AGENDA

PART A: HEALTH

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

WEDNESDAY, MAY 12, 2021

1:30 PM, STATE CAPITOL, ROOM 437

Due to the regional stay-at-home order and guidance on physical distancing, seating for this hearing will be very limited for press and for the public. All are encouraged to watch the hearing from 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.

A moderated telephone line will be available to assist with public participation. After all witnesses on all panels and issues have concluded, and after the conclusion of member questions, the public may provide public comment by calling the following toll-free number: ***1-877-692-8957 / access code: 131 54 37.***

ITEMS TO BE HEARD

NON-PRESENTATION ITEMS

ACTION-ONLY ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 1: ESTABLISHING THE OFFICE OF SUICIDE PREVENTION WITHIN THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (AB 2112) (SFL ISSUE 226 BCP AND TBL)

PANEL 1 - PRESENTERS

California Department of Public Health
- **Mónica Morales**, Deputy Director, Center for Healthy Communities,
- **Terri Sue Canale-Dalman**, Assistant Deputy Director, Center for Healthy Communities

Mental Health Services Oversight and Accountability Commission
- **Toby Ewing**, Executive Director

PANEL 1 – Q&A ONLY

Department of Finance
- **Jack Zwald**, Principal Program Budget Analyst
- **Erin Carson**, Finance Budget Analyst

Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal & Policy Analyst

4120 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 2: OFFICE OF HEALTH CARE AFFORDABILITY (GB BCP AND TBL)

PANEL 2 - PRESENTERS

Office of Statewide Health Planning and Development
- **Elizabeth Landsberg**, Director

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

PANEL 2 – Q&A ONLY

Office of Statewide Health Planning and Development
- **Michael Valle**, Deputy Director and Chief Information Officer, Information Services Division
- **Ryan Buckley**, Acting Chief Counsel, Legal Services Division

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Madison Sheffield**, Finance Budget Analyst

ISSUE 3: OSHPD RECAST AND MODERNIZATION (SPRING BCP AND TBL)

PANEL 3 – PRESENTERS

Office of Statewide Health Planning and Development
- **Elizabeth Landsberg**, Director

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

PANEL 3 – Q&A ONLY

Office of Statewide Health Planning and Development
- **Caryn Rizell**, Deputy Director, Healthcare Workforce Development Division

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Madison Sheffield**, Finance Budget Analyst

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 4: ANNUAL HEALTH CARE SERVICE PLAN HEALTH EQUITY AND QUALITY REVIEWS (SFL ISSUES 022 AND 177, BCP AND TBL)

PANEL 4 – PRESENTERS

Department of Managed Health Care
- **Mary Watanabe**, Director
- **Dan Southard**, Chief Deputy Director

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal & Policy Analyst

Health Access
- **Diana Douglas**, Policy and Legislative Advocate

California Pan-Ethnic Health Network
- **Cary Sanders**, Senior Policy Director

PANEL 4 – Q&A ONLY

Department of Health Care Services
- **Susan Philip**, Deputy Director, Health Care Delivery Systems
- **Palav Babaria**, Deputy Director and Chief Quality Officer, Quality and Population Health Management
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Madison Sheffield**, Finance Budget Analyst
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: MEDI-CAL TELEHEALTH PROPOSAL (TBL)

PANEL 5 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

Stakeholders
- **Dr. Ganga Hematillake**, Chief Medical Officer, United Health Centers of the San Joaquin Valley, California Primary Care Association
- **Dr. Claire Horton**, Chief Medical Officer, San Francisco Health Network, California Association of Public Hospitals and Health Systems
- **Robert Badilla**, Patient Navigator & Virtual Health Coordinator, Planned Parenthood California Central Coast
- **David Ford**, Vice President of Health Information Technology, California Medical Association
- **Jennifer Stoll**, Executive Vice President of Government Relations and Public Affairs, OCHIN

PANEL 5 – Q&A ONLY

Department of Health Care Services
- **Rene Mollow**, Deputy Director, Health Care Benefits & Eligibility
- **Lindy Harrington**, Deputy Director, Health Care Financing
- **Bruce Lim**, Deputy Director, Audits & Investigations
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

Department of Finance
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst

ISSUE 6: OFFICE OF MEDICARE INNOVATION AND INTEGRATION (SFL ISSUE 173)

PANEL 6 – PRESENTERS

Department of Health Care Services

- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

PANEL 6 – Q&A ONLY

Department of Health Care Services

- **Anastasia Dodson**, Associate Director for Policy
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

Department of Finance

- **Tyler Woods**, Principal Program Budget Analyst
- **Alek Klimek**, Finance Budget Analyst

Legislative Analyst's Office

- **Ben Johnson**, Principal Fiscal & Policy Analyst

ISSUE 7: LOCAL EDUCATIONAL AGENCIES MEDI-CAL BILLING OPTION PROGRAM EXPANSION (SFL ISSUE 172)

PANEL 7 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

PANEL 7 – Q&A ONLY

Department of Health Care Services
- **Lindy Harrington**, Deputy Director, Health Care Financing
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

ISSUE 8: BEHAVIORAL HEALTH QUALITY IMPROVEMENT PROGRAM (SFL ISSUE 174)

PANEL 8 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

County Behavioral Health Directors Association
- **Michelle Cabrera**, Executive Director

PANEL 8 – Q&A ONLY

Department of Health Care Services
- **Lindy Harrington**, Deputy Director, Health Care Financing
- **Kelly Pfeifer**, Deputy Director, Behavioral Health
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

County Behavioral Health Directors Association
- **Elia Gallardo**, Director, Government Affairs

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Sonal Patel**, Finance Budget Analyst

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 9: BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE PROGRAM (SFL ISSUES 175 AND 195)

PANEL 9 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

Mental Health Services Oversight and Accountability Commission
- **Toby Ewing**, Executive Director

County Behavioral Health Directors Association
- **Michelle Cabrera**, Executive Director

PANEL 9 – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director, Behavioral Health
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

County Behavioral Health Directors Association
- **Elia Gallardo**, Director, Government Affairs

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Sonal Patel**, Finance Budget Analyst

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

ISSUE 10: MENTAL HEALTH SERVICES ACT FLEXIBILITIES (TBL)

PANEL 10 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

Mental Health Services Oversight and Accountability Commission
- **Toby Ewing**, Executive Director

County Behavioral Health Directors Association
- **Michelle Cabrera**, Executive Director

PANEL 10 – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director, Behavioral Health
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

County Behavioral Health Directors Association
- **Elia Gallardo**, Director, Government Affairs

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Sonal Patel**, Finance Budget Analyst

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

ITEMS TO BE HEARD

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 1: ESTABLISHING THE OFFICE OF SUICIDE PREVENTION WITHIN THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (AB 2112) (SFL ISSUE 226 BCP AND TBL)

PANEL 1 – PRESENTERS

California Department of Public Health
- **Mónica Morales**, Deputy Director, Center for Healthy Communities,
- **Terri Sue Canale-Dalman**, Assistant Deputy Director, Center for Healthy Communities

Mental Health Services Oversight and Accountability Commission
- **Toby Ewing**, Executive Director

PANEL 1 – Q&A ONLY

Department of Finance
- **Jack Zwald**, Principal Program Budget Analyst
- **Erin Carson**, Finance Budget Analyst

Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal & Policy Analyst

REQUEST

The California Department of Public Health (CDPH), Center for Healthy Communities (CHC), Injury and Violence Prevention Branch (IVPB) requests five positions and $780,235, General Fund appropriation in 2021-22 and ongoing to establish and administer an Office of Suicide Prevention as authorized by AB 2112 (Ramos, Chapter 142, Statutes of 2020).

