, and adjustments for all CCT service codes and modifiers (including but not limited to: transition coordination, habilitation, family and informal caregiver training, personal care services, home set-up, home modification, vehicle adaptations, and assistive devices) from 2007 to the present;
    - All demographic data for the Community Care Transitions (CCT) project from 2007 to the present regarding: (a) Age, (b) Ethnicity, (c) Gender, (d) Primary language, and (e) Level of care (i.e. NF-A/B, Subacute, Acute);
    - CCT general fund costs per year since 2007;
    - CCT general fund cost savings per year since 2007; and
    - Medi-Cal reimbursement rates for skilled nursing facilities since 2007.

2. Approval of a 40 percent rate increase for CCT providers, at an estimated General Fund cost of $5.8 million.

STAFF COMMENTS/QUESTIONS

Programs like the CCT both save the state money, by helping people leave expensive institutional care, and improve the quality of life for these patients. For these reasons, the Legislature has been pushing for greater state support of the CCT for many years, particularly when ongoing federal funding has been uncertain. Shortly before the pandemic, the Subcommittee had received a proposal from stakeholders to use state General Fund to replace federal funding (which appeared to be ending), and the Department of Finance confirmed that the proposal overall would result in savings to the state.

The Subcommittee requests DHCS to present this proposal, and respond to the concerns and requests of stakeholders.

The Subcommittee requests East Bay Innovations describe the challenges and short-comings of the CCT program.

Staff Recommendation: Subcommittee staff recommends approval of the administration's proposal, and adoption of Supplemental Report Language that requests the information being requested by stakeholders, at a future hearing.

ISSUE 12: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) MONITORING AND PROGRAM OPERATIONS BCP

PANEL

- **Lori Walker**, Deputy Director & Chief Financial Officer, DHCS
- **Hersh Gupta**, Finance Budget Analyst, DOF
- **Andrew Duffy**, Principal Program Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS, Integrated Systems of Care Division (ISCD) and the Office of Legal Services (OLS) requests 10.0 permanent positions and expenditure authority of $1,678,000 ($713,000 General Fund (GF); $965,000 Federal Fund (FF)) in fiscal year (FY) 2023-24 and $1,588,000 ($674,000 GF; $914,000 FF) in FY 2024-25 and ongoing. The resources are necessary to meet all federal and state requirements related to the administration, operation, monitoring, and oversight of the Program of All-Inclusive Care for the Elderly (PACE).

BACKGROUND

The Administration provided the following background information:

ISCD is responsible for policy development, program administration, and quality monitoring and oversight of PACE. The PACE model of care provides a comprehensive health care and social service delivery system using an interdisciplinary team approach in a PACE center that provides and coordinates all needed preventive, primary, acute and long-term support services. The PACE model affords eligible individuals the opportunity to remain independent and in their homes for as long as possible.

Since the passage of the PACE Modernization Act (Chapter 30, Statutes of 2016), DHCS has experienced a surge in new PACE Organization (PO) applications and the expansion of existing POs. There are currently 21 operational POs in California, an increase of 10 new POs since the end of 2018. Additionally, the ISCD PACE Section is screening inquiries from 17 entities which have submitted intent to apply to become a PO in California, or are exploring opportunities to implement new PACE over the next 4 years.

DHCS's recent experience of steady growth of four to six new POs or PACE expansions per year has added additional workload to the existing DHCS staff allocated to PACE. As a result, ISCD has identified an immediate need for additional positions to support the continuous growth in PACE workload. The requested resources in this BCP are

necessary to properly and thoroughly review new PO requests and PO expansions. An expansive and meticulous review of PO applications is essential to ensure DHCS is contracting with PACE providers that are equipped to deliver the highest quality health care services to PACE participants, resulting in improved health outcomes for the PACE population. Additionally, the requested resources will establish a dedicated team to monitor contractual, federal, and/or state requirements to verify and protect the health and safety of all participants. In addition, the growth of the PACE program requires a dedicated team to investigate and respond to inquiries, complaints, and grievances; and to perform program assessments and program compliance. Securing the requested resources will fortify the current work being done in PACE. This will guarantee the program's growth is matched with staff that can safeguard the quality of care delivered to PACE participants.

DHCS states that the continued growth of PACE necessitates increased resources to adequately monitor and improve the program's performance. Additionally, it is essential that DHCS is sufficiently staffed to promptly investigate and address complaints and health/safety concern. One of the strongest tools ISCD utilizes to verify compliance and delivery of quality services is regular and ad hoc audits of all POs. Audits are required to be performed by the state, and are an extremely critical monitoring and oversight function. As PACE expands, there will be a respective increase in the number of audits to perform, analyze, and track. Without sufficient staffing resources, ISCD is at risk of being unable to properly complete PACE audits, thus being ineffective in ensuring PACE is properly monitored and overseen.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to any questions raised by members of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends approval of this proposal at a future hearing.

ISSUE 13: POST ELIGIBILITY TREATMENT OF INCOME TRAILER BILL

PANEL

- **Lori Walker**, Deputy Director & Chief Financial Officer, DHCS
- **Hersh Gupta**, Finance Budget Analyst, DOF
- **Andrew Duffy**, Principal Program Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS proposes trailer bill to amend the Welfare and Institutions (W&I) Code in order to align its Long-Term Care (LTC) policy with federal guidelines; specifically, how DHCS describes the cost sharing provisions for individuals subject to the Post-Eligibility Treatment of Income (PETI) and spenddown of excess income to become eligible for Medi-Cal, and Notices of Action for individuals in LTC. Specifically, this proposal would:

- Expand the definition of "share of cost" to include "spenddown of excess income" in the Medically Needy statute to maintain share of cost as a valid term with legal meaning while introducing the new term of spenddown of excess income. California is transitioning away from the term share of cost (W&I Code Section 14054).

- Replace references of "share of cost" to "spenddown of excess income" as California is moving away from using the term share of cost. The term spenddown of excess income will be used to explain that in order for individuals to become eligible for Medi-Cal through the Medically Needy Program, they have to spenddown their excess income (W&I Code Sections 14005.7, 14005.9, 14005.11, 14005.12, 14005.21, 14005.26, 14005.32, 14005.41, 14005.42, 14009, 14011, 14011.65, 14011.8, 14015, 14015.12, 14016, 14019.4, 14054, 14132, 14132.56, 14132.95, 14148.5, and 14154.5).

- Define "PETI" as the determination of LTC Patient Liability for each month, as specified (W&I Code Section 14051.7).

- Define "LTC Patient Liability" as the term that will be used as a result of the PETI calculation for individuals who are institutionalized and liable to pay a portion of their income for the cost of long term care before Medi-Cal will begin to pay (W&I Code Section 14051.8).

- Explain that for persons in LTC, any income deductions with the exception of other health insurance premiums shall not be deducted in the PETI determination (W&I Code Section 14005.95).

- Replace references to "share of cost" to "LTC Patient Liability" as California is moving away from using the term share of cost (W&I Code Sections 14005.13, 14006.4, 14100.8, and 14132.99).

The full language can be found here:
https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/847

BACKGROUND

The Administration provided the following background information:

California currently operationalizes its LTC program in the Medically Needy (MN) program. Institutionalized individuals are transitioned into the MN program where the PETI rules are applied for ease of administration. The scope of the individual's coverage remains the same as their original program coverage.

DHCS has used the term share of cost (SOC) to describe the PETI rules for many years and has applied the PETI rules correctly and in accordance with the federal regulations. However, DHCS uses the SOC terminology to explain both the PETI rules and the concept of spenddown of excess income in order to be eligible for the MN program interchangeably.

The federal Centers for Medicare and Medicaid Services (CMS) and consumer advocates raised concerns with the use of the SOC terminology in the Notices of Action and requested DHCS revise the Notices of Action to more appropriately communicate with beneficiaries the PETI rules in a consumer-friendly way and to remove the SOC terminology and to align our LTC Notices of Action with DHCS' operational practices.

In summary, DHCS states that these changes would align state statute with federal guidelines in order to be in compliance with CMS' LTC policy recommendation, address concerns raised by stakeholders, and provide guidance to the counties to support the integrity and accountability of DHCS' policy requirements.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to any questions raised by members of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends approval of this proposal at a future hearing.

ISSUE 14: SKILLED NURSING FACILITIES (SNF) PAYMENT DELAYS

PANEL

- **Jennifer Snyder**, Legislative Advocate, California Association of Health Facilities
- **Michelle Baass**, Director, DHCS
- **Hersh Gupta**, Finance Budget Analyst, DOF
- **Andrew Duffy**, Principal Program Budget Analyst, DOF

PROPOSAL

The California Association of Health Facilities (CAHF) has shared with the Subcommittee that, since the transition of SNFs to managed care, many SNFs have not received payment from the managed care plans since January. In light of this situation, CAHF is requesting amendments to the administration's proposed budget trailer bill (related to CalAIM implementation) to address these payment delays. Specifically, CAHF requests the following two amendments, and provided the accompanying explanations:

Require Medi-Cal Managed Care Plans to provide retroactivity in contracts with Skilled Nursing Providers.

Medi-Cal managed care plans may arrange for skilled nursing care for Medi-Cal beneficiaries by contracting with providers through contracts or alternative arrangements including a letter of agreement, a single-case agreement or paying for out of network services. Use of non-contract arrangements often occurs at the discretion of the managed care plan which elects not to enter into contracts for various reasons including reduced administrative burden and increased flexibility to amend provider relationships. Skilled nursing providers that provide care under an arrangement other than a contract are not recognized as network providers and care days provided outside of a contract are not eligible for supplemental payment programs such as the DHCS Workforce and Quality Incentive Program (WQIP). This places nursing facilities with little to no leverage to assure they will receive quality incentive directed payments for services provided to Medi-Cal patients.

CAHF requests amendments to the CalAIM trailer bill which would require all health plan contracts executed prior to July 1, 2024 to be retroactive to January 1, 2023. The retroactivity would only apply to long term care custodial contracts to maintain a nursing facility's eligibility for directed quality incentive payments.

CAHF requests the following amendment be added to WIC 14184.201(b):

> *(4) Medi-Cal managed care plan contracts that are offered to skilled nursing facilities certified for Medi-Cal participation within the counties served by the Medi-Cal managed care plan as well as to each skilled nursing facility outside of such counties that is providing or has been requested to provide skilled nursing services to members of the managed care plan shall be retroactive to January 1, 2023 for long term care custodial payments. This paragraph shall remain in effect until July 1, 2024.*

Require health plans to report network utilization and timely payment compliance specifically for long term care facilities and make these reports publicly accessible.

Health plans are not required to provide information to the Department of Health Care Services that tracks their compliance with network adequacy and timely payments separately for long term care facilities. Unfortunately, lack of data prevents the accountability necessary to assure that health plans are executing appropriate contracts and providing timely payments to nursing facilities. As of January 1, 2023 with the integration of Long Term Care Services and Supports into CalAIM, most nursing homes have not received a Medi-Cal payment from a health plan consistent with the timely payment requirement of 45 days. Nursing facilities rely almost completely on government funds for patient care services so three months without any payment for services has a significant impact on their ability to provide services, pay their staff and ultimately keep their doors open.

CAHF requests that following amendment be added to Section 14184.201 of the Welfare and Institutions Code:

> *(h) A Medi-Cal managed care plan shall submit to the department, in a manner specified by the department, data on Medi-Cal beneficiary placement in skilled nursing facilities within 5 business days, 7 business days, or 14 calendar days of a request, depending on the county of residence, pursuant to Welfare and Institutions Code section 14197 (d)(2); data on timely payment to network contracted and non-contracted skilled nursing facility providers within 30 business days, 45 business day, and 90 business days of claim submission; and data on Medi-Cal beneficiary utilization of the skilled nursing facility benefit. The department annually publish a public report on reported data by January 1.*

BACKGROUND

CAHF provided the following background information:

Long term care facilities are struggling to stay open and viable as they work to recover from the COVID-19 pandemic. Extreme workforce challenges, new infrastructure requirements and the implementation of Medi-Cal managed care for long term care providers have created an overwhelming situation for these essential 24-hour nursing care facilities. Recent studies show that over 50% of nursing homes in California are operating in the red. With 20% operating at 7% percent below their costs. For example, in 2021, of the skilled nursing facilities in Fresno County, 48 percent had an operating margin below -1.7%.

CAHF states: "These two requested amendments will strengthen CalAIM statutory requirements and ensure that Medi-Cal beneficiaries have stable access to SNF services from network providers, ensure more equitable treatment of SNF providers by managed care plans and make sure nursing facilities are receiving timely payments as required by statute. Without these amendments, CAHF's long term care facility members will be at risk of closure and unable to receive the needed Medi-Cal directed quality incentive payments they have earned, through providing care to Medi-Cal beneficiaries."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CAHF explain the problem being raised here, as well as CAHF's proposed solution, and requests DHCS provide reactions to this issue and proposed trailer bill solutions.