BACKGROUND

CDPH explains that public health utilizes "upstream" approaches to suicide prevention by addressing risk and protective factors for suicide. Promoting positive social norms, access to services, social support, housing, and economic stability creates conditions that

prevent suicide but also contributes to other public health goals like increasing physical activity, reducing chronic disease and obesity, promoting healthy eating, and reducing depression. The National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC) has recently released a Suicide Prevention Strategic Plan that outlines strategic priorities and goals for public health in addition to a technical package of policies, evidence-based programs and practices for suicide prevention.

The CDPH Injury and Violence Prevention Branch (IVPB) is responsible for developing and implementing policies and program interventions and surveillance to prevent deaths and disability from injury, and promotes a public health approach to addressing violence. Using data from CDPH Vital Statistics death files, IVPB is a source of public health surveillance data on intentional injury-related fatalities, including suicide, for the state of California. With a grant from the CDC, IVPB also administers California's National Violent Death Reporting System (CalVDRS) which compiles data on circumstances surrounding violent deaths, including suicides, for Californians.

IVPB also houses CDPH's Violence Prevention Initiative (VPI), which is implemented utilizing in-kind staff from multiple centers within the department to highlight and frame the role of governmental public health in addressing all types of violence, including suicide prevention. This initiative works to elevate violence prevention as a departmental priority, integrate and align efforts across multiple CDPH programs, and build local health department capacity. VPI staff provided data and information to the Mental Health Services Oversight and Accountability Commission in the development of their strategic plan for suicide prevention. Other related activities have included the release of a data brief focusing on homicide and suicide data trends in California in March 2019, entitled Data Brief 1: Overview of Homicide and Suicide Deaths in California. Additionally, VPI hosted a webinar highlighting CDPH suicide-related data briefs, local efforts, and California's new suicide prevention plan.

In light of the increased risk for suicide during the COVID-19 pandemic, CDPH collaborated with the Department of Health Care Services and the Office of the California Surgeon General in June 2020, to develop a new resource letter for providers related to suicide prevention. This letter was designed to help front-line providers quickly learn how to screen for people at risk of suicide utilizing four "Ask Suicide-Screening Questions" developed by the National Institute on Mental Health, and what to do if they find someone at risk. This letter was shared widely in an effort to reach frontline medical and behavioral providers, including partners and stakeholder groups.

On September 8, 2020, IVPB was awarded a Comprehensive Suicide Prevention grant from the federal CDC of $900,000 annually over a five-year period (September 1, 2020 to August 31, 2025). The grant supports three positions and up to four local health departments will be funded to implement evidence-based suicide prevention strategies, including reducing access to lethal means among people at risk via safe storage practices

for both firearms and medications, treatment to prevent reattempts via emergency department brief interventions and active follow-up contact approaches, and providing parenting skills, family relationship programs, and social-emotional learning programs.

Through the 2017 budget, the legislature directed the Mental Health Services Oversight and Accountability Commission (OAC) to develop a new suicide prevention plan for California; in 2020, the OAC published and released the *California Strategic Plan for Suicide Prevention 2020-2025: Striving for Zero*, which includes the establishment of a state office of suicide prevention as one of its highest priority recommendations.

CDPH further states that, despite the challenges, research demonstrates that effective interventions can save lives, and that public health strategies can prevent loss of life on a broad scale. The Public Health Model involves four repeating steps: 1) defining the problem; 2) identifying the factors that increase or lower risk; 3) developing and evaluating prevention interventions; and 4) implementing interventions and disseminating results to increase the use of effective interventions. The Public Health Model is a key feature of the statewide strategic suicide prevention plan.

AB 2112 authorizes the establishment of an Office of Suicide Prevention within CDPH and proposes the following responsibilities for the office, which aligns with MHSOAC's recommendations from Striving for Zero: Strategic Plan for Suicide Prevention 2020-2025:

- Providing information and technical assistance to statewide and regional partners regarding best practices on suicide prevention policies and programs.
- Conducting state level assessment of regional and statewide suicide prevention policies and practices, including those from other states, and including specific metrics and domains as appropriate. Focusing activities on groups with the highest risk, including youth, Native American youth, older adults, veterans, and LGBTQ people.
- Monitoring, tracking (surveillance) and dissemination of data to inform prevention efforts at the state and local levels.
- Convening experts and stakeholders, including, but not limited to, stakeholders representing populations with high rates of suicide, to encourage collaboration and coordination of resources for suicide prevention.
- Reporting on progress to reduce rates of suicide.
- Sharing and receiving data from other state entities relevant to the responsibilities and objectives of the office.
- Consulting with the Mental Health Services Oversight and Accountability Commission to implement suicide prevention efforts consistent with the Mental Health Services Oversight and Accountability Commission's Suicide Prevention Report "Striving for Zero."

CDPH is requesting five positions and associated funding in 2021-22 and ongoing to establish and administer an Office of Suicide Prevention consistent with AB 2112. The positions and duties are as follows:

- Health Program Manager II (1.0 position): To direct, oversee, and supervise project staff; provide direction and oversight to all elements of the Office of Suicide Prevention; interface with the MHSOAC and other primary stakeholders; oversee contract development and procurement processes, proposal reviews, award and negotiation of contracts, contract and project monitoring, and evaluation processes; be responsible for fiscal management; and advise on program and policy implications.

- Health Education Consultant III, Specialist (1.0 position): To develop performance expectations, assist with development, coordination and dissemination of best practices, educational materials, and evaluation efforts related to suicide prevention practices and policies, monitor contracts, provide highly specialized technical assistance; provide leadership and foster collaboration among state agencies and state/local stakeholders and constituencies.

- Staff Services Analyst (1.0 position): To conduct fiscal analyses to assure appropriate program expenditure authority; prepare and process contract documents, including work plans, budgets, and amendments as needed; develop contracts and interagency agreements; act as liaison with Accounting, Budgets, and Contract Management; review and process invoices and monitor reimbursement process; and compile data and assist in preparation of program progress reports.

- Research Scientist III (1.0 position): To serve as the lead Research Scientist for the Office of Suicide Prevention and conceive plans, conduct, organize and direct major, highly specialized program-specific surveillance analyses, and complex epidemiologic and statistical analyses using appropriate techniques and complex data sources.

- Health Program Specialist I or equivalent (1.0 position) – To assist with the provision of technical assistance to local entities, conduct ongoing program assessments, meeting planning and facilitation, and report writing.

Proposed Trailer Bill:

AB 2112 includes language that requires the OSP to be supported only with “existing staff and resources.” Hence the administration has proposed trailer bill to delete this provision, thereby allowing this proposed investment of new resources.

The proposed trailer bill can be found here:

https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/357

STAFF COMMENTS/QUESTIONS

CDPH:
Please provide a brief presentation of this proposal, and respond to the following questions:

1. What is a realistic timeline to expect that the proposed positions will be filled and the office will be operational?

2. Can you identify priorities that the OSP will have when it begins its work?

3. Do you plan to implement all of the components of AB 2112, including:

   Convening experts and stakeholders, including, but not limited to, stakeholders representing populations with high rates of suicide, to encourage collaboration and coordination of resources for suicide prevention.

4. Do you expect that the OSP will be able to collect, analyze, and make public suicide data in a timely fashion, such as having data that is no more than 1 year old? If so, when would you expect this to begin, and what barriers continue to exist to rapid (real time) data collection?

5. Is the Department involved with the design of the State's 988 rollout? How do you envision connecting suicide prevention activities of the new Office with the work to implement 988 in California?

6. More than a dozen California counties are working to implement Crisis Now as a strategy to improve how we respond to people in crisis; what opportunities do you see to connect the work of the new Office to the Crisis Now planning work that is underway?

OAC:
Please provide overall feedback on this proposal, and respond to the following questions:

1. Are you recommending any changes to this proposal?

2. What do you believe should be the initial priorities of the OSP?

3. Are there critical recommendations in the *Striving for Zero Strategic Plan* that could be implemented with a larger investment of resources in the OSP?

Staff Recommendation: Subcommittee staff recommends holding this item open to allow for additional discussion and evaluation, and urges the Subcommittee to consider a larger investment in the OSP and in state suicide prevention work and leadership generally.

4120 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 2: OFFICE OF HEALTH CARE AFFORDABILITY (GB BCP AND TBL)

PANEL 2 – PRESENTERS

Office of Statewide Health Planning and Development
- **Elizabeth Landsberg**, Director

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

PANEL 2 – Q&A ONLY

Office of Statewide Health Planning and Development
- **Michael Valle**, Deputy Director and Chief Information Officer, Information Services Division
- **Ryan Buckley**, Acting Chief Counsel, Legal Services Division

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Madison Sheffield**, Finance Budget Analyst

PROPOSAL

The Governor's budget includes proposed trailer bill and a budget change proposal to establish a Health Care Affordability Program (Program). Specifically, OSHPD requests 58 positions and $11.2 million in 2021-22, 106 positions and $24.5 million in 2022-23, 123 positions and $27.3 million in 2023-24, and annually thereafter from the California Health Data and Planning Fund to establish the Health Care Affordability Program.

For 2021-22, fifty-eight (58) key staff positions are needed to establish the Program. This includes one (1) Deputy Director at the Career Executive Assignment (CEA B), one (1) Chief Medical Officer at the exempt appointment level, one (1) Pharmaceutical Consultant II (Specialist), two (2) branch chiefs at the Career Executive Assignment (CEA A) managing the Health Care Cost Trends, Quality Performance, and Investigations & Enforcement branches, one (1) Deputy Chief Counsel at the Career Executive Assignment (CEA B), one (1) Assistant Chief Counsel, four (4) managers, and forty-seven (47) staff level positions. For subsequent years, the phase-in of staffing is expected to grow to one hundred six (106.0) staff positions in 2022-23 and one hundred twenty-three (123) staff positions in 2023-24.

OSHPD also requests corresponding provisional language providing availability of a General Fund cash flow loan as needed due to potential delays in collecting health care facility assessments. In addition, OSHPD requests provisional language specifying that $1 million of the 2021-22 requested amount is for information technology resources and is contingent upon approval of the Project Approval Lifecycle documents. The requested provisional language is as follows:

2021 Budget Act, Item 4140-001-0143, Provisions 1 and 2:
1. The General Fund shall make a cash loan available to the Office of Statewide Health Planning and Development not to exceed a cumulative total of $6,000,000. The loan funds shall be transferred to this item as needed to meet cashflow needs due to delays in collecting assessments from health facilities pursuant to Section 127280 of the Health and Safety Code, and are subject to the repayment provisions in Section 16351 of the Government Code.

2. Of the funds appropriated in Schedule (1) of this item, $1,000,000 is for the development of a data system for annual health plan expenditure reporting. This amount is available contingent upon approval of Project Approval Lifecycle documents by the Department of Technology.

This request includes $1,650,000 in 2021-22, $1,150,000 in 2022-23, and $900,000 in 2023-24 and annually thereafter in information technology costs.

This request includes $1,300,000 in 2021-22, $3,350,000 in 2022-23, and $2,850,000 in 2023-24 and annually thereafter in contracting resources.

The proposed trailer bill includes:

1. Set Health Care Cost Targets: The Director will establish a statewide health care cost target and will also set targets by health care sector and geographic region, which may include by payer, provider, insurance market or line of business. These targets will be based on the recommended targets set by the Health Care Affordability Advisory Board public hearings and public comments prior to formally adopting the targets are required.

2. Increase Cost Transparency through an Annual Report and Public Meeting: The Program will collect and analyze data from existing and emerging public and private data sources to publicly report total health care spending and factors contributing to health care cost growth, including in the pharmaceutical sector. The Program will publish an Annual Report and conduct public hearings to inform the Health Care Affordability Advisory Board, policymakers including the Governor and Legislature, and the broader public about performance against the cost target, cost trends and actionable recommendations for mitigating cost growth.

3. Enforcement of the Cost Target: The Program, through a progressive enforcement mechanism, will oversee the state's progress towards the health care cost target by providing technical assistance, requiring public testimony, requiring submission of corrective action plans, monitoring progress within corrective action plans, and assessing civil penalties, including escalating civil penalties for noncompliance.

4. Promote and Measure Quality and Health Equity: In consultation with other state departments, external quality improvement organizations and forums, payers, physicians and other providers, the Program will utilize OSHPD data, as well as data collected by other departments, and adopt a priority set of standard quality measures for evaluating the spending of health care service plans, health insurers, hospitals, and physician organizations, with consideration for minimizing administrative burden and duplication.

5. Advance and Monitor Adoption of Alternative Payment Models (APM): The Program will promote the shift from payments based on fee-for-service to those rewarding high quality and cost-efficient care. In furtherance of this goal, the Program will set statewide goals for the adoption of APMs and measure the state's progress. In addition, the Program will develop standards for APMs that may be used by payers and providers during contracting.

6. Advance Standards for Health Care Workforce Stability and Training Needs: The Program will monitor the effects of cost targets on health care workforce stability, high-quality jobs, and training needs of health care workers. To assist health care entities in implementing cost-reducing strategies that advance the stability of the health care workforce, and without exacerbating existing health care workforce shortages, the Program will develop standards in consultation with the Health Care Affordability Advisory Board.

7. Address Consolidation and Market Power: The Program will monitor cost trends, including conducting research and studies, on the health care market including, but not limited to, consolidation and market power on competition, prices, access, and quality. In collaboration with the Attorney General, Department of Managed Health Care and California Department of Insurance, as appropriate, the Program will promote competitive health care markets by examining mergers, acquisitions, or corporate affiliations that entail a material change to ownership, operations or governance structure involving health care service plans, health insurers, hospitals or hospital systems, physician organizations and/or pharmacy benefit managers, and other health care entities. The review of proposed material changes by the Program is not intended to supplant the role of the Attorney General but provide increased bandwidth for examining these market issues through dedicated staff performing rigorous data analysis.

The full proposed trailer bill language can be found here:

https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/344

BACKGROUND

A handful of states – Massachusetts, Rhode Island, Delaware, and Oregon – have implemented health care cost targets, with the goal that transparency-based, public reporting can reduce cost growth and better data and analytics can inform cost containment efforts. For all four states, a program for a health care cost target requires collecting data on total health care expenditures (all claims and non-claims based payments to providers, cost-sharing paid by consumers, and administrative costs and profits) and performing data analysis on cost trends by dimensions such as service category, payer, and provider. Given that the goal is an affordable high-value system, not just a low-cost system, each state program also simultaneously monitors performance on quality of care measures.