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for ongoing conversations with the Administration and stakeholders.

MENTAL HEALTH MODERNIZATION

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 15: MENTAL HEALTH SERVICES ACT: HISTORY AND OVERVIEW

PANEL

- **Darrell Steinberg**, Mayor, City of Sacramento / Founder, Steinberg Institute
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission (OAC)

PROPOSAL

On March 19, 2023, as part of Governor Newsom's "State of the State Tour," the Governor announced a 2024 ballot initiative to improve how California responds to mental health needs, substance use disorders, and homelessness. The following is an outline of the key components of the Governor's proposal:

1. Authorize a $3-$5 billion general obligation bond to fund unlocked community behavioral health residential settings and provide housing for homeless veterans.

2. Modernize the Mental Health Services Act (MHSA):

    - Revise MHSA funding allocations to 30 percent for housing and enhanced care in residential settings for individuals with serious mental illness/serious emotional disturbance and/or substance use disorder (SUD); 35 percent for Full Service Partnerships (FSP); and 35 percent for other services including Community Services and Supports (non FSP), Prevention and Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, and prudent reserve.

    - Authorize MHSA funding to provide treatment and services to individuals with SUD but do not have a co-occurring mental health disorder.

    - Require counties to bill Medi-Cal for all reimbursable services.

    - Reduce allowable prudent reserve amounts from 33 percent to 20 percent for large counties and 25 percent for small counties and reassess prudent reserve balances more frequently from every 5 years to every 3 years.

- Authorize up to 2 percent of local MHSA revenue to fund administrative needs.

- Pare back the requirements for three-year program and expenditure plans.

- Require that the Commission become advisory under the California Health and Human Services Agency and its Executive Director to be a gubernatorial appointee.

3. Improve statewide accountability and access to behavioral health services:

    - Require counties to report more detailed fiscal information including allocations and unspent funds.

    - Develop outcome measures, not just process measures.

    - Require the Department of Managed Health Care and the Department of Health Care Services to develop a plan for achieving parity between commercial and Medi-Cal mental health and substance use disorder benefits.

BACKGROUND

The Commission provided the following background information on the MHSA:

In 1967, California shut down many state hospitals for people with severe mental health challenges without adequately funding community-based mental health services to serve them. The impacts of that deinstitutionalization were many and lasting and notably included many people with unmet mental health needs experiencing homelessness.

To address the urgent need for accessible, community-based mental health services focusing on recovery, California voters in 2004 approved Proposition 63, also known as the Mental Health Services Act (MHSA). This sweeping law calls for transformation of the mental health system while improving the quality of life for Californians living with mental health challenges.

The MHSA levies a 1 percent tax on personal incomes above $1 million and generates enough dollars each year to fund nearly 25 percent of the state's public mental health system. Its proceeds support a wide range of prevention, early intervention, treatment services, and the development of the infrastructure, technology, and workforce needed to deliver them.

The MHSA provided the first opportunity in many years to expand county mental health programs for all populations, including children, transition-age youth, adults, older adults, families, and most significantly, the unserved and underserved.

However, the economy took a severe downturn soon after Prop 63 passed, and in many cases, rather than expanding the continuum of services, counties used MHSA money to maintain current levels of services because it was the only source of stable funding.

Over time, the vital role Prop. 63 money plays in maintaining county services grew: Funds from the Act initially accounted for 10 percent of California's public mental health budget, and that number is now approximately 24 percent.

The MHSA has the following 5 components:

1. **Community Services and Supports**

   CSS, the largest component, is 76 percent of county MHSA funding. CSS funds direct services to individuals with severe mental illness. These services are focused on recovery and resilience while providing clients and families an integrated service experience. CSS has four service categories:

   - Full Service Partnerships
   - General System Development
   - Outreach and Engagement
   - MHSA Housing Program

   W&I Code Section 5892 requires counties to allocate 80% of MHSA funds to the CSS component and to allocate 5% of those funds to the INN component. Five percent of 80% equals 4%. Eighty percent minus 4% equals 76%. Therefore, W&I Section 5892 requires counties to allocate 76% of total MHSA funds to the CSS component.

   Full Service Partnerships

   Full Service Partnerships (FSPs) consist of a service and support delivery system for the public mental health system's (PMHS) clients with the most complex needs, as described in W&I Sections 5800 et seq. (Adult and Older Adult Systems of Care) and 5850 et. seq. (Children's System of Care). The FSP is designed to serve Californians in all phases of life that experience the most severe mental health challenges because of illness or circumstance. FSPs provide substantial opportunity and flexibility in services for a population that has been historically underserved and greatly benefits from improved access and participation in quality mental health treatment and support services. FSPs provide wrap-around or "whatever it takes" services to clients. The majority of CSS funds are dedicated to FSPs.

General System Development

General System Development (GSD) funds are used to improve programs, services, and supports for all clients consistent with MHSA target populations. GSD funds help counties improve programs, services, and supports for all clients and families. Counties also use GSD funds to change their service delivery systems and build transformational programs and services. For example, counties may use GSD funds to include client and family services such as peer support, education and advocacy services, and mobile crisis teams. GSD programs also promote interagency and community collaboration and services, and develop the capacity to provide value-driven, evidence-based and promising clinical practices. Counties may only use this funding for mental health services and supports to address mental illness or emotional disturbance.

Outreach and Engagement Activities

Outreach and engagement activities target populations who are unserved or underserved. The activities help to engage those reluctant to enter the system and provide funds for screening of children and youth. Examples of organizations that may receive funding include, but are not limited to, racial-ethnic community-based organizations, mental health and primary care partnerships, faith-based agencies, tribal organizations, and health clinics.

MHSA Housing Program

The Mental Health Service Act Housing Program was developed in 2008 as a result of voter approved Proposition 63 and offers permanent financing and capitalized operating subsidies for the development of permanent supportive housing to serve persons with serious mental illness and their families who are homeless or at risk of homelessness. The MHSA Housing Program sunset in 2016.

2. Capital Facilities and Technological Needs

The CF/TN component provided funding from FY 2007-08 to enhance the infrastructure needed to support implementation of MHSA, which includes improving or replacing existing technology systems and/or developing capital facilities to meet increased needs of the local mental health system. Counties received $453.4 million for CF/TN projects and had through FY 2016-17 to expend these funds.

Counties must use funding for Capital Facilities to acquire, construct, and/or renovate facilities that provide services and/or treatment for those with severe mental illness or that provide administrative support to MHSA funded programs.

Counties must use funding for Technological Needs for county technology projects that contribute toward improving access to and delivery of mental health services.

3. Workforce Education and Training

In 2004, MHSA allocated $444.5 million for the WET component. These funds support counties and the Department of Health Care Access and Information (HCAI) (previously, the Office of Statewide Health Planning and Development) to enhance the public mental health workforce.

Local WET Programs

In FY 2006-07 and FY 2007-08, counties received $210 million of the total allocation for local WET programs. They had through FY 2016-17 to expend these funds.

Statewide WET Programs

Pursuant to W&I Section 5820, HCAI develops and administers statewide programs to increase the number of qualified personnel in the mental health workforce serving individuals who have a serious mental illness. In 2008, $234.5 million was set aside from the total $444.5 million WET allocation for state administered WET programs. From 2008 to 2013, the former Department of Mental Health (DMH) administered the first Five-Year Plan of $119.8 million. The Legislature transferred responsibility for administering the plan to HCAI in 2013. The HCAI is administering the 2020-2025 WET Plan supported with $15 million General Fund and $45 million MHSF as of the 2021 Budget Act.

4. Prevention and Early Intervention

The MHSA allocates 19 percent of MHSA funds distributed to counties for PEI programs and services. The overall purpose of the PEI component is to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for underserved populations. The PEI component enumerates outcomes that collectively move the PMHS from an exclusive focus on late-onset crises to inclusion of a proactive “help first” approach.

5. Innovation

The MHSA allocates five percent of MHSA funds distributed to counties for the INN component, which provides counties the opportunity to design and test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of the INN component is to infuse new, effective mental health approaches into the mental health system, both for the originating county

and throughout California. The purpose of an INN project is to increase access to underserved groups, increase the quality of services including measurable outcomes, promote interagency and community collaboration, or increase access to mental health services, including but not limited to, services provided through permanent supportive housing.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked this panel to provide an overview of the history of the MHSA for purposes of evaluating the MHSA reforms that are part of the Governor's overall proposal. Issues 16-19 on this agenda examine the key components of the Governor's proposal more closely.

The Subcommittee requests the panelists respond to the following:

1. Who was involved with the development and drafting of Proposition 63 (MHSA) in 2004?

2. What are the key lessons learned from the past almost-20 years of the MHSA?

3. What were the goals of the drafters and supporters of Proposition 63 specific to the required set-asides for Prevention and Early Intervention (PEI) and Innovation (INN)?

4. What is known about what the counties have accomplished with PEI and INN funds?

Staff Recommendation: Subcommittee staff recommends that the Subcommittee urge the Administration to engage with consumers, peers and people with lived experience in the development of reforms to California's behavioral health system, and particularly the MHSA.

ISSUE 16: MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION: TRANSFER TO ADMINISTRATION

PANEL

- **Michelle Baass**, Director, DHCS
- **Andrea Wagner**, Executive Director, California Association of Mental Health Peer Run Organizations
- **Ivan Arellano**, Student, Imperial County High School
- **Carlos Gastelum**, Student, Imperial County High School
- **Aiyanna Hoffman**, Student, Imperial County High School
- **Dave Gordon**, Superintendent, Sacramento County Office of Education
- **Kelechi Ubozoh**, Author of *We've Been Too Patient: Voices from Radical Mental Health*, Lived Experience (*Remote*)
- **Bill Brown**, Sheriff, County of Santa Barbara
- **Robert Harris**, Legislative Advocate, SEIU California
- **Tyler Rinde**, Deputy Director of Child Welfare Policy, California Alliance of Child and Family Services
- **Toby Ewing**, Executive Director, OAC
- **Diana Vazquez-Luna**, Finance Budget Analyst, DOF
- **Iliana Ramos**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

The Governor's proposal includes shifting the Mental Health Services Oversight and Accountability Commission from its current independent status to be within the Health and Human Services Agency, thereby becoming a part of the Administration and no longer independent. The Administration asserts that this will "ensure their work is connected and coordinated with the State's overall behavioral health system."

Specifically, the Administration proposes:

- MHSOAC will continue to examine data and outcomes to identify key policy issues and emerging best practices and promote high-quality programs.

- MHSOAC will also continue to report to the Legislature and include representation from the Legislature, and maintain their responsibilities related to stakeholder engagement. Under the proposal, DHCS will provide oversight of the fiscal allocations and counties' use of funding, including accountability for contracted services.

- Require that the Commission would become advisory, and its Executive Director would be a gubernatorial appointee.

BACKGROUND

While the MHSA established the Commission, it did not specify its governance structure. As such, the Commission originally operated within the former State Department of Mental Health (DMH). In 2011, recognizing the ineffectiveness of the Commission at that time, and as part of the elimination of DMH, the Legislature initiated its restructuring, transitioning it to be an independent state entity outside of the Administration.

Since becoming independent, the Commission has evolved into a significant partner, voice, and thought leader on behavioral health. Many strategies and programs now supported by the Administration were initiated by the Commission, including the Mental Health Student Services Partnership Grant Program, allcove youth drop-in centers, early psychosis treatment programs, state suicide prevention efforts, and others. Moreover, many of the initiatives and projects supported by the Commission were initially opposed by the Administration, but supported by the Legislature.

As an oversight agency, the Commission regularly identifies state and local problems in the MHSA's implementation. For example, several years ago, the Commission informed the Legislature of the fact that the MHSA requires that county funds that have not been spent in three years revert back to the state. Yet this reversion of funds had simply discontinued when DMH was eliminated. As a result, the reversion process was clarified and restarted through budget trailer bill. More recently, the Commission has brought to the attention of the Legislature and Administration the fact that counties have created an unofficial reserve with an estimated $2-5 billion in unspent MHSA funds that, technically and legally, are spent within the required three years, but are not actually being spent because they roll over from one year to the next.

STAFF COMMENTS/QUESTIONS

Over the past decade, the Commission's role and authority has expanded beyond oversight, into the development of programs and policies, and to the promotion of evidence-based best practices. As a result, the Commission has made significant contributions to the overall mental health field, as authorized and required to do so through legislation, including both policy bills and budget trailer bills. The Legislature has consistently looked to the Commission for help and support with legislative priorities because the Commission has a commendable track-record dating back to it becoming an independent Commission. Arguably, the Commission's effectiveness is inextricably linked to its independence and small size, both of which allow it to be innovative, resourceful, nimble, and aggressive.

The Subcommittee requests the Administration present this proposal, and requests the other panelists share their perspectives on this proposal and/or their personal lived experiences.

Staff Recommendation: Subcommittee staff recommends the Subcommittee strongly urge the Administration to withdraw this component of the Governor's Mental Health Modernization proposal.

ISSUE 17: MENTAL HEALTH SERVICES ACT REFORM

PANEL

- **Michelle Baass**, Director, DHCS
- **Robert Harris**, Legislative Advocate, SEIU California
- **Ahmadreza Bahrami**, Division Manager, Public Behavioral Health, Fresno County (*Remote*)
- **Lishaun Francis**, Senior Director, Behavioral Health, Children Now
- **Tyler Rinde**, Deputy Director of Child Welfare Policy, California Alliance of Child and Family Services
- **Dannie Ceseña**, Executive Director, California LGBTQ Health and Human Services Network (*Remote*)
- **Toby Ewing**, Executive Director, OAC
- **Michelle Cabrera**, Executive Director, County Behavioral Health Directors Association (CBHDA)
- **Diana Vazquez-Luna**, Finance Budget Analyst, DOF
- **Iliana Ramos**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

The Governor's proposal seeks to modernize the Mental Health Services Act (MHSA) as described below.

Update Local Categorical Funding Buckets

30% for housing in residential settings for individuals with serious mental illness/serious emotional disturbance and/or substance use disorder.

- Counties will manage the funds and direct the funds toward local priorities that meet designated purposes including but not limited to rent subsidies, operating subsidies, shared housing, and nonfederal share for housing related Medi-Cal services. Capital investments will require authority from DHCS.

A services bucket with two sub-categories:

- 35% of the local assistance for Full Service Partnership (FSP) which should be optimized to leverage Medicaid as much as is allowable

- 35% for other services including Community Services and Supports (non FSP), Prevention and Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, and prudent reserve

To reduce overlap with the Children and Youth Behavioral Health Initiative and close the gap in preventive services, Prevention and Early Intervention (PEI) dollars for schools should be focused on school-wide behavioral health supports and programs and not services and supports for individuals.

Housing Interventions

- Dedicate 30% in local MHSA funding for housing interventions for people living with serious mental illness/serious emotional disturbance and/or substance use disorder who are experiencing homelessness. 30% is approximately $1 billion but will vary year to year.

- Funding could be used for full spectrum of housing services, rental subsidies, operating subsidies, capital and non-federal share for certain housing-related Medi-Cal covered services. It also could be used to further the California Behavioral Health Community-Based Continuum Demonstration.

- Funding for capital development projects, subject to DHCS limits established through bulletin authority.

Workforce

- Expand the use of local MHSA funds under the Workforce Education and Training (WET) component to include activities for workforce recruitment, development, and retention.

- The use of these funds could include professional licensing and/or certification testing and fees, loan repayment, stipends, internship programs, retention incentives, and continuing education and that increase the racial/ ethnic and geographic diversity of the workforce.

- In addition to expanding the local MHSA funds under WET, allocate MHSA funds to create a new Behavioral Health Workforce Initiative, while drawing down additional federal funds for a five-year period.

Broaden Target Population

- Authorize MHSA funding to provide treatment and services to individuals who have a debilitating substance use disorder (SUD) but do not have a co-occurring mental health disorder.

- Increase access to SUD services for individuals with moderate and severe SUD.

- Require counties to incorporate SUD prevalence and local unmet need data into spending plans. Use data to inform and develop accountability to improve the balance of funding for SUD.

Focus on Most Vulnerable

Adults

- Adults with serious mental illness (SMI) or substance use disorder (SUD) who are or at risk of experiencing homelessness or are or are at risk of being justice-involved, and/or meet the criteria for behavioral health linkages under the CalAIM Justice-Involved Initiative

- Adults with SMI at-risk of conservatorship

Children and Youth

- Children and youth with serious emotional disturbance or SUD, who are experiencing homelessness, are involved or at risk of being justice-involved, meet the criteria for behavioral health linkages under the CalAIM Justice-Involved Initiative or are in or transitioning out of the child welfare system

Fiscal Accountability and County Spending

- Require counties to bill Medi-Cal for all reimbursable services in accordance with Medicaid State Plan and applicable waivers, to further stretch scarce dollars and leverage MHSA to maximize federal funding for services.

- Reduce allowable prudent reserve amounts from 33% to 20% for large counties and 25% for small counties.

- Reassess prudent reserve more frequently from every 5 years to every 3 years.

- Authorize up to 2 percent of local MHSA revenue to be used for administrative resources to assist counties in improving plan operations, quality outcomes, reporting fiscal and programmatic data and monitoring subcontractor compliance for all county behavioral health funding.

Revise County Process

- Pare back the requirements for Three-Year Program and Expenditure Plans, standardize the level of detail and submission process, and provide additional flexibilities for transparent amendment process.

- Provide county behavioral health agencies with more flexibility to adjust spending.

- Transform the MHSA planning process into a broader county/region behavioral health planning process. Require counties to work with Medi-Cal Managed Care

Plans in the development of their Population Needs Assessments and with Local Health Jurisdictions in the development of their Community Health Improvement Plans and for these reports to inform the MHSA planning process to ensure strategic alignment of funding and local cross-system collaboration.

- Require plans be approved by boards of supervisors by June 30.

STAFF COMMENTS/QUESTIONS

As is always the case with public health, prevention is very difficult to measure. We may never know how many people didn't die from COVID due to effective prevention strategies such as isolation and mask wearing. Similarly, we can't count how many people have not died by suicide, or have not dropped out of school or been fired from their jobs, because they benefited from early psychosis treatment or a myriad of other prevention and early intervention programs funded by county MHSA dollars. Disinvesting in prevention can only increase the number of people who suffer from more severe illness resulting in destabilized lives.

The Subcommittee requests the Administration present this MHSA modernization proposal, and requests stakeholders on the panel provide their perspectives on this proposal. Please also respond to the following:

1. Under this proposal, do you anticipate that counties will continue to invest in PEI and INN?

2. Does Medi-Cal, and CalAIM specifically, cover the same types of PEI that is currently covered with MHSA funds?

3. What are the reasons that counties sometimes don't bill Medi-Cal even when providing and paying for Medi-Cal covered services?

4. Is it possible that deprioritizing children with mild to moderate behavioral health needs will ultimately lead to youth or adults with more severe needs later on?

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

ISSUE 18: IMPROVE STATEWIDE ACCOUNTABILITY AND ACCESS TO BEHAVIORAL HEALTH SERVICES

PANEL

- **Michelle Baass**, Director, DHCS
- **Mary Watanabe**, Director, Department of Managed Health Care (DMHC)
- **Dan Southard**, Chief Deputy Director, DMHC
- **Michelle Cabrera**, Executive Director, CBHDA
- **Toby Ewing**, Executive Director, OAC
- **Kiran Savage-Sangwan**, MPA, Executive Director, California Pan Ethnic Health Network (CPEHN)
- **Diana Vazquez-Luna**, Finance Budget Analyst, DOF
- **Iliana Ramos**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

The Governor's proposal seeks to improve statewide accountability and access to behavioral health services by addressing the following:

1. ***Fiscal Transparency***. Counties would be required to report:
    - Annual allocation of MHSA, Realignment, and all federal block grants;
    - Annual spend on non-federal match payments including MHSA, Realignment or other county sources;
    - MHSA, Realignment and Block Grant only spend;
    - Any other behavioral health investments using local General Fund or other funds;
    - Any unspent MHSA, Realignment or block grant funds for that fiscal year;
    - Cumulative unspent MHSA, Realignment or block grant funds, inclusive of reserves;
    - Admin costs; and
    - Information on services provided to persons not covered by Medi-Cal, including commercial insurance, Medicare, and uninsured.

2. ***County Accountability and Infrastructure***:
    - Develop outcome measures;
    - Align county behavioral health plans and Medi-Cal managed care plan contract requirements, including, but not limited to:
        - Require key administrative positions (e.g., quality director, chief financial officer, operations director, compliance officer)
        - Compliance oversight and monitoring of subcontractors

- Post on their website network adequacy filings, annual number of utilizers and utilization by service type
- Establish a robust set of quality metrics for county BH plans and establish quality thresholds/goals
- Require county BH plans annually report utilization and quality to Board of Supervisors (BOS) and require the BOS to attest that they are meeting their obligation under Realignment
- Require county BH plans to form member advisory council to inform policy and programs
- Implement closed loop referrals

3. ***Alignment between Medi-Cal and commercial coverage of behavioral health services***.
    - Over the next year, DMHC and DHCS will develop a plan for achieving parity between commercial and Medi-Cal mental health and substance use disorder benefits. This may include, but is not limited to, phasing in alignment of utilization management, benefit standardization, and covered services.

    - DMHC and DHCS will establish a stakeholder process that will include health plans, and other system partners to develop framework.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration present this proposal and requests stakeholders on the panel provide their perspectives on the proposal.

The Subcommittee also requests the OAC describe their Fiscal Transparency Tool as well as other oversight activities and functions of the OAC. Please also provide an update on county unspent MHSA funds.

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

ISSUE 19: BOND MEASURE TO FUND BEHAVIORAL HEALTH RESIDENTIAL TREATMENT SETTINGS

PANEL

- **Michelle Baass**, Director, DHCS
- **Nicole Eberhart**, PhD, Senior Behavioral Scientist, RAND Corporation (*Remote*)
- **Diana Vazquez-Luna**, Finance Budget Analyst, DOF
- **Iliana Ramos**, Principal Program Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

A key component of the Governor's proposal is to place a General Obligation Bond measure on the ballot in 2024 in order to generate $3-5 billion to "build thousands of new unlocked community behavioral health beds in residential settings to house Californians with mental illness and substance use disorders." A focus of these resources will be for housing homeless veterans. The proposal envisions two main types of housing/facilities, as follows:

- ***Multi-Property Settings***. Residential campus- style settings where multiple individuals can live, attend groups, recover, and further stabilize with a number of onsite supportive services.

- ***Cottage Settings***. Smaller residential settings, where many services will be available but will also allow individuals to access existing services in the community.

BACKGROUND

The RAND Corporation recently conducted research and analysis on California's psychiatric bed capacity, need and shortage. Their findings are published in a report, *Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California – 2021*, and the full report can be found here: https://www.rand.org/pubs/research_reports/RRA1824-1-v2.html

The RAND research sought to answer the following questions:

1. What are the levels of care represented by psychiatric bed infrastructure?
2. What will be the estimated need for psychiatric beds in the period from 2021 to 2026?
3. What are the primary drivers of California's psychiatric bed shortage?
4. Where is the greatest need among levels of care throughout the state?

5. What factors contribute to bottlenecks and flow issues in the psychiatric bed infrastructure?

Key findings:

The magnitude of California's need for adult psychiatric beds is expected to grow modestly over the next five years

- California faces an estimated 1.7-percent growth in its psychiatric bed need from 2021 to 2026.
- California's adult psychiatric bed capacity varies by region and by level of care.
- Growth in the need for psychiatric beds is projected to be largest in the Northern and Southern San Joaquin Valley.

California faces shortages of psychiatric beds at all three major levels of adult inpatient and residential care

- Synthesizing findings for bed capacity and bed need, the authors estimated that the state has a shortfall of approximately 1,971 beds at the acute level (6.4 additional beds required per 100,000 adults) and a shortage of 2,796 beds at the subacute level (9.1 additional beds required per 100,000 adults)—or 4,767 subacute and acute beds combined, excluding state hospital beds. Separately, the state faces an estimated shortage of 2,963 community residential beds.
- The authors noted significant regional differences in the estimated shortfall of beds at each level of care.

Hard-to-place populations contribute disproportionately to bottlenecks in the existing system

- A majority of psychiatric facilities at all levels of care reported an inability to place individuals with comorbid dementia or traumatic brain injury, nonambulatory individuals, those requiring oxygen, and those who tested positive for COVID-19. Individuals involved in the criminal justice system—particularly those with arson or sex offense convictions—were reportedly difficult to place in community residential settings.

Recommendations:

- California officials should prioritize psychiatric bed infrastructure where need is greatest, considering shortfalls according to both geographic region and level of care.

- California officials should focus on building or remodeling infrastructure for the most hard-to-place populations, such as those with criminal justice involvement who are unable to step down from subacute to community residential settings

because of a lack of facilities that can accommodate them at the lower level of care.

- California officials should consider establishing a mechanism by which psychiatric facilities report periodically on bed occupancy rates, wait list volume, number of requested transfers to higher and lower levels of care, psychiatric patient boarding in emergency departments, and sociodemographic and clinical information on patients who utilize psychiatric beds. This would allow California to have a precise and sensitive system for tracking the impact of investments that seek to address psychiatric bed shortages.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration present this proposal, and requests the RAND Corporation share their research findings and recommendations on psychiatric bed capacity, need, and shortage in California.

The Subcommittee also requests LAO and DOF provide information on state costs associated with general obligation bonds.