AB 80 (2020 budget trailer bill) provided OSHPD the authority to establish the Health Care Payments Database (HPD), often referred to as an All Payer Claims Database (APCD). The HPD will be a large research database derived from individual health care payment transactions. Similar to other states that have already implemented an HPD, this database will be used to analyze total health care expenditures and allow for deeper data dives on cost drivers and high cost service categories, such as diabetes treatment and specialty drug prices.

The proposal for a Health Care Affordability Program builds on efforts in other states to reduce costs, such as the Massachusetts Health Policy Commission (HPC), which was established in 2012 with the charge of setting a target for health care cost target, monitoring health care spending and providing data-driven policy recommendations regarding health care delivery and payment system reform.

The administration included a nearly identical proposal in the 2020 Governor's Budget, which was subsequently not pursued due to the pandemic.

AB 1130 Wood

AB 1130 contains the same proposal and identical language as the administration's proposed trailer bill. AB 1130 is currently in Assembly Appropriations Committee.

California Hospital Association Concerns and Requests:

The California Hospital Association (CHA) has concerns with this proposal and recommends that the following issues be addressed:

"Treating all health care entities equitably and holding all to the same standards. As proposed, the bill includes preferential treatment for payers compared to providers—where the Office would only hold entities accountable for profit and administrative costs but not insurance premiums – one of the most direct ways to lower monthly health care costs for Californians. Additionally, the Office should engage in the same level of comparative analysis of health plans as it does for providers, including but not limited to, trends in insurance premiums, medical loss ratios, disaggregated analysis of spending on health care claims, investments in data analytics, and quality initiatives. Last, for enforcement purposes, health plans should be held accountable to the same total health care expenditure targets as providers—not just their profit and administrative costs.

The Office should bend the health care cost curve without jeopardizing access to or the quality of care and coverage. This underscores the need for a predictable and stable glide path. The Office, when setting targets applicable to all entities, should ensure access and quality are protected. Currently, the proposal does not require the Office to do so, nor does it recognize that health care spending may actually need to increase in certain areas for the right reasons, such as more behavioral health investments, increasing access to care in underserved communities, providing life-saving treatment such as a high-cost cancer drugs for children, etc. Additionally, the timelines proposed should be adjusted to allow the Office to complete the required analysis, develop health care spending targets, and enforce corrective action plans as needed. Additional time is needed to notify health care entities of individual targets, corrective action plans, and enforcement steps.

The process used by the Office should prevent perverse incentives and unintended consequences. The proposal is not clear that the intent is to reduce the rate of increase in health care spending, rather than cutting current levels of health care spending in California. This is best illustrated by the requirement for the Office to protect primary care and behavioral health investments in California "without increasing costs to consumers or increasing the total cost of health care." Additionally, the proposal assumes that health care spending in California is in the right places and in the right amounts. The Office is not required to account for the decisions made by state and federal governments about spending in Medi-Cal and Medicare (covering approximately 44% of the California population), nor does the proposal require analysis of key underlying cost drivers—pharmaceuticals, medical devices, real estate, labor, etc.

The Office would have responsibility for overseeing hundreds of billions of dollars in health care spending, limiting its growth, and assessing penalties. This enormous responsibility requires a strong foundation built on integrity and confidence in the process from all stakeholders. The Office should focus

on greater transparency and establishing confidence in decisions made through a public process, instead of the current version, which provides for a full exemption from the Administrative Procedures Act. The proposal provides no due process or potential to seek relief to stakeholders affected by the spending caps, leaving undue control in the hands of one individual—the Director. Instead, the legislature should have a greater role of involvement with regular briefings, reports, and the final approval of the statewide health care spending targets recommended by the Office."

STAFF COMMENTS/QUESTIONS

OSHPD:
Please present this proposal, address to the concerns of CHA, and respond to the following questions:

1. Please describe any changes that have been made to the proposal since January.

2. Please describe how the proposed OHCA would impact health care consumers in California.

3. Please describe how the proposed OHCA would impact physician providers, health plans and hospitals in California.

LAO:
Please present your feedback, analysis and recommendations on this proposal, and respond to the following:

1. Do you find the staffing and other resource requests for this program to be reasonable?

Staff Recommendation: Subcommittee staff recommends holding this item open to allow for more time for discussion, and urges the Subcommittee to support this proposal later in the spring as this is a high priority for both the Assembly and the administration.

ISSUE 3: OSHPD RECAST AND MODERNIZATION (SPRING BCP AND TBL)

PANEL 3 – PRESENTERS

Office of Statewide Health Planning and Development
- **Elizabeth Landsberg**, Director

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

PANEL 3 – Q&A ONLY

Office of Statewide Health Planning and Development
- **Caryn Rizell**, Deputy Director, Healthcare Workforce Development Division

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Madison Sheffield**, Finance Budget Analyst

PROPOSAL

OSHPD requests nine positions and total expenditure authority from various fund sources of $6.3 million in 2021-22 and 13 positions and $3.9 million annually thereafter to recast and reorganize the Office into the Department of Health Care Access and Information (HCAI). The reorganization includes transferring the Office of Rural Health and the J-1 Visa Waiver Program from DHCS to the new department. These positions and resources would be allocated as follows:

Department Name Change – OSHPD requests expenditure authority of $1 million ($782,000 Hospital Building Fund, $171,000 Health Data and Planning Fund, $39,000 Health Facility Construction Loan Insurance Fund, and $8,000 Mental Health Services Fund) in 2021-22 to support one-time consulting services to, in collaboration with technology consultants: 1) plan, build new domain name, server environment, and authentication services; 2) migrate existing data; 3) validate data migration; 4) ensure appropriate security controls and interoperability with other systems; and 5) decommission the old domain name.

Health Workforce Research and Data Center – OSHPD requests expenditure authority of $770,000 from various special funds in 2021-22 and four positions and $1 million in 2022-23 to support consulting and software resources to establish and operate the Workforce Research and Data Center, which will replace the Healthcare Workforce

Clearinghouse. Specifically, the four requested positions, in addition to one requested reclassification of an existing position, are as follows:

Healthcare Workforce Development Division (HWDD)

- One Research Data Manager position would be reclassified from the Executive Director position at HPEF and would be responsible for management of the Research and Data Center, planning long-term vision and strategies, and communicating to executive management and external stakeholders.
- Two Research Data Specialist I positions would be responsible for health workforce data management, data analysis, and grant program evaluation.

Information Services Division

- One Information Technology Associate would be responsible for data management activities to maintain the existing enterprise data warehouse, data management environment, and data analytics toolsets.
- One Information Technology Specialist I position would be responsible for the most complex data management activities to maintain the existing enterprise data warehouse, data management environment, and data analytics toolsets.

The requested consulting resources for the Research and Data Center are as follows:

- $500,000 annually for workforce evaluation and research contracts to support the center in data collection and public reporting, including expertise on graduate medical education and training programs. Workload may include survey development and administration, data collection from healthcare facilities, educational institutions, or health workforce training programs. Public reporting may include grant program evaluation reports and analysis regarding the supply, demand, or educational capacity of the health workforce in the state.
- $150,000 annually for information technology (IT) consulting to support data dashboard design, development, and ongoing support, using existing toolsets.
- $4,000 annually for software licensing of existing toolsets for three data analysis staff.
- $86,000 in 2021-22 for system enhancements for the Department of Consumer Affairs (DCA) to collect required workforce data from healing arts board licensees.
- $30,000 annually for annual transmission of required workforce data from DCA.