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

NON-PRESENTATION ITEMS

THERE ARE NO PANELS FOR NON-PRESENTATION ITEMS, HOWEVER ANY ITEM CAN BE MOVED TO PRESENTATION AT ANY TIME BEFORE OR DURING THE HEARING BY ANY MEMBER. AT THE END OF THE HEARING, PUBLIC COMMENT IS WELCOME ON ALL ITEMS ON THE AGENDA, INCLUDING THE NON-PRESENTATION ITEMS.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 20: APPOINTMENT OF A CHIEF MEDICAL OFFICER, SFL ISSUE 17

PROPOSAL

EMSA requests one permanent position and $312,000 General Fund in 2023-24 and ongoing to establish a Chief Medical Officer (CMO) position at EMSA.

BACKGROUND

The Administration provided the following background information:

Existing law requires the EMSA Director to be a licensed physician and surgeon (medical doctor (MD)) with substantial experience in the practice of emergency medicine. The EMSA Director's role requires a high level of public administration experience to effectively manage all aspects of the statewide emergency medical services (EMS) system. This includes managing nonclinical programs that include policy development and implementation, personnel licensure, disaster response operations, system design and organization, and legal review. Therefore, an ideal EMSA Director would need to be both a highly experienced emergency physician as well as an effective and experienced state public administrator. Historically these requirements have made filling the position exceptionally challenging, as the pool of interested candidates meeting these requirements is limited, and the state is also competing with the private sector when recruiting, which also contributes to increased recruitment difficulties.

The Administration has proposed statutory changes to remove the MD requirement from the Director position and add a CMO to EMSA's leadership team. This will assist EMSA with tapping into a broader candidate pool while at the same time focusing on the appropriate skillset regarding public administration and patient care. By removing the MD requirement from the Director position and amending Health and Safety Code to add a CMO, the Administration will be able to select an EMSA Director and CMO from a much broader qualified applicant pool, each with the necessary skill sets to effectively manage these critical functions across the organization.

The creation of a CMO position within the leadership team will address the clinical components needed for patient safety and care while bringing substantial experience in the practice of emergency medicine. The CMO position highlights the importance of having a physician as part of the leadership team who has a strong medical perspective and who can contribute to statewide decision-making and policy implementation.

The CMO's duties include approving revisions to the Standard Scope of Practice for all EMS providers, Local Optional Scope of Practice (LOSOP) Applications, and Trial Study applications. The CMO will also review and approve all LEMSA EMS plan sections having a clinical care impact, EMSA regulations that set clinical practice, training and continuing education standards, and Quality Improvement. Additionally, the CMO will also provide oversight of state-level Quality Improvement through California Emergency Medical Services Information System (CEMSIS) data analysis and reporting and EMSA response activities that affect patient care and outcomes, including:

a. Medical personnel qualifications (licensing requirements), staffing levels, and medical/pharmaceutical inventories for any medical teams sent into the field, such as California Medical Assistance Teams (CAL-MAT), Alternate Care Site (ACS) teams, Ambulance Strike Teams, etc.).
b. Clinical operations manual for any type of team sent out to support a Disaster Medical Services (DMS) response.

The EMSA Director will continue to oversee departmental operations, public administration, short-term and long-term strategic planning, and stakeholder engagement. This includes, but is not limited to, establishing internal and external organizational goals and objectives, managing EMSA personnel, administering budgetary activities to oversee continuity of operations, interfacing with elected officials and government leadership, collaborating with system stakeholders on policy issues, and maintaining operational readiness for disaster medical support and response.

Staff Recommendation: Subcommittee staff recommends that this proposal be evaluated in the context of the related proposed trailer bill language. Various stakeholders have requested amendments to that language and therefore the Subcommittee recommends urging the Administration to consider and respond to those requested amendments.

ISSUE 21: CALIFORNIA EMERGENCY MEDICAL SERVICES INFORMATION SYSTEM M&O, SFL ISSUE 15

PROPOSAL

EMSA requests $4.9 million General Fund in 2023-24 and $185,000 in 2024-25 for the maintenance and operations of the California Emergency Medical Services Information System (CEMSIS), so that EMSA can continue to monitor and continuously improve California's Emergency Medical Services (EMS) System to meet the patient and clinical care needs of its 39 million residents and 268 million visitors per year.

BACKGROUND

The Administration provided the following background information:

CEMSIS is a secure, centralized data system for collecting data about individual emergency medical service requests, patients treated at hospitals, and EMS provider organizations. CEMSIS uses the universal standard for collecting patient care information from an emergency 9-1-1 call for assistance, called the National Emergency Medical Services Information System (NEMSIS). CEMSIS provides the only statewide means of monitoring the care EMS agencies provide to Californians and those visiting our state, the overall health of the EMS system, and of identifying areas where local or statewide events are exerting strains on or imperiling that system. Throughout the COVID-19 pandemic, CEMSIS has proven an essential source of critical information for evaluating patient care.

CEMSIS is able to exchange data with other appropriate state and national data sources to create a timely, accurate, complete, uniform database that is used to assess the EMS system in California. CEMSIS has been designed to receive EMS, Trauma, Stroke, ST segment Elevated Myocardial Infarction (STEMI), and Emergency Medical Services for Children (EMSC) data electronically from each of California's 34 Local Emergency Medical Services Agencies (LEMSA). Data is necessary to assess performance, quality, utilization, and prevention benchmarks against existing national standards and inform EMS officials in making quality improvement policies for EMS and trauma care in California.

CEMSIS data related to EMS in California is currently captured locally by EMS provider agencies, trauma centers, stroke centers, STEMI centers, and EMS for Children (EMSC) EMSC centers, as required by Title 22 of the California Code of Regulations. In most cases, this data is transferred to one of California's 34 LEMSAs which are responsible for the administration of EMS in accordance with Division 2.5 of the California Health and Safety Code. The data reflects patient treatment in EMS, trauma, stroke, STEMI, and

EMSC, while outcome data includes trauma, stroke, STEMI, and EMSC cases at the local level based on local data collection standards.

Participation by LEMSAs in CEMSIS serves as a valuable tool for local EMS system quality improvement, improved EMS system management, and the ability to benchmark against and comply with existing EMS national standards. Additionally, the State Trauma Registry, Stroke Registry, STEMI Registry, and the EMSC Registry components of CEMSIS provide the necessary data for research and quality assessment to inform clinicians and policy makers about methods to optimize the care of patients and their medical outcomes.

California Health and Safety Code section 179.227 and sections 100171 and 100450.200 of the California Code of Regulations require the maintenance and security of CEMSIS. EMSA has historically contracted the management, hosting, and support of this data repository to a LEMSA. EMSA was in the second year of a three-year contract with the LEMSA when the LEMSA informed EMSA in July 2022 that they would not be able to fulfill their contractual obligations to support CEMSIS, which created an immediate and urgent need to migrate the hosting and management of CEMSIS to EMSA in order to maintain operations.

To this end, EMSA issued an emergency contract to ImageTrend, Inc. on September 22, 2022, for the migration and maintenance and operations of CEMSIS. The emergency contract includes a two-year base term with two optional years. EMSA secured emergency funding from the Department of Finance and the Legislature for the first year of the base term and one year of consulting support from the Office of Systems Integration (OSI) for contract management and operational support.

EMSA is currently in Stage 2 of the California Department of Technology's Project Approval Lifecycle (PAL) process for the development of a new statewide database, the California EMS Data Resource System, known as CEDRS, which includes the migration of CEMSIS to EMSA in its business case. EMSA intends to complete the PAL planning process by June 2024.

This proposal requests $4.9 million General Fund in 2023-24 and $185,000 General Fund in 2024-25 for staffing and consultant resources to provide for the maintenance and operations of the CEMSIS system. Because EMSA previously contracted out the management of CEMSIS to the LEMSA, EMSA requests limited-term staffing and contract resources to support state responsibilities for the management of both the system and the ImageTrend contract. In addition, EMSA is currently in Stage 2 of the PAL process with the Office of Systems Integration (OSI) for CEDRS, which will include the replacement for the current CEMSIS solution. Therefore, the funding requested in this proposal is intended to support the operation of CEMSIS until the implementation of the new CEDRS solution is complete.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 22: STAFFING ALLOCATION RESOURCES, SFL ISSUE 18

PROPOSAL

EMSA requests 4 positions and $775,000 General Fund in 2023-24 and ongoing to allow EMSA to properly align staff allocation and reporting structure requirements mandated by the California Department of Human Resources (CalHR) which is critical for EMSA to sustain operations and achieve its mission.

BACKGROUND

The Administration provided the following background information:

EMSA is responsible for overseeing a safe, effective, and efficient system of prehospital emergency care for all citizens and visitors in California. Dedicated resources are requested to provide necessary administrative oversight over existing rank-and-file EMSA staff. EMSA currently has a 45 percent vacancy rate, with approximately 83 percent of the vacancies being rank-and-file positions. According to CalHR's staffing allocation requirements, EMSA is unable to hire vacant rank-and-file positions until a proportionate number of managerial staff are also hired.

In the past several years, EMSA has experienced an increased workload in operations and staffing levels through the implementation of new programs and the expansion of existing programs within the Emergency Medical Services (EMS) and EMS Personnel Divisions. As a result of the increased workload, program complexity, and increased staff numbers, EMSA's span of control for its managers within these Divisions has exceeded requirements mandated by CalHR.

The resources requested in this proposal will begin to properly align the proportion of management staff with rank-and-file staff based on actual and projected workloads and meet critical operational requirements vital to achieving EMSA's mission.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

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

ISSUE 23: TRANSFER ADMINISTRATION FOR AFFORDABLE DRUG MANUFACTURING ACT TO THE DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION, SFL ISSUES 40 AND 57

PROPOSAL

The Administration proposes to transfer and reappropriate a one-time Fiscal Year 2021-22 appropriation of $1.184 million General Fund from the California Health and Human Services Agency (CalHHS) to the Department of Health Care Access and Information (HCAI) to support implementation of the California Affordable Drug Manufacturing Act of 2020 (SB 852, Chapter 207, Statutes of 2020).

The $1 million is for consulting services related to generic drug manufacturing and one position ($184,000 General Fund ongoing). In addition, HCAI requests the funding be available for encumbrance or expenditure until June 30, 2026.

BACKGROUND

The Administration provided the following background information:

The 2020-21 Governor's Budget included a proposal for the State to increase access to more generic drug alternatives in the marketplace. SB 852 advances this work by charging CalHHS to enter into partnerships that result in the production or distribution of generic prescription drugs. SB 852 directs CalHHS to consult with public and private payers, including health plans, health insurers, and hospitals. The intent of partnerships under CalRx are to increase access to affordable medications, target failures in the market for generic drugs, and produce savings. Current law requires CalHHS to report progress on CalRx implementation to the Legislature by December 31, 2022, and submit a legislative report by December 1, 2023, on the feasibility of the State directly manufacturing and selling prescription drugs at a fair price.

The Budget Act of 2021 approved funding of $2.2 million for SB 852 implementation and included encumbrance or expenditure authority until June 30, 2023, for consulting resources related to generic drug manufacturing. This funding also included 1.0 permanent position and ongoing funding of $184,000.

CalHHS has delegated the responsibility of implementing SB 852 to HCAI. CalHHS entered into an Interagency Agreement to reimburse HCAI for legal services performed regarding the California Affordable Drug Manufacturing Act of 2020. HCAI entered into a contract with a vendor to perform legal services involving complex issues related to the

development, regulatory approval, marketing, and distribution of generic and biosimilar drugs. This contractor is providing services for CalRx's first drug project supporting the development of a generic version or "biosimilar" insulin. Referred to as the CalRx Biosimilar Insulin Initiative, the Department of Health Care Access and Information (HCAI) secured in the 2022 Budget Act a one-time appropriation of $102.8 million General Fund. This budget appropriation will use $50 million to work with a partner to develop and bring to market interchangeable biosimilar insulin products in both vial and pen form at a fraction of existing cash prices for insulin, as well as support $50 million towards the development of a California-based manufacturing facility

The Administration explains that this requested transfer of the program, position, and associated funding aligns with the CalRx work currently performed at HCAI and centralizes the administrative resources for SB 852 to one department. There are no additional resources requested. The reappropriation requested would allow for additional time to expend and encumber the funds.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 24: SKILLED NURSING FACILITIES: BACKUP POWER SOURCE (AB 2511) BCP

PROPOSAL

HCAI requests 6.0 positions, and $1,452,000 expenditure authority from the Hospital Building Fund in Fiscal Year (FY) 2023-2024, ongoing to implement AB 2511 (Irwin, Chapter 788, Statutes of 2022).

BACKGROUND

The Administration provided the following background information:

AB 2511 requires skilled nursing facilities (SNFs) to have an alternative power source to protect resident health and safety for at least 96 hours during any type of power outage (public safety power shutoff, an emergency, a natural disaster, or other cause). Currently, there are numerous statutes and regulations governing emergency preparedness protocols such as regulations outlining safe temperature levels for the safety of facility residents, shelter in place or evacuation measures, emergency generator capacity including requirements regarding how many hours are required for emergency power, which range from 6 to 96 hours under current law, and what equipment is required by regulations to be connected to each branch of the power system. AB 2511 requires compliance by January 1, 2024.

AB 2511 did not include a provision for regulations, however, the Governor's signing letter directed HCAI to begin the regulation process and encouraged the author and stakeholders to engage with HCAI, in order for implementation to reflect a more realistic timeframe for facilities to come into compliance.

HCAI had given technical assistance recommending a later implementation deadline which was not accepted Accordingly, AB 2511 becomes effective January 1, 2023, and requires facility compliance by January 1, 2024. This is an unworkable timeframe for both SNFs and HCAI; one which requires an aggressive HCAI implementation plan to ensure guidance is provided to the stakeholders in an expedited manner.

There are over 1,000 SNFs in California that will require electrical system and equipment additions and/or modifications because of this statute. They will need to engage in: project design, review and permit approval; equipment supply line issues in the current environment; construction, and inspection timelines.

For a SNF to participate in Medicare or Medicaid programs, facilities are required to be certified by The Centers Medicare & Medicaid Services (CMS) as meeting all federal requirements for long-term care facilities (LTC) of which a SNF is one of eight types of licenses. One of these requirements is that safe temperature levels must be maintained

at a range of 71o F (minimum) to 81o F (maximum). This may require a SNF to provide air conditioning to comply with the provisions of the federal regulations and AB 2511. To comply, a facility would be required to upgrade their emergency generator and/or install an alternative source of power that will have sufficient storage and generation capacity to maintain operation for no fewer than 96 hours.

HCAI is required by AB 2511 to develop a work-plan in an expedited timeframe to ensure guidance to stakeholders prior to January 1, 2024.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 25: ADD POSITION AUTHORITY FOR WORKLOAD FUNDED IN THE GOVERNOR'S BUDGET, SFL ISSUE 41

PROPOSAL

DMHC requests position authority for 19.5 permanent positions in 2023-24 and ongoing to support the staff resources necessary to address critical information technology gaps, effectively conduct investigations and conduct more frequent financial examinations of health plans and Risk Bearing Organizations (RBOs) in accordance with Health and Safety Code 1382. *DMHC will use ongoing funding requested through the 2023-24 workload Budget Change Proposals to fund the positions and requests position authority only.*

BACKGROUND

The Administration provided the following background information:

The number of the DMHC licensed health plans and covered lives under the DMHC's jurisdiction has steadily increased from 121 licensed health plans and 25 million covered lives in 2015 to 140 licensed health plans and over 28 million covered lives in 2021. As a result of these increases, the workload associated with routine financial examinations and non-routine financial examinations has progressively increased. Due to the increasing financial solvency and statutory compliance issues identified during the examinations, it is also necessary for the DMHC to increase the frequency of routine examinations of RBOs to ensure each RBO is reviewed at least once every five years.

In addition, the DMHC currently lacks sufficient resources to implement, operationalize and maintain the required security systems and controls. The information and cybersecurity threats have increased exponentially in frequency and sophistication. The DMHC has limited resources to address these ongoing threats. The current staffing levels are not sufficient to provide adequate project management, re-engineer and automate critical business processes and mitigate security vulnerabilities.

Recent legislative and workload Budget Change Proposals (BCPs) have provided the DMHC with funding to modernize a small set of antiquated systems. However, to achieve its program goals, the DMHC intends to develop and implement a comprehensive IT and enterprise data strategy and develop solutions to support the DMHC's growing needs. The current staffing levels are not sufficient to support activities related to maintaining the current systems portfolio needs, including maintenance, operations, and low-level enhancements. This includes overall project/process management, accessibility

remediation and business process reengineering support. The DMHC currently lacks sufficient ongoing resources to implement, operationalize and maintain the required security controls.

The DMHC submitted three 2023-24 workload BCPs in the fall of 2022 requesting resources to address the additional workload and funding needs. The workload BCP requests did not include position authority due to the DMHC's 22 percent vacancy rate at that time. The 22 percent vacancy rate was a result of the DMHC's authorized position authority increasing by approximately 18% or 89.5 positions as of July 1, 2022. The DMHC's existing authorized vacant positions are obligated for critical legislative approved workload and the DMHC is continuing to focus on filling all vacant positions. The DMHC addresses the workforce challenges through its resource management and administrative flexibility to meet the workload obligations. The increased workload has resulted in staff working overtime and managers working well above 40 hours per week to address the workload and meet critical deadlines and mandates. The anticipated workload is ongoing and long-term. Currently, all vacant positions are in an active recruitment process. The DMHC has made substantial progress this fall. The DMHC vacancy rate as of March 30, 2023, is 11.1 percent and continues to decline each week. The DMHC anticipates filling most of the remaining vacancies prior to June 2023.

The DMHC is requesting position authority to establish 19.5 permanent positions to address the additional workload. This request will increase the DMHC's regular/ongoing positions but will not include additional expenditure authority for salaries and benefits. The additional position authority will also allow the DMHC to receive prospective annual funding for employee compensation and retirement rate adjustments, which is not provided for non-authorized positions that are established through a temporary Blanket. Additionally, placing permanent employees in temporary blanket positions to address the DMHC's ongoing workload conflicts with the State's directive under the Department of Finance Budget Letter 22-17 to establish authorized positions for permanent position needs in lieu of using the Blanket.

With information security impacting all program areas within the DMHC and growing IT concerns, the OTI resources to support the DMHC must increase to address these concerns. The OTI support staff have seen a workload increase resulting from the technical complexity, modernization initiatives, increasing desktop support and information security from a growing DMHC workforce, which requires ongoing support.

The current staffing cannot keep pace with the business needs or with the exponentially increasing information and cybersecurity threats to provide sufficient project management and efficient business processes to reduce security vulnerabilities and risks. The current staffing level is not sufficient to conduct timely routine examinations of health plans and of health plans and RBOs and to keep up with modernization efforts and cyber security vulnerabilities. The less frequent examinations of RBOs, untimely review of financial statements and less frequent financial examinations of health plans may result in an

increase in the number of health plans and RBOs that are financially insolvent and/or non-compliant with the Knox-Keene Act.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 26: TECHNICAL ERROR FOR FTE DISPLAY ERROR, SFL ISSUE 45

PROPOSAL

DMHC requests a technical adjustment of -62.6 Full Time Equivalent (FTE) in 2023-24 to correct the FTE display error in Hyperion and the Galley. This inadvertent posting error was due to a positive 31.3 positions that should have been a negative 31.3 in 2023-24 entry pursuant to the Budget Letter 19-25 Position Transparency budget drill during 2020-21 budget process. This is a technical fix and results in a net-zero impact to the Managed Care Fund and authorized positions.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 27: MANDATORY USE OF STANDARDIZED FORMS FOR OVERSIGHT, SFL ISSUE 46 BCP AND TRAILER BILL

PROPOSAL

DMHC requests 1.0 position and limited-term expenditure authority (equivalent to 2.0 staff) and $1,254,000 in 2023-24, $1,229,000 in 2024-25, $258,000 in 2025-26 and annually thereafter from the Managed Care Fund to implement the mandatory use of standardized forms that describe the benefits of the enrollee's health plan product.

This request includes limited-term consultant funding of $500,000 in 2023-24 and 2024-25 to assist in developing various final template documents and limited-term expenditure authority (equivalent to 2.0 staff) of $490,000 in 2023-24 and $472,000 in 2024-25.

DMHC also proposes trailer bill to implement the mandatory use of standardized forms.

The full language can be found here:
https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/873

BACKGROUND

The Administration provided the following background information:

Under existing law, the health plans must provide their enrollees with certain documents that describe the benefits of the enrollee's health plan product. The state and federal law dictate the types of information health plans must include in these documents. However, each plan is left to develop its own documents, which requires significant health plan resources. Under the Knox-Keene Act, the DMHC is required to annually review documents filed by health plans. Because each health plan's documents are slightly different, DMHC staff are required to review each of these documents to ensure compliance with the Knox-Keene Act. Additionally, it is difficult for enrollees to compare products across health plans. The DMHC is proposing to require health plans to use the DMHC-developed templates for these documents.

Currently, the health plans are required to provide their enrollees and employer groups with a document known as an Evidence of Coverage (EOC) that discloses the benefits, exclusions, limitations and associated costs for health care services under the plan product the enrollee or employer purchased. The EOCs and related documents are often hundreds of pages in length and can be complicated. Although current law dictates the type of information a plan must include in enrollee-facing documents, including EOCs, the law requires plans to use specific templates for only a limited handful of documents.

The chart below lists the major required enrollee-facing documents health plans must utilize and whether existing law requires the use of a standardized template:

Document	Template Required by Federal or State law?
Evidence of Coverage (EOC)	• Yes, required by state law for Medi-Cal products. • Existing law does not require health plans to use a model template for their commercial products.
Disclosure Form	• Yes, required by state law for Medi-Cal products. • Existing law does not require health plans to use a model template for their commercial products.
Summary of Benefits and Coverage (SBC)	• Yes, required by federal law for commercial products.
Prescription Drug Formulary Template	• Yes, required by state law for commercial products.
Cost-Share Summaries and Schedule of Benefits	• No, health plans have flexibility in the presentation of information.
Explanation of Benefits	• No, health plans have flexibility in the presentation of information.

The DMHC proposes to develop templates for the EOC and Disclosure Forms used by health plans for their commercial products and to develop templates for Cost-Share Summaries and Explanations of Benefits the health plans provide to enrollees.

The standardized forms will help ensure enrollee-facing documents clearly and correctly explain benefits, cost-sharing, limitations and exclusions of health care services in an organized and standardized manner by accomplishing the following goals:

- The use of mandatory templates explaining health care benefits will standardize documents across health plans to provide consistency in information presented to consumers.
- Health plans will not need to develop the documents on their own, which will save health plan time and resources.
- Health plan documents will be largely uniform, which will decrease the amount of time the DMHC must spend reviewing the plan documents to ensure the documents comply with state and federal law.

The DMHC intends to use, as appropriate, documents developed by its sister agencies, including Department of Health Care Services (DHCS) and Covered California, as guides in the development of the templates.

The DMHC requests an Administrative Procedures Act (APA) exemption. The APA generally sets forth the notice and comment requirements for promulgating regulations and involves an often years-long process. Once finalized, updates are possible only by engaging in additional rounds of formal rulemaking. The lengthy and procedurally complex nature of formal rulemaking presents challenges to developing and updating standardized templates, because the laws dictating contents of those templates change with each year's newly enacted legislation. The APA waiver is essential to allowing the DMHC to develop, implement and refine the templates, consistent with ever-changing laws, in a timely and efficient manner.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 28: WITHDRAWAL OF DUPLICATE ENFORCEMENT INVESTIGATION AND EDISCOVERY SOFTWARE APPLICATION BCP, SFL ISSUE 47

PROPOSAL

DMHC requests to reduce expenditure authority by $368,000 in 2023-24, $376,000 in 2024-25, $402,000 in 2025-26, $422,000 in 2026-27, $445,000 in 2027-28, $471,000 in 2028-29 and annually thereafter. This reduction is tied to the withdrawal of the Enforcement Investigations and eDiscovery Software Application Budget Change Proposal (BCP) 4150-009-BCP2023-GB that was included in the 2023-24 Governor's Budget. The resources were inadvertently duplicated in the legislative BCP for SB 858.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 29: GENDER AFFIRMING CARE FUND TECHNICAL CHANGE (SB 923), SFL ISSUE 48

PROPOSAL

The Administration requests that Item 0530-001-0001 be decreased by $350,000 to reflect the correct amount proposed one-time at the Governor's Budget for consultant services to plan, organize and facilitate the required transgender, gender diverse, or intersex working group. This is a technical adjustment to align the system with the posted budget change proposal at the Governor's Budget.

The administration is proposing this technical correction to the related BCP included in the Governor's budget, which was heard in Sub 1 on March 13, 2023.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 30: INTEROPERABILITY FEDERAL RULE IMPLEMENTATION, SFL ISSUE 203

PROPOSAL

DHCS requests the extension of 9.0 existing two-year limited-term (LT) resources and expenditure authority of $1,483,000 ($148,000 General Fund (GF); $1,335,000 Federal Fund (FF)) in fiscal year (FY) 2023-24 and FY 2024-25 to implement and plan for the new interoperability rules required by the federal Centers for Medicare and Medicaid Services (CMS).