State Office of Rural Health and J-1 Visa Waiver Program – OSHPD requests four positions and expenditure authority of $3.4 million ($2.7 million federal funds and $690,000 Health Data and Planning Fund) in 2021-22 and $1.9 million ($1.2 million federal funds and $690,000 Health Data and Planning Fund) in 2022-23 for administration and grant awards of the J-1 Visa Waiver Program administered by the Office of Rural Health. Specifically, the four requested positions are as follows:

Healthcare Workforce Development Division (HWDD)

- One Health Program Manager I position would be responsible for program supervision and evaluation of the Small Rural Hospital Improvement Program (SHIP) within the Office of Rural Health, and integration of the office's workforce priorities into HWDD programs.
- One Health Program Specialist II position would be responsible for administration, planning, and implementation of the Medicare Rural Hospital Flexibility Program within the Office of Rural Health.
- One Health Program Specialist I position would be responsible for coordination, monitoring, and evaluation of the Office of Rural Health grant activities and the J-1 Visa Waiver Program.
- One Associate Governmental Program Analyst (AGPA) would administer SHIP and provide supportive services to the Office of Rural Health and J-1 Visa Waiver Program.

As a result of the transfer of responsibilities from DHCS to HCAI, DHCS requests a corresponding decrease of four positions and expenditure authority of $1.9 million ($690,000 General Fund and $1.2 million federal funds) annually.

Dissolution of Health Professions Education Foundation (HPEF) – OSHPD requests reclassification of one Marketing and Outreach Director to one Staff Services Manager II position to oversee increased staffing of the Grants Management section. No change in expenditure authority is requested for this purpose.

Shared Services – OSHPD requests three positions and expenditure authority of $576,000 ($329,000 Hospital Building Fund, $217,000 Health Data and Planning Fund, $26,000 Health Facility Construction Loan Insurance Fund, and $4,000 Mental Health Services Fund) annually for administrative, IT, legal, and other shared services resources to support the additional workload and staff included in this request. Specifically, the three requested positions are as follows:

- One Associate Budget Analyst in the Administrative Services Division responsible for technical analytical work related to the preparation and maintenance of the budget.
- One IT Associate position in the Information Services Division's help desk, responsible for IT services and support, triaging support requests, providing training on enterprise tools, and researching and troubleshooting issues.
- One Attorney IV position in the Legal Division to support IT contracting, advise and assist HCAI in privacy law and navigation of intersecting state and federal regulations in operation of the Data Center, advise and support in the implementation and operation of the council activities, policies, and procedures, and support and advise the Office of Rural Health.

Business Application and Design – OSHPD requests two positions and expenditure authority of $341,000 ($171,000 General Fund, $124,000 Health Data and Planning Fund, $12,000 federal funds, $11,000 Health Professions Education Fund, $12,000 Registered Nurse Education Fund, $3,000 Mental Health Practitioner Education Fund, $6,000 Medically Underserved Account of Physicians Health Professions Education Fund, and $2,000 Vocational Education Fund) annually to support maintenance of the electronic application for workforce grant applicants. Specifically, the two requested positions are as follows:

- One IT Associate position would be responsible for business application engineering and maintenance activities for continuous operations of existing toolsets.
- One IT Specialist I position would be responsible for the most complex business application engineering and maintenance activities for continuous operations of existing toolsets.

Organizational Change Management Support – OSHPD requests expenditure authority of $250,000 from various funds in 2021-22 to support consulting services for organizational change management associated with the transition from OSHPD to HCAI. The consulting support would help facilitate organizational design, organizational process improvements, and creation of business interaction models. Additional responsibilities would include leadership development, team dynamics, employee training, coaching, and robust virtual and digital communication campaigns.

OSHPD also proposes trailer bill language to implement these changes, including:

- Amends Statutory References – Renames the Office of Statewide Health Planning and Development to the Department of Health Care Access and Information, and amends references to the "office" to the "department."

- Licensing Board Demographic and Other Data Collection – Amends the Business and Professions Code to require healing arts licensing boards to collect certain demographic and other data from its licensees. This language is similar to that contained in AB 1236 (Ting), pending in the current legislative session.

- Access to Vital Records – Allows the new department to request access to certain vital records from the Department of Public Health for the purpose of public reporting and research on health care quality and outcomes.

- Updates SB 17 Prescription Drug Reporting – SB 17 (Hernandez, Chapter 603, Statutes of 2017), requires manufacturers of prescription drugs to submit specific cost transparency information to OSHPD on drugs for which prices increase by more than 16 percent. The proposed trailer bill language would: 1) add data

submission requirements to help identify the therapeutic type of drug, factors describing the reason for a price increase, and the basis for withholding or limiting any information otherwise required to be submitted; 2) clarify definitions and requirements for reporting; 3) add information to support comparisons between brand name and generic drugs; and 4) clarify imposition of civil penalties on manufacturers that fail to provide required information.

- Transition Health Care Workforce Clearinghouse to California Health Workforce Research and Data Center – The Health Care Workforce Clearinghouse was established in 2007 by SB 139 (Scott, Chapter 522, Statutes of 2007). The clearinghouse collects, analyzes, and publishes information on educational and employment trends for healthcare occupations in the state. The proposed trailer bill language would transition the clearinghouse into the California Health Workforce Research and Data Center. The Data Center would be the recipient of the demographic and other data collected by healing arts licensing boards and, in addition to continuing the analysis and reporting previously conducted by the clearinghouse, would also report on the outcomes and effectiveness of health care workforce programs.

- Transition California Healthcare Workforce Policy Commission to California Health Workforce Education and Training Council – The California Health Care Workforce Policy Commission consists of 15 members, nine appointed by the Governor, and three each appointed by the Assembly and Senate. The Commission recommends funding awards for programs that demonstrate the ability to place graduates in medically underserved areas, attract and admit members of minority groups, and locate programs in medically underserved areas. The proposed trailer bill language would transition the commission to the California Health Workforce Education and Training Council. The council would also consist of 15 members, with six appointed by the Governor, three each by the Assembly and Senate, and representatives of the Department of Health Care Services, HCAI, and the University of California. According to OSHPD, the council would provide guidance on statewide education and health workforce training needs across key areas, including general physician education, primary care and behavioral health, and would advise on increasing the supply and diversity of physician and non-physician providers, as well as the placement of providers in medically underserved areas. The council would support the programs currently covered by the commission, such as the Song-Brown Program, as well as those currently covered by the Health Professions Education Foundation (HPEF), which is proposed to transition its programs to HCAI. HCAI would consider the council's policy recommendations as part of its administration of all of its workforce programs, including funding and award selection.