BACKGROUND

The Administration provided the following background information:

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

The HITECH Programs, including PIP, ended in Fall 2021. However, CMS continues to advance interoperability requirements through new regulations. In May 2020, CMS passed the Interoperability and Patient Access Final Rule (CMS-9115-F). This rule places specific requirements on state Medicaid agencies, Medicaid managed care plans, Children's Health Insurance Program (CHIP) agencies, and CHIP managed care entities. While the Interoperability and Patient Access Rule was published in the Federal Register May 1, 2020, due to the COVID-19 response efforts, DHCS did not have the resources to meet all enforcement deadlines required by the rule. CMS has indicated that it will work with states through the process of Advanced Planning Documents (APDs) and Corrective Action Plans to address implementation requirements. While financial consequences are not yet formalized, CMS has stated that reductions to enhanced funding could be possible if states do not present clear approaches with acceptable timelines.

In order to develop a departmental plan for the CMS Interoperability and Patient Access Rule, DHCS submitted BCP (4260-168-BCP-2021-A1) for FY 2021-22. The BCP included permanent funding for 5.0 existing positions and one-year LT funding for 10.0 contract

positions. DHCS subsequently submitted BCP (4260-193-BCP-2022-A1) for FY 2022-23. This supplemental BCP included a re-appropriation of contract resources from the FY 2021-22 BCP and additionally included permanent funding for 6.0 existing positions diverted from the PIP, three-year LT resources equivalent to 12.0 positions, the extension of one LT position for one year, and 8.0 one year LT positions.

With these resources, DHCS has implemented education and coordination for crosscutting teams to develop an implementation plan for the different components of the Interoperability and Patient Access Rule. DHCS has issued specific guidance to contracted plans with respect to their obligations under the final rule and has engaged in necessary planning activity to prepare DHCS' administrative and technical Infrastructure for the implementation phase. This work can be grouped into the following focus areas:

- Managed care plan technical assistance and oversight activities;
- Interoperability expertise and coordination for planning and implementation; and
- Data infrastructure to implement services specific to DHCS.

As DHCS continues to move through the planning process for the data infrastructure to implement services specific to DHCS, the department needs to extend the planning resources necessary for DHCS to achieve compliance with the rule.

This BCP for FY 2023-24 requests an extension of resources to advance DHCS' capacity to achieve compliance with the Interoperability and Patient Access Rule. A component of the planning phase and subsequent implementation effort involves mapping administrative data (Health Insurance Portability and Accountability Act of 1996 (HIPAA) claims transactions) to the United States Core Data for Interoperability (USCDI). Doing so represents a significant change with respect to how data is organized and coded. Associated training and communication with plans, counties, and health information organizations (HIOs) to support the use of the USCDI standard represents a significant component of both the planning and implementation work for managed care plans and for DHCS. An APD was approved on July 13, 2021, for the Interoperability and Patient Access Rule and an updated Planning APD was approved by CMS effective May 20, 2022.

In addition to the federal interoperability rule, AB 133 (budget trailer bill, 2022) requires the establishment of the California Health and Human Services Data Exchange Framework, which will govern and require the exchange of health care data among health care providers and payers through any health information exchange network, health information organization, or technology that adheres to specified standards and policies, including DHCS. As the infrastructure required under the federal interoperability rule and AB 133 are similar, staff proposed in this BCP will simultaneously contribute to AB 133 compliance.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 31: NURSING FACILITY FINANCING REFORM, SFL ISSUE 205

PROPOSAL

DHCS, Fee for Service Rates Development Division (FFSRDD), and Quality and Population Health Management (QPHM) requests 2.0 permanent positions and expenditure authority of $1,332,000 ($666,000 General Fund (GF); $666,000 Federal Fund (FF)) in Fiscal Year (FY) 2023-24, and $1,314,000 ($657,000 GF; $657,000 FF) in FY 2024-25 and ongoing to implement three major new Skilled Nursing Facility (SNF) financing programs authorized by AB186 (budget trailer bill, Chapter 46, Statutes of 2022): Workforce & Quality Incentive Program (WQIP), Workforce Standards Program (WSP), and Accountability Sanctions Program (ASP).

BACKGROUND

The Administration provided the following background information:

AB 186 requires DHCS to implement three new SNF financing programs. These programs are intended to better incentivize and hold facilities accountable for quality patient care, emphasize the critical role of workforce, and result in long term financial viability of facilities in the Medi-Cal managed care environment.

- The WQIP requires DHCS to distribute a targeted amount of $280 million in directed payments to SNFs for the 2023 rate year. WQIP will score facilities based on performance on a set of clinical, workforce, and equity metrics. The WQIP replaces the former Quality and Accountability Supplemental Payment (QASP) program and is intended to more broadly distribute funding to incentivize workforce and quality improvement as a core component of facilities' reimbursements. Beginning in 2024, half of the annual rate increase for non-labor costs will be directed to increasing the WQIP rather than base per diem rates.

- The WSP requires DHCS to establish workforce standards such as maintaining a collective bargaining agreement or paying prevailing wage. Facilities that meet the workforce standards will receive a facility-specific workforce rate adjustment in CY 2024 determined by calculating the CY 2024 base rate without applying annual growth limits to the labor cost category. The workforce rate adjustment is intended to broadly supplant the temporary PHE rate increase set to expire on December 31, 2023, while holding facilities accountable for investing these funds in the workforce.

- The ASP authorizes DHCS to sanction facilities that do not meet quality standards established by DHCS.

AB 186 requires DHCS to establish the methodology, parameters, and eligibility criteria for these programs in consultation with representatives from the long-term care industry, organized labor, consumer advocates, and managed care plans.

The WSP and ASP are entirely new workload. DHCS operated the former QASP through a $1 million contract with the California Department of Public Health (CDPH). CDPH subcontracted the data processing and scoring of QASP with a qualified vendor. The state share of the QASP program, including administrative costs, was funded through the SNF Quality & Accountability Special Fund and budgeted in the Medi-Cal Local Assistance Estimate. The Special Fund was financed through regular statutory transfers from the GF. AB 186 abolishes the Special Fund and finances the state share of the WQIP directly from the GF. DHCS staff and contract resources will directly operate the WQIP rather than subcontracting through CDPH.

The FY 2022-23 Budget Act provided over $400 million annually in local assistance funding for AB 186 programs but did not include any state operation resources to replace the former allocation from the Quality & Accountability Special Fund or to support the new workload necessary to implement and operate the WSP and ASP. DHCS temporarily redirected existing staff from other programs to begin stakeholder engagement and program development in Fall 2022 to submit the WQIP directed payment for federal approval to the Centers for Medicare and Medicaid Services (CMS) by December 31, 2022. DHCS will develop the Workforce Standards and ASP in 2023.

Historically, Medi-Cal primarily paid for SNF services through the Fee-For-Service (FFS) delivery system, however; SNF services were carved into managed care in County Organized Health System and Coordinated Care Initiative counties. As part of California Advancing and Innovating Medi-Cal (CalAIM), SNF services are carved into managed care statewide effective January 1, 2023.

DHCS requires ongoing staff and contract resources to implement and operate the new AB 186 programs. For the WQIP, the requested resources replace the previous $1 million allocation to CDPH to operate the former QASP program. The WSP and ASP are entirely new workload that current staffing will not be able to absorb. The temporary redirection of staff to stand-up the WQIP has resulted in delays in completing regular operational workload for other programs.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 32: CENTER FOR HEALTH CARE QUALITY ESTIMATE

PROPOSAL

Current Year 2022-23

The 2022 Budget Act appropriated $441.2 million to the CDPH Center for Health Care Quality (CHCQ). CHCQ projects a $7.3 million increase in current year expenditure authority due to the Extreme Heat: Enhanced Protection for Vulnerable Populations BCP, and baseline adjustments.

Budget Year 2023-24

For 2023-24, CDPH estimates expenditures will total $436.1 million, which is a decrease of $5.1 million or -1.2 percent compared to the 2022 Budget Act. This decrease is due to a $5 million reduction in General Fund authority, a $3 million reduction in authority for the Internal Departmental Quality Improvement Account (IDQIA), and a $1 million reduction in local assistance expenditure authority from the Federal Health Facilities Citation Penalties Account and various baseline adjustments.

Additionally, CHCQ is requesting $926,000 for Hospice Facility Licensure and Oversight (AB 2673), $286,000 for Skilled Nursing Facilities Change of Ownership and Change of Management Application Requirements (AB 1502), and $321,000 for Gender Affirming Health Care (SB 107).

The full CHCQ Estimate can be found here:
https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/2023-24_CHCQ_November_Estimate_1102023.pdf

BACKGROUND

The Administration provided the following background information:

The California Department of Public Health (CDPH), Center for Health Care Quality (CHCQ), Licensing & Certification (L&C) Program is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and health care quality for all Californians. CHCQ fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to determine compliance with federal and state laws and regulations. CHCQ licenses and certifies over 14,000 health care facilities and agencies in California in 30 different licensure and certification categories.

The U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) awards federal grant monies to CHCQ to certify that facilities accepting Medicare and Medicaid (Medi-Cal) payments meet federal requirements. CHCQ evaluates health care facilities for compliance with state and federal laws and regulations, and contracts with the Los Angeles County Department of Public Health (LAC) to certify health care facilities located in Los Angeles County.

In addition, CHCQ oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators. These activities are funded by the CDPH L&C Program (Fund 3098), federal funds (Title XVIII and Title XIX Grants), reimbursements associated with interagency agreements with the Department of Health Care Services (DHCS), and General Fund to support survey activities in state-owned facilities.

Staff Recommendation: Subcommittee staff recommends holding this issue open and likely approval of the updated May Revision estimate.

ISSUE 33: GENDER AFFIRMING HEALTH CARE (SB 107) BCP

PROPOSAL

CDPH, Center for Health Care Quality (CHCQ), requests expenditure authority of $321,000 in 2023-24, 2024-25, and 2025-26 from the State Department of Public Health Licensing and Certification Program Fund (Fund 3098) to provide resources to implement the provisions of SB 107 (Wiener, Chapter 810, Statutes of 2022), which expands the Confidentiality of Medical Information Act (CMIA) by adding additional protections for a child receiving gender-affirming health care.

BACKGROUND

The Administration provided the following background information:

CHCQ is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and health care quality for all Californians. CHCQ fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to determine compliance with federal and state laws and regulations. CHCQ licenses and certifies over 14,000 health care facilities and agencies in 30 different licensure and certification categories.

SB 107 expands CMIA by adding additional protections for medical information related to a child receiving gender-affirming health care. This bill modifies an exception to existing law permitting the release of medical information in response to a subpoena. Providers of health care, health care service plans, or contractors would be prohibited from releasing medical information related to minors receiving gender-affirming health care even in response to a subpoena or other legal request, if that request is based on another state's law authorizing civil or criminal actions for allowing a child to receive gender-affirming health care.

Under the CMIA, providers of health care, health care service plans, or contractors are prohibited from sharing medical information without the patient's written authorization, subject to certain exceptions.

Under current law, health care facilities licensed by CDPH are required to prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information. CDPH is responsible for enforcement of unlawful disclosure requirements in health facilities and entities licensed by CDPH, in addition to any violations of the CMIA. CDPH investigates incidents both reported by facilities in compliance with current reporting requirements and received via complaint. If a breach is found to have occurred, these investigations may result in either a deficiency or administrative penalty being issued to a facility. Current law permits disclosure of medical information pursuant to a

valid subpoena or with authorization from the patient or patient representative. An out-of-state subpoena for information regarding a minor's gender-affirming health care would not be considered a breach.

Releasing medical records in violation of SB 107's requirements, would constitute an unlawful disclosure of medical information. Therefore, the proposed Civil Code §56.109 and Penal Code §1326 would be enforceable as a breach of medical information. However, because CDPH's jurisdiction is limited to only health care facilities it licenses, a violation outside of the scope of those licensing statutes will be beyond CDPH's enforcement jurisdiction.

CHCQ received 1,657 medical breach complaints in 2021-22. For each complaint received, CDPH may need to conduct both a facility investigation and an individual investigation.

SB 107 may increase the number of complaints received by CDPH by up to an estimated 5 percent. This would result in up to 75 new complaints being received annually. The average time estimated to complete a facility and individual investigation of a complaint is 88 hours. To accommodate the review of new complaints, CDPH will require limited-term resources equivalent to 2.0 Special Investigator (SI) FTE at a cost of $321,000 in 2023-24, 2024-25, and 2025-26.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 34: EXTREME HEAT: STATEWIDE EXTREME HEAT RANKING SYSTEM (AB 2238) BCP

PROPOSAL

CDPH Office of Health Equity (OHE) requests 2 positions and $369,000 General Fund in 2023-24 and ongoing to implement AB 2238 (Luz Rivas, Eduardo Garcia, Cristina Garcia, Chapter 264, Statutes of 2022) to support the creation of a statewide extreme heat ranking system and developing a public communication plan for the extreme heat ranking system, statewide guidance for local and tribal governments in preparing and planning for extreme heat events, and recommendations on local heat adaptation, preparedness, and resilience measures.

BACKGROUND

The Administration provided the following background information:

Extreme heat kills more Americans directly than any other climate-related hazard. In August, 2020, and again in July, 2021, the highest temperatures ever reliably recorded on Earth —130 degrees Fahrenheit—occurred in Southern California. On August 31, 2022, Governor Newsom declared a heat wave state of emergency for California; and over the next ten days, the state experienced unprecedented extreme heat that broke all-time heat records for cities across the state, including for Sacramento, which hit an all-time high temperature of 116 degrees Fahrenheit. As severe heat worsens over coming decades due to climate change, it is projected to result in up to 4,300 excess deaths per year in the state in 2025, increasing to up to 11,300 excess deaths per year by 2050. Exposure to high temperatures can cause heat-related illnesses, such as heat cramps, heat rashes, heatstroke, heat exhaustion, and even death. High heat has been associated with acute renal failure, stroke, diabetes, and suicide, and high heat during pregnancy increases risks of congenital heart disease, pre-term delivery, and stillbirth.

The Climate Change and Health Equity Section (CCHES) is part of the Office of Health Equity (OHE) in CDPH. The CCHES program embeds health and equity strategies in California's climate change policy and planning and embeds climate change and equity strategies in public health policy and planning. CCHES coordinates with state and local agencies to implement California's climate change laws and to inform state grants, plans, and policies. CCHES also provides health and climate vulnerability data and indicators, conducts research, and creates tools for state and local partners to improve health through climate action. CCHES also leads coordination of other climate change and health activities within CDPH.

Additionally, CCHES is the lead author for the Public Health content of the California Climate Adaptation Strategy (previously known as "Safeguarding California"), and leads reporting on progress in meeting the plan's public health objectives, and implementing

various actions to meet public health goals in the State's Extreme Heat Action Plan. CCHES convenes the Public Health Workgroup of the California Climate Action Team (CAT). CCHES maintains the Climate Change and Health Vulnerability Indicators (CCHVIs) for California, which provide local agencies, Tribes, and other partners tools to better understand the people and places in their jurisdictions that are more susceptible to adverse health impacts associated with climate change, specifically extreme heat, wildfire, sea level rise, drought, and poor air quality. CCHES also advises the Health and Human Services Agency representatives that serve on the State's Integrated Climate Adaptation and Resilience Program (ICARP) technical advisory council, and on the Strategic Growth Council.

In accordance with AB 2238, CDPH will collaborate with the California Environmental Protection Agency (CalEPA) and other state agencies on developing a statewide extreme heat ranking system, outreach and communications about the ranking system, and recommendations to local governments relevant to extreme heat adaptation, preparedness, and resilience measures. CDPH will provide technical assistance and subject matter expertise on data resources, analytic plans, public health literature, public health communications, statewide guidance for local health departments and Tribes regarding extreme heat preparation and planning, community partnership and participation strategies, and the inclusion of vulnerable communities. CDPH will also review and provide guidance on communications strategies so that they are focused on populations that are most at risk of public health and emergency impacts from extreme heat events, culturally appropriate and translated into languages commonly spoken in the target communities, and are based on public health evidence and recommendations. Additionally, CDPH will leverage partnerships with local health departments and tribal entities.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 35: SNF STAFFING REQUIREMENTS COMPLIANCE (AB 81) TECHNICAL ADJUSTMENT, SFL ISSUE 318

PROPOSAL

CDPH requests a net-zero shift of $939,000 in expenditure authority and 6 positions from the State Department of Public Health Licensing and Certification Program Fund (Fund 3098) to General Fund reimbursement authority in 2023- 24 and ongoing to align budget authority with the correct funding source.

BACKGROUND

The Administration provided the following background information:

Center for Healthcare Quality (CHCQ) is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and quality of health care for all Californians. CHCQ fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to determine compliance with Federal and State laws and regulations. CDPH receives funds through Title XVIII and Title XIX grants from Center for Medicare and Medicaid Services and licensing fees paid by health care facilities. CHCQ licenses and certifies over 14,000 health care facilities and agencies in California in 30 different licensure and certification categories.

Pursuant to Health and Safety Code Section 1276.66, CHCQ's Staffing Audit Section (SAS) audits Skilled Nursing Facility (SNF) compliance with the minimum staffing requirements of Health and Safety Code Section 1276.65 or 1276.5 as applicable and assesses administrative penalties for non-compliance. Audits of all freestanding SNFs are conducted annually and include the review of 24 days of staffing data.

The 2021 Budget included ongoing positions and resources from the Licensing and Certification Fund (Fund 3098) to implement the provisions of AB 81 (Ting, Chapter 13, Statutes of 2020). Due to a clerical error, the fund source was listed as Fund 3098 instead of General Fund reimbursement authority. Because these activities are reimbursed through an interagency agreement with the Department of Health Care Services, this request aligns the program's budget authority with the appropriate funding source.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 36: SNF STAFFING AUDITS, SFL ISSUE 319

PROPOSAL

CDPH requests $4 million General Fund in 2023-24 and ongoing to support the ongoing workload of the Staffing Audits Section (SAS) for SNF minimum staffing requirement audits. This support will backfill the $4 million that was previously provided from the SNF Quality and Accountability Special Fund, which sunsetted on December 31, 2022. This proposal will not impact health facility licensing fees. CDPH will continue to have an Interagency Agreement with DHCS in 2023-24 and ongoing that will provide an additional $4 million in federal funding to match the state funding.

BACKGROUND

The Administration provided the following background information:

Center for Health Care Quality (CHCQ) is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and quality of health care for all Californians. CHCQ fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to determine compliance with Federal and State laws and regulations. Public Health receives funds through Title XVIII and Title XIX grants from Center for Medicare and Medicaid Services and licensing fees paid by health care facilities. CHCQ licenses and certifies over 14,000 health care facilities and agencies in California in 30 different licensure and certification categories.

Pursuant to Health and Safety Code Section 1276.66, SAS audits SNF compliance with the minimum staffing requirements of Health and Safety Code Section 1276.65 or 1276.5 as applicable and assesses administrative penalties for non-compliance. Audits of all freestanding SNFs are conducted annually and include the review of 24 days of staffing data.

In 2021-22 and prior years, a Department of Health Care Services (DHCS) interagency agreement for $8 million reimbursed CHCQ staffing audit costs. Fifty percent of the reimbursement flowed through Federal Funds, and the remaining flowed through DHCS's SNF Quality and Accountability Special Fund. The SNF Quality and Accountability Fund was financed primarily by transfers from the General Fund. Compliance was also included in the criteria for the Medi-Cal SNF Quality and Accountability Supplemental Payment System (SNF QASP).

Per Welfare and Institutions Code Section 14126.036, CDPH's minimum staffing audits responsibilities, administrative penalty authority and the Medi-Cal SNF QASP program sunset on December 31st, 2022; however, the 2022 Budget Act extended CDPH's audit requirements and administrative penalty authority and established a successor to the

Medi-Cal SNF QASP. The new Medi-Cal SNF Workforce and Quality Incentive Program (WQIP) is financed directly by the General Fund.

The 2022 Budget Act provided $4 million one-time General Fund to fund the activities of the Staffing Audits Section in 2022-23. At the time, it was signaled that CDPH would submit a request for ongoing resources in 2023-24 that would reevaluate and, if needed, align its workload with WQIP and statutory changes.

DHCS will continue to utilize the CDPH Staffing Audit data as a component of the annual Medi-Cal rate-setting process to assess compliance with Medi-Cal funding requirements pursuant to Welfare & Institutions Code Section 14126.033(g)(1)(A). DHCS will not utilize CDPH Staffing Audits data as a metric to score facilities' staffing hours for the WQIP, and instead will use Payroll-Based Journal (PBJ) data reported by facilities to the Centers for Medicare and Medicaid Services (CMS). The continued CDPH Staffing Audits will serve to validate the accuracy of data reported by facilities to CMS in PBJ.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 37: SNF CHANGE OF OWNERSHIP AND CHANGE OF MANAGEMENT APPLICATION REQUIREMENTS (AB 1502) BCP

PROPOSAL

CDPH Center for Health Care Quality (CHCQ) requests expenditure authority of $286,000 in 2023-24 2024-25, and 2025-26 from the State Department of Public Health Licensing and Certification Program Fund (Fund 3098) to provide resources to implement the provisions of AB 1502 (Muratsuchi, Chapter 578, Statutes of 2022), which affects Skilled Nursing Facilities (SNF) licensing requirements in California.

BACKGROUND

The Administration provided the following background information:

CHCQ is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and quality of health care for all Californians. CHCQ fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to determine compliance with federal and state laws and regulations. Public Health receives funds through Title XVIII and Title XIX grants from the Centers for Medicare and Medicaid Services (CMS) and licensing fees paid by health care facilities. CHCQ licenses and certifies over 14,000 health care facilities and agencies across California in 30 different licensure and certification categories. CHCQ evaluates health care facilities for compliance with state and federal laws and regulations, and CDPH contracts with the Los Angeles County Department of Public Health (LAC) to license and certify health care facilities located in Los Angeles County.

The Centralized Applications Branch (CAB) processes health care facility licensure and certification applications for CHCQ. CAB processes all of CDPH's applications for initial facility licenses, changes to existing licenses, licensure renewals, and conducts activities associated with license expiration and license revocation. CAB processes applications on a first-in, first-out basis and often works with applicants to address incomplete or inaccurate application materials.

AB 1502 revises the license application, review, and approval process for SNFs, specifically the applications for change of ownership (CHOW) and change of management (CHOM), which are processed by CAB.

AB 1502 revises the license application, review, and approval process for SNFs improving CDPH's oversight when SNF's change management and/or ownership, among other things. Specifically, this bill:

- Requires CDPH approval before a Change of Ownership (CHOW) or Change of Manager (CHOM) occurs and that the applicant submit a complete application to CDPH at least 120 days before the transaction will occur.
- Expands the application contents to include all persons or entities acquiring a direct or indirect ownership interest in the SNF, including the applicant's parent corporation or corporate chain.
- Directs CDPH to determine whether the applicant is reputable and responsible, as evidenced by, among other things, the applicant's long-term care experience and compliance history for the prior five years and its financial resources.
- Requires CDPH to approve or deny the application within 120 days of receipt of the complete application, with expedited review allowed under limited circumstances.
- Provides grounds for application denial, applicant disqualification, and new civil penalties. The bill requires the current and prospective licensees to provide certain notices to CDPH.
- Applies to applications submitted to CDPH on or after July 1, 2023.

Current Sequence of SNF Licensing Events

Currently, when a SNF is sold or an ownership interest is transferred, the licensee must notify CDPH within 30 days after the event, with the new owner being required to apply to CDPH for a CHOW immediately thereafter. Until the CHOW is granted, the prior owner continues to be the licensee and is responsible for all SNF operations and the care of the residents. The current licensee remains responsible for resident care and any violations that take place until the CHOW application is approved. In those situations, the current licensee and the prospective licensee will enter into an interim management operations transfer agreement that allows the prospective licensee to operate the SNF until the CHOW is approved. Current law is silent on the length of time in which an "interim" owner or management company may operate a facility under a temporary management agreement. If CDPH finds the new owner is not reputable and responsible, it denies the new owner's CHOW application, meaning the current licensee continues to be responsible for the operation of a facility that is owned by another person or entity.

Likewise, when a licensee contracts with a management company for some aspect of the facility's operations, under current law, written notice is required to be given to CDPH not more than 10 days after the management company begins its duties. CDPH then reviews the qualifications of the management company and issues a corrected license reflecting the reported change.

Sequence of SNF Licensing Events Under AB 1502 AB 1502 will reverse that sequence of SNF licensing events by requiring CDPH approval before any change of ownership, operations, or management including, but not limited to, the following:

- A transaction by a person, firm, association, organization, partnership, business trust, corporation, limited liability company, or company that enables them to operate, establish, manage, conduct, or maintain a SNF in California, for which a license is required by Health and Safety Code (HSC) §1253 or other state laws and regulations.
- The transfer, purchase, or sale of an ownership interest of 5 percent or more in the either the SNF or its licensee.
- The sale or transfer of the entity licensed by CDPH.
- The lease of all or part of a SNF.
- A transfer of any type of ownership interest, including an indirect one such as one a parent company acquires.
- A transaction described in HSC Section 1267.5 (e.g., contracting for the SNF to be operated, in whole or part under a management contract).
- Establishment of an interim or longer-term management agreement transferring operational control or management responsibilities from the SNF owner or licensee to a new entity.
- Establishment of any type of agreement with a management company hired, retained, or authorized to act on behalf of a licensee to make financial decisions for the SNF, direct or control aspects of patient care and quality within the SNF, or be involved in the hiring, firing, supervision, and direction of direct care staff.
- Any transaction, if a SNF licensee is part of a chain, that changes ownership interests or management responsibilities throughout all SNFs in the chain, with the bill not limiting those transactions to chain facilities located only within California.