- Absorb Health Professions Education Foundation Programs – OSHPD administers the Health Professions Education Foundation (HPEF), a 501(c)(3) non-profit public benefit corporation established in 1987 through legislation. The HPEF offers scholarships and loan repayments for students and graduates willing to practice in underserved areas. The HPEF manages the following scholarship and loan repayment programs: 1) Allied Healthcare Scholarship and Loan Repayment Programs; 2) Vocational Nurse Scholarship and Licensed Vocational Nurse (LVN) Loan Repayment Programs; 3) LVN to Associate Degree Nursing Scholarship Program; 4) Associate Degree Nursing Scholarship Program; 5) Bachelor of Science in Nursing Scholarship and Loan Repayment Programs; 6) Advanced Practice Healthcare Scholarship and Loan Repayment Programs; 7) Licensed Mental Health Services Provider Education Program; 8) Mental Health Loan Assumption Program; and 9) Steven M. Thompson Physician Corp Loan Repayment Program. The proposed trailer bill language would dissolve the 501(c)(3) structure as of January 1, 2022, and absorb its programs within the new department. The California Healthcare Workforce Education and Training Council would support these programs and make recommendations on funding and awards.

- Expansion of Coronary Artery Bypass Graft Outcomes Reporting – OSHPD reports outcomes data for coronary artery bypass graft (CABG) surgeries in its CABG Outcomes Reporting Program. The reports and visualizations provide quality ratings for the state-licensed hospitals and surgeons that perform CABG surgery. The proposed trailer bill language would expand reporting to new and emerging cardiac procedures, such as transcatheter aortic valve replacement.

The full proposed trailer bill language can be found here:

https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/359

OSHPD also proposes to transition the following two programs from DHCS to the HCAI Primary Care Office:

- Office of Rural Health – The California State Office of Rural health links rural communities with state and federal resources and collaborates with statewide rural health associations and other public and private agencies to promote rural health services.

- J-1 Visa Waiver Program – Federal law requires foreign physicians seeking to pursue graduate education or training in the United States to obtain a J-1 Exchange Visitor Visa. The J-1 Visa Waiver Program makes recommendations to the United State Department of State regarding which visa applications should be

granted. The program gives priority to applications from primary care physicians who will work in federally designated underserved areas.

BACKGROUND

The Office of Statewide Health Planning and Development (OSHPD) collects and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes. OSHPD also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities.

California's health care system has changed dramatically since the Office's creation in 1978. OSHPD states that recent changes to OSHPD's responsibilities, including management of the Health Care Payments Data (HPD) Program, as well as the proposed Office of Health Care Affordability (OHCA), require a recasting of OSHPD's role. OSHPD believes the Department of Health Care Access and Information (HCAI) would be a more descriptive name for its new responsibilities and focus. OSHPD provided the following description of the purpose of this proposed recast/modernization:

> "Pursuant to the Governor's January Budget, this proposal would recast OSHPD as a department and align and improve its competencies to continue implementation of the Health Care Data Payments Program (HPD) and support the proposed Office of Health Care Affordability's (OHCA) role in lowering health care costs while promoting an adequate health workforce that provides quality and equitable care. With the addition of the OHCA and the proposed changes on workforce programs and data assets, the new Department is poised to be a thought leader on health care access and information. The new Department is well-suited to play a key role in providing the data, vision, and programs to develop the health workforce to meet the state's needs through a robust research and data center, development of workforce policy recommendations, and continued development and administration of its data assets."

STAFF COMMENTS/QUESTIONS

OSHPD:
Please present this proposal and respond to the following questions:

1. Please clarify the key goals with this proposal? I.e., what do you hope this new department will accomplish that OSHPD hasn't?

2. Please explain how the new department will evaluate its own performance?

3. How will the new department measure outcomes, such as for its health care workforce programs? I.e., how will the state know that its investments in HCAI workforce programs are actually increasing and diversifying the health care workforce?

LAO:
Please present your feedback, analysis, and recommendations on this proposal.

Staff Recommendation: Staff recommends holding this issue open to allow for more discussion and evaluation.

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 4: ANNUAL HEALTH CARE SERVICE PLAN HEALTH EQUITY AND QUALITY REVIEWS (SFL ISSUES 022 AND 177, BCP AND TBL)

PANEL 4 – PRESENTERS

Department of Managed Health Care
- **Mary Watanabe**, Director
- **Dan Southard**, Chief Deputy Director

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal & Policy Analyst

Health Access
- **Diana Douglas**, Policy and Legislative Advocate

California Pan-Ethnic Health Network
- **Cary Sanders**, Senior Policy Director

PANEL 4 – Q&A ONLY

Department of Health Care Services
- **Susan Philip**, Deputy Director, Health Care Delivery Systems
- **Palav Babaria**, Deputy Director and Chief Quality Officer, Quality and Population Health Management
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Madison Sheffield**, Finance Budget Analyst
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst

PROPOSAL

The Governor's Spring Finance Letter includes both proposed trailer bill and Budget Change Proposal to establish and enforce health equity and quality standards for all Department of Managed Health Care (DMHC) licensed full-service and behavioral health plans on an annual basis. Specifically, DMHC requests:

- 2 positions and limited term expenditure authority (equivalent to 0.5 position) and $952,000 Managed Care Fund in 2021-22,
- 2 positions and $351,000 in 2022-23,
- 15 positions and $3,584,000 in 2023-24,
- 19.5 positions and limited term expenditure authority (equivalent to 0.5 position) and $4,441,000 in 2024-25,
- 19.5 positions and limited term expenditure authority (equivalent to 0.5 position) and $4,402,000 in 2025-26,
- 24.5 positions and limited term expenditure authority (equivalent to 2.5 positions) and $6,315,000 in 2026-27,
- 24.5 positions and limited term expenditure authority (equivalent to 2.5 positions) and $5,999,000 in 2027-28,
- 24.5 positions and $5,434,000 in 2028-29 and annually thereafter.

This request includes the following:

- A requirement that the DMHC will produce an annual public Health Equity and Quality Compliance Report.

- $500,000 in 2021-22 for consultant services to assist with planning, organizing, and facilitating a Health Equity and Quality Committee to advise the Department on establishing a priority set of standard quality measures, including developing the health equity and quality benchmark standards.

- $539,000 in 2023-24 and annually thereafter for clinical consulting services to assist in interpreting data, and determining trends related to reducing health disparities and improving the quality of care delivered.

- $387,000 in 2026-27 and $127,000 beginning in 2027-28 and annually thereafter for enforcement and trial-related costs.

- $103,000 in 2023-24, $105,000 in 2024-25, and $106,000 in 2025-26 and annually thereafter for the annual software licenses costs for the new positions.

- $30,000 annually, beginning in 2023-24, for National Committee for Quality Assurance (NCQA) data access.

- Limited term resources of $72,000 (equivalent to 0.5 position) in 2021-22 to address the short-term workload related to the Health Equity and Quality Committee.

- $92,000 (equivalent to 0.5 position) in 2024-25 and $88,000 (equivalent to 0.5 position) in 2025-26 to assist with anticipated procedural enforcement referrals.

- $585,000 (equivalent to 2.5 positions) in 2026-27 and $569,000 (equivalent to 2.5 positions) in 2027-28 to assist with the anticipated three trial cases during 2026-27 through 2027-28 by providing legal support to investigate the health equity referral cases, including the preparation and oversight of the investigation and course of resolution.

In addition to the DMHC requests, DHCS requests 2 positions and expenditure authority of $296,000 ($148,000 General Fund (GF); $148,000 Federal Fund (FF)) in 2021-22 and 2 positions and $278,000 ($139,000 GF; $139,000 FF) in 2022-23 and ongoing to coordinate with DMHC on the establishment and enforcement of health equity and quality standards and to perform related data analysis.