Only those approved by CDPH may operate or manage a SNF. Any SNF transaction, including but not limited to the sale of the facility, involving a person or entity that does not receive CDPH approval cannot occur.

Application Contents

The contents of applications for SNF licensure, CHOWs and CHOMs under current law include basic identifying information (HSC §1265 and §1267.5) for the applicant and the facility (e.g., names of the applicant and the person in charge of the SNF, contact information, name and location of the SNF). Under AB 1502, the application will collect significantly more information about the owner(s), such as:

- Evidence satisfactory to CDPH that the applicant is reputable and responsible to assume the facility's license or management of its operations and meets the requirements of the HSC licensing chapter and other applicable laws, rules, and regulations.
- Evidence that the applicant has the financial capacity to operate the facility and to provide services required by state and federal laws and regulations for 90 days.
- Information, for the past five years, whether the applicant(s) have had any actions taken against them, such as revocations, penalties, injunctions, etc. whether from

CMS, or Attorneys General, or any other law enforcement agency related to facilities they have owned or operated.

Applicants will also be required to submit all required fees with its application, instead of submitting them at the end of CDPH's application review process, as is currently required.

In 2020-21 and 2021-22, CAB received an average of 56 SNF CHOWs and 13 SNF CHOMs per year. Each application takes approximately 190 hours for review, primarily done by an Associate Governmental Program Analyst (AGPA). The bill's requirement that CAB complete its CHOW/CHOM processing within 120 days after receipt of a complete application will shorten the time frame for completing the review of the application, which will necessitate additional staffing.

AB 1502 will require CAB to obtain and examine additional information about the applicant, including persons and entities having an indirect ownership interest, and complete its review within 120 days. The bill also requires CAB to examine the applicant's compliance history for two additional years. Although CAB has recently streamlined its SNF application process, CDPH anticipants that AB 1502 is likely to increase the current processing time commitment for either a CHOW or CHOM application by up to 40 or 50 hours.

Accommodating that additional review within the proposed review period for both CHOW and CHOM applications will require $286,000 in additional expenditure authority from Fund 3098 in 2023- 24, 2024-25, and 2025-26 for two administratively established AGPA positions. Because the bill does not affect applications submitted before July 1, 2023, the fiscal impact will not occur until after that date.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 38: HOSPICE FACILITY LICENSURE AND OVERSIGHT (AB 2673) BCP

PROPOSAL

CDPH, Center for Health Care Quality (CHCQ) requests three positions in 2023-24 and ongoing, and $926,000 in 2023-24, $759,000 in 2024-25, $698,000 in 2025-26, and $615,000 in 2026-27 and ongoing from the State Department of Public Health Licensing and Certification Program Fund (Fund 3098) to implement the provisions of AB 2673 (Irwin, Chapter 797, Statutes of 2022), which affects Hospice Facilities Licensing Requirements in California.

BACKGROUND

The Administration provided the following background information:

CHCQ is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and quality of health care for all Californians. CHCQ fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to determine compliance with federal and state laws and regulations. Public Health receives funds through Title XVIII and Title XIX grants from the Centers for Medicare and Medicaid Services (CMS) and licensing fees paid by health care facilities. CHCQ licenses and certifies over 14,000 health care facilities and agencies across California in 30 different licensure and certification categories. CHCQ evaluates health care facilities for compliance with state and federal laws and regulations, and CDPH contracts with the Los Angeles County Department of Public Health (LAC) to license and certify health care facilities located in Los Angeles County.

The Centralized Applications Branch (CAB) processes health care facility licensure and certification applications for CHCQ. CAB processes all of CDPH's applications for initial facility licenses, changes to existing licenses, licensure renewals, and conducts activities associated with license expiration and license revocation. CAB processes applications on a first-in, first-out basis and often works with applicants to address incomplete or inaccurate application materials.

AB 2673 extends the general moratorium on hospice licensure and increases CDPH's regulatory oversight over hospices. Specifically, this bill:

- Prohibits CDPH from approving Change of Ownership Applications (CHOW) of a licensed hospice agency within five years of license issuance, unless CDPH makes an exception for extenuating circumstances upon finding a transfer necessary to ensure continuity of care or that there is both a financial hardship and an unmet geographic need of hospice services.

- Requires a hospice agency to have specified management personnel and to submit information for them to CDPH for use in mandated and optional verification activities.
- Requires a hospice agency license applicant to demonstrate unmet need of hospice services in the proposed service area, and it permits exceptions for CHOW applicants if the license has been continually held by the previous licensee for five years and the hospice agency has either previously demonstrated unmet need or can demonstrate it is currently meeting a need for hospice services.
- Requires CDPH to annually survey a selective sample of five percent of hospice agencies whose initial licensure via accreditation occurred in the previous year.
- Requires CDPH to adopt emergency regulations with specified components to implement recommendations in the California State Auditor's (CSA) Report No. 2021-123 dated March 29, 2022, on hospice licensure and oversight by January 1, 2024, and to maintain the new hospice agency licensure moratorium until adoption, but no later than March 29, 2024. This bill exempts hospice facilities (HOFAs) from the moratorium.
- Establishes a complaint process for hospice agencies and requirements for CDPH's investigations.
- Expands the reasons why CDPH may deny, suspend, or revoke a hospice agency.
- Requires CDPH to verify the professional licensure status for management personnel, and it permits CDPH to verify their work history and association with the hospice agency by contacting the personnel or previous employers by telephone.
- Establishes moratorium exception criteria requiring the applicant to prove unmet need in their geographic area as a permanent requirement for hospice agency licensure and permits CDPH to make exceptions for CHOWs that will allow for continuing service provision by hospice agencies that have historically met a geographic need.

Although current law permits CDPH to survey licensed hospices to investigate complaints, it does not establish a complaint process. This bill's provisions parallel existing complaint processes for other licensed health care facilities, such as long-term care facilities.

Each hospice agency must have five specified management personnel positions. Hospice agencies would be required to submit information related to these individuals and their qualifications by March 31, 2023, for current licensees, or as part of the initial licensure application for new applicants. CDPH would be required to use this documentation to verify the status of these individuals' professional licensure. CDPH's ongoing workload for reviewing the qualifications of management staff for new hospice agencies seeking initial licensure will entail only minor and absorbable costs. Conducting a one-time review of the five management personnel, at an estimated average of 0.5 hours per individual, for 3,061 currently licensed hospice agencies would generate an additional 7,653 hours

for work for CDPH. This is equivalent to the workload of 4.25 FTE Associate Governmental Program Analysts (AGPAs) for one year. However, CDPH estimates that the workload of 2.25 of these analysts could be absorbed by existing CDPH personnel given the anticipated overall decrease in new licensure applications that will qualify for review. Therefore, CDPH would need additional 2.0 FTE AGPAs in 2023-24.

CDPH must conduct validation surveys of five percent of all hospices that attained licensure via accreditation in the prior calendar year. CDPH anticipates this cost to be minor and absorbable.

According to the 2022-23 Annual Fee Report, CDPH spends 117 hours on average conducting validation surveys for deemed (accredited) facilities. If all ten facilities projected to qualify for licensure each year were accredited, this would result in one validation survey per year, or an additional workload of 117 hours. An unknown number of applicants will qualify for an exception to the unmet need requirement.

This bill requires CDPH to investigate complaints against hospice agencies alleging violations of state law or regulations. For calendar years 2016-2020, CDPH received an average of 229 complaints annually for hospice agencies. From Jan 1, 2021 through Dec 31, 2021, 313 complaints were filed against hospice agencies, reflecting an increase of 37 percent over the preceding 5- year average. Of those 313, 58 complaints were substantiated, 52 of which were for accredited hospices. Given the new statutory requirements, CDPH anticipates an increase in the number of complaints. Assuming that this increase is roughly similar to the magnitude of increase in 2021, this would result in approximately 420 hospice agency complaints a year, or an increase of 107 new hospice agency complaints. Applying the same proportions for substantiated complaints, 20 of the new complaints would be substantiated, with 18 new substantiated complaints for accredited hospices. CDPH projects that the workload associated with the increase in complaints will require an additional 3.0 FTE Health Facilities Evaluator Nurses (HFENs) beginning in 2023-24.

This bill requires CDPH to adopt emergency regulations to implement the recommendations in CSA report no later than March 29, 2024. CDPH will require 1.0 FTE AGPA for 2.5 years beginning in 2023-24 to develop and promulgate the emergency regulations package and the subsequent supporting documents for the full regulation adoption.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

ISSUE 39: INDUSTRIAL HEMP LICENSING AND COMPLIANCE PROGRAM, SFL ISSUE 313

PROPOSAL

CDPH requests a reappropriation of $1.2 million General Fund included in the 2022 Budget Act, and associated provisional language, to implement the regulation of Industrial Hemp (IH) products mandated in AB 45 (Aguiar-Curry, Chapter 576, Statutes of 2021).

BACKGROUND

The Administration provided the following background information:

IH-derived cannabinoids, including cannabidiol (CBD) in foods, beverages, and cosmetics, have gained significant popularity with consumers. CBD is one of approximately 100 cannabinoid compounds and can be found in both cannabis plants and IH plants. Scientific evidence regarding the health and safety of CBD for consumption is being closely tracked and studied, and additional information continues to be gathered and analyzed by the scientific and regulatory communities.

The federal Farm Bill of 2018 removed IH from the Schedule I Controlled Substances list and changed the legal landscape for IH by treating it similar to other agricultural commodities and allowing for cultivation of IH. Additionally, it allowed for the transfer of hemp-derived products across state lines. However, the 2018 Farm Bill did not change federal food and drug laws, and the United States Food and Drug Administration (FDA) has not yet approved the use of CBD in food, drug, and cosmetics. The FDA continues to gather information and study CBD in order to determine how it will be regulated on a national level. In the meantime, at the federal level CBD from IH in any of those products is considered unapproved and the FDA appears to only be taking enforcement action against those manufacturers that make medical/health claims or are linked to a verified complaint.

Absent federal standards for IH CBD, many other states have enacted their own laws to allow the sale of IH products. In California, AB 45 authorized CDPH to establish a program regulating the use of IH and its cannabinoids, extracts, or derivatives in foods, beverages, cosmetics, and pet food products. Further, the statute allows for the manufacture of IH inhalable products only if sold outside California. AB 45 established the Industrial Hemp Enrollment and Oversight (IHEO) Fund for the collection of fees.

CDPH is currently establishing a regulatory structure for food, beverages, cosmetic products, pet food, and inhalables containing IH. The regulations that established the initial fees and application process became effective July 5, 2022. This process took longer than expected and CDPH was not able to collect revenue in 2021-22. CDPH conducted outreach to IH industry associations including the California Hemp Council and

U.S. Hemp Roundtable, and informed these associations and existing food, beverage, cosmetic products and pet food manufacturers of the new requirement to apply for the IH licensing. CDPH also set up an IH program website with Frequently Asked Questions to assist the industry in understanding the licensing process. While some IH firms have applied, revenues still remain lower than anticipated for 2022-23. Despite the outreach, CDPH believes this industry to be more diverse than originally anticipated and it is harder to locate firms that are engaging in IH product manufacturing.

The 2021 Budget Act appropriated General Fund resources in 2021-22 and 2022-23, with the fund source intended to switch to the Industrial Hemp Enrollment and Oversight Fund in 2023- 24. While program works to bring the industry into compliance, CDPH requests to reappropriate unspent General Funds from 2022-23 to continue supporting the regulation of this industry and support work already underway. The 2023-24 Governor's Budget also proposes to reappropriate unspent General Fund from 2021-22.

To date, CDPH has received less than expected IH applications. This seems contrary to the number of IH products available in the marketplace. Therefore, CDPH has established a labor-intensive process to identify IH manufacturers (via complaints, referrals from other agencies, social media searches, Internet searches, and observations of products available in the marketplace) that are required to be licensed by CDPH. CDPH is currently conducting site inspections, educating facilities about the requirements of AB 45, and conducting enforcement actions when needed. These steps are labor intensive and require staff resources.

To implement the mandates of AB 45, CDPH is required to license, inspect, investigate, and enforce manufacturers of IH-derived products in California, and to do the same for manufacturers of IH inhalable and smoke-able products for out-of-state sale. AB 45 requires out-of-state IH extract manufacturers who intend to import their product into California to obtain the same authorization as in-state IH manufacturers. CDPH inspectors may travel and conduct inspections out-of-state to make sure IH manufacturers conform to the requirements of AB 45.

CDPH will also need to inspect and perform label reviews to oversee compliance regarding purported health-related claims to their CBD product(s). This includes laboratory analysis to verify CBD concentrations and IH status.

Staff Recommendation: No significant concerns have been raised with this proposal and therefore Subcommittee staff recommends approval at a future hearing.

PUBLIC COMMENT

(PUBLIC COMMENT WILL BE TAKEN ON ALL ITEMS ON THE AGENDA)

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