Proposed Trailer Bill Language:
The proposed trailer bill can be found here:

https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/356

The Administration is proposing statutory changes to authorize the DMHC to establish health equity and quality standards for health plans and review compliance with those standards. The proposed statutory changes would apply to full-service and behavioral health care service plans licensed by the DMHC, including health care service plans that contract with the State Department of Health Care Services to provide health care services to Medi-Cal beneficiaries, and specialized health care service plans that provide behavioral health care. Currently, 44 commercial and Medi-Cal Managed Care Plans under the DMHC's jurisdiction would be subject to the anticipated statutory changes. The statutory changes may also impact up to 27 managed care plans that contract with the Department of Health Care Services (DHCS) for Medi-Cal services. The statutory changes include the following:

- The DMHC will develop data collection and reporting requirements and establish thresholds for compliance with health equity and quality benchmark standards.

- The DMHC will convene a Health Equity and Quality Committee in the first half of 2022 to make recommendations to the DMHC on a priority set of standard health equity and quality measures, including benchmark standards for assessing equity and quality in health care delivery. The Health Equity and Quality Committee will

make recommendations by selecting a limited subset of quality measures currently collected by health plans, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, and consumer satisfactions surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Examples of potential quality measures include diabetes, asthma, high blood pressure, prenatal and postpartum care, transitions in care, opioid use, vaccinations, mental health utilization, and depression screening. Examples of consumer satisfaction survey questions include those related to consumer experiences obtaining necessary and timely care, access to culturally and linguistically appropriate care, health plan customer service, and the ability to receive specialty behavioral health care. The Committee will also make recommendations on setting annual health equity and quality benchmarks, which the DMHC may use to measure health plan compliance and take appropriate enforcement action.

- The Health Equity and Quality Committee members will include state departments, purchasers, consumer advocates, healthcare service plan representatives, provider representatives, representatives with expertise in quality measurement, representatives with expertise in health equity and disparities in health care delivery, and other entities that it deems appropriate. The DMHC will contract with an external consultant with expertise in this subject area to assist the Department in planning, organizing, and facilitating the Committee meetings.

- Full Service and Behavioral health plans, and their subcontracted health plans, will be required to obtain and maintain National Committee for Quality Assurance (NCQA) accreditation by January 1, 2026.

- Full Service and Behavioral health plans will make applicable modifications to Quality Assurance program policies and procedures and annually collect and submit data on the priority set of health equity and quality measures, among other information, to the DMHC beginning in 2024 for Measurement Year 2023.

- The DMHC shall:
  - Establish the priority set of standard measures and benchmarks for equity and quality in health care delivery, taking into account the recommendations of the Committee.

  - Specify how health plans shall submit reports to the DMHC and annually review health plan reports for compliance with the health equity and quality benchmark standards.

  - Have the authority to require corrective action plans and take enforcement measures when benchmark standards are not met.

- Monitor corrective action plans and improvement efforts, where needed.

- Take progressive enforcement action against non-compliant health plans, as appropriate.

- Produce an annual Health Equity and Quality Compliance Report beginning in 2025.

- On an annual basis and until the requirements are codified in regulations, make changes to the priority measures and health equity and quality benchmark standards.

- The department may, at the department's discretion, reconvene the Health Equity and Quality Committee following the establishment of standard measures and annual benchmarks for the purpose of reviewing or revisiting the measures and benchmarks after the department has received data from health care service plans.

- Throughout the development and implementation of this proposal, the DMHC will coordinate its efforts with DHCS, OSHPD, Covered California, and CalPERS.

- The DHCS County Organized Health System (COHS) is a Medi-Cal managed care health plan model that operates in 22 California counties. Each COHS is created by a county board of supervisors and governed by an independent commission. In COHS counties, a single plan serves all Medi-Cal beneficiaries enrolled in managed care. COHS plans are not required to be Knox-Keene licensed and are not subject to DMHC monitoring.

- The DHCS will:

  - Monitor COHS plans for consistency to Knox-Keene regulation standards.

Advocates' Concerns and Requests

On behalf of various advocacy organizations, Health Access has shared requested changes to this proposal, including:

1. The metrics should be updated every three years, and therefore updates should not require changes to regulations given how slow the regulatory process tends to be; and

2. The trailer bill language should be explicit that these provisions apply to Medi-Cal managed care plans that are not Knox-Keene licensed.

STAFF COMMENTS/QUESTIONS

DMHC:
Please present this proposal and respond to the changes requested by advocates.

DHCS:
Please clarify what DHCS's role will be in terms of non-Knox-Keene-licensed Medi-Cal managed care plans.

LAO:
Please present any concerns any recommendations you have on this proposal.

HEALTH ACCESS and CPEHN:
Please present any concerns any recommendations you have on this proposal, and respond to the following questions:

1. Do you agree with the overall approach that the administration is taking with this proposal?

2. What else would you recommend that the state do to increase equity in health care?

Staff Recommendation: Staff recommends holding this item open to allow for additional discussion and evaluation, with likely approval later this spring reflecting modifications requested by advocates.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: MEDI-CAL TELEHEALTH PROPOSAL (TBL)

PANEL 5 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

Stakeholders
- **Dr. Ganga Hematillake**, Chief Medical Officer, United Health Centers of the San Joaquin Valley, California Primary Care Association
- **Dr. Claire Horton**, Chief Medical Officer, San Francisco Health Network, California Association of Public Hospitals and Health Systems
- **Robert Badilla**, Patient Navigator & Virtual Health Coordinator, Planned Parenthood California Central Coast
- **David Ford**, Vice President of Health Information Technology, California Medical Association
- **Jennifer Stoll**, Executive Vice President of Government Relations and Public Affairs, OCHIN

PANEL 5 – Q&A ONLY

Department of Health Care Services
- **Rene Mollow**, Deputy Director, Health Care Benefits & Eligibility
- **Lindy Harrington**, Deputy Director, Health Care Financing
- **Bruce Lim**, Deputy Director, Audits & Investigations
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

Department of Finance
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst

PROPOSAL

DHCS proposes trailer bill language to allow the delivery of certain Medi-Cal benefits, under specified circumstances, via telehealth, telephonic/audio-only, remote patient monitoring, and other virtual communication modalities. DHCS requests expenditure authority of $94.8 million ($34 million General Fund and $60.8 million federal funds) to support a new remote patient monitoring benefit as part of the telehealth proposal.

BACKGROUND

In response to the pandemic emergency, DHCS provided broad flexibilities for the delivery of Medi-Cal services through telehealth, telephonic/audio only, and other virtual communication modalities. According to DHCS, providing these telehealth flexibilities proved to be critically important during a time when in-person care put beneficiaries at risk of exposure to COVID-19. DHCS is proposing to allow Medi-Cal benefits and services to be provided via telehealth across all delivery systems when clinically appropriate.

DHCS implemented the following temporary policy changes during the public health emergency, related to telehealth:

- Expanded ability for providers to render all applicable services that can be appropriately provided via telehealth modalities, including home- and community-based services, Local Education Agency, and Targeted Case Management services.

- Allowed most telehealth modalities to be provided for new and established patients.

- Allowed many covered services to be provided via telephone/audio-only for the first time.

- Allowed payment parity between services provided in-person face-to-face, by synchronous telehealth, and by telephonic/audio only when the services met the requirements of the billing code by various provider types, including federally qualified health centers (FQHCs) and rural health centers (RHCs).

- Waived site limitations for providers and patients of FQHCs and RHCs.

- Allowed expanded access to telehealth through non-public technology platforms, based on a federal exemption to Health Insurance Portability and Accountability Act (HIPAA) requirements.

According to DHCS, the availability and need for telehealth has led to a significantly wider adoption of the use of these modalities for service delivery. Providers have become familiar with delivering services via telehealth and receiving reimbursement for telehealth services.

DHCS proposes trailer bill language to allow the delivery of certain Medi-Cal benefits, under specified circumstances, via telehealth, telephonic/audio-only, remote patient monitoring, and other virtual communication modalities. Specifically, DHCS proposes the following permanent flexibilities, contingent on federal approval:

- Allow an FQHC or RHC to establish new patients, within its federally designated service area, through telehealth (synchronous only).

- Permanently remove the site limitations on the provision of services by FQHCs and RHCs.

- Expand synchronous and asynchronous telehealth services to home- and community-based services waivers, the Targeted Case Management (TCM) Program, and the Local Education Agency Billing Option Program (LEA-BOP).

- Add synchronous telehealth and telephonic/audio-only services to State Plan Drug Medi-Cal.

- Require payment parity between in-person face-to-face visits and synchronous telehealth modalities only.

- Expand use of clinically appropriate telephonic/audio-only, other virtual communication, and remote patient monitoring for established patients, subject to a separate fee schedule and not billable by FQHCs or RHCs.

- Provides that the TCM Program and LEA BOP will follow traditional certified public expenditure reimbursement methodologies when rendering services via telehealth.

According to DHCS, it is not proposing to extend the following telehealth flexibilities implemented during the pandemic emergency:

- Telephonic/audio-only modalities as a billable visit for FQHCs or RHCs reimbursed at the per-visit rate.

- Telephonic/audio-only modalities to establish a new patient.

- Payment parity for telephonic/audio-only modalities and virtual communications.

- Various flexibilities for Tribal 638 clinics.

Local Assistance for Remote Patient Monitoring

DHCS requests expenditure authority of $94.8 million ($34 million General Fund and $60.8 million federal funds) to support a new remote patient monitoring benefit as part of the telehealth proposal. Remote patient monitoring allows clinical staff to use the results of remote physiological monitoring devices to manage a patient under a specific treatment plan. Common physiological data collected include vital signs, weight, blood pressure, and heart rate. The benefit would be implemented on July 1, 2021, for beneficiaries 21 years of age or older with a primary diagnosis of an acute or chronic condition. Beneficiaries would receive the devices from their providers, who would be reimbursed for remote monitoring activities.

Concerns of FQHC/RHCs

The California Primary Care Association (CPCA) and other stakeholders have expressed strong objection to the provisions in the proposed trailer bill that prohibit reimbursement for telephone care provided by FQHC/RHCs. DHCS and others assert that it is inappropriate to reimburse providers for telephonic care at the same rates as is reimbursed for in-person or synchronous video-based telehealth; nevertheless, at this point in time, DHCS is not aware of a payment methodology that could be implemented quickly to pay clinics a lower rate for telephone care.

In April of 2020, CPCA conducted a survey of community based organizations which serve many community clinic patients. The survey, based on 92 respondents, found:

- 1 in 8 California households lack internet access;
- Cost inhibits internet access for more than 1 in 5 Californians;
- More than 50% of survey patients who are racial and ethnic minorities, or special populations, lack internet access;
- 2 out of 3 patients rely on cell phones to receive virtual care;
- 1 out of 4 patients rely on non-mobile devices to receive virtual care;
- 91% of patients are most comfortable using phones for care (as compared to 76 percent for texting and 29% for video chat)

Stakeholders feel strongly that if telephonic care is not accessible for patients of FQHC/RHCs, this creates a significant inequity in the delivery and access to care in California.

AB 32 (Aguiar-Curry) also extends telehealth flexibilities in Medi-Cal. AB 32 was amended in Health Committee to allow payment parity for audio-only telehealth, temporarily for FQHCs/RHCs and permanently for other providers.

STAFF COMMENTS/QUESTIONS

Telehealth has proven to be enormously valuable during the pandemic, significantly increasing access to care for many people who could not have otherwise accessed care safely. This experience during the pandemic has also shone a light on how much more accessible health care can be, by fully supporting telehealth, addressing barriers to care affecting many people during non-pandemic circumstances. However, it is inequitable and unfair to make telephonic telehealth available only to patients who receive care from providers outside of community health clinics, but not for clinic patients.

DHCS/DOF:
Please present the Governor's telehealth proposal, respond to the key concerns and requests of stakeholders, and respond to the following questions:

1. For what reasons does the administration not support payment parity for telephone/audio-only care?

2. Please describe any efforts by DHCS to create a lower telephonic reimbursement rate for FQHC/RHCs.

3. Please provide a cost estimate on the amendments taken to AB 32 to allow for audio-only payment parity.

LAO:
Please present any feedback and recommendations you have to this proposal.

STAKEHOLDERS:
Please present your primary concerns or objections to the Governor's telehealth proposal.

Staff Recommendation: Subcommittee staff recommends holding this item open to allow for additional discussion and evaluation, and urges the Subcommittee and administration to give serious consideration to the amendments taken to AB 32.

ISSUE 6: OFFICE OF MEDICARE INNOVATION AND INTEGRATION (SFL ISSUE 173)

PANEL 6 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

PANEL 6 – Q&A ONLY

Department of Health Care Services
- **Anastasia Dodson**, Associate Director for Policy
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

Department of Finance
- **Tyler Woods**, Principal Program Budget Analyst
- **Alek Klimek**, Finance Budget Analyst

Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal & Policy Analyst

REQUEST

DHCS requests 4.0 permanent positions and expenditure authority of $602,000 ($452,000 General Fund (GF); $150,000 Federal Fund (FF)) in fiscal (FY) year 2021-22 and $566,000 ($425,000 GF; $141,000 FF) in FY 2022-23 and ongoing to establish a new DHCS Office of Medicare Innovation and Integration. This Office is proposed to provide focused leadership and expertise to lead innovative models for Medicare beneficiaries in California, including both Medicare-only beneficiaries and individuals dually eligible for Medicare and Medi-Cal.

BACKGROUND

In January 2021, the California Health & Human Services Agency published the Master Plan for Aging to serve as a comprehensive framework that will prepare the state for significant demographic changes in the years ahead, including the growth of the 60-and-over population to 10.8 million people by 2030. The Master Plan was developed pursuant to Governor Newsom's Executive Order N-14-19. The Master Plan for Aging serves as a blueprint for state government, local communities, private organizations, and philanthropy to build environments that promote an age-friendly California.

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease. Approximately 6.3 million Californians are enrolled in Medicare, including 1.5 million individuals dually eligible for Medicare and Medi-Cal. Over 2.5 million California Medicare beneficiaries (including some dually eligible individuals) are enrolled in Medicare managed care.

The Master Plan for Aging identified that long-term services and supports (LTSS) may be out of reach for some middle income Medicare beneficiaries who are not eligible for Medi-Cal, and do not have the resources to pay privately. This places them at greater risk of unnecessary institutionalization or "spending down" assets to qualify for Medi-Cal.

For dually eligible individuals, the Medicare and Medi-Cal programs operate independently and under different funding streams. Medicare is entirely federally funded and administered by the federal Centers for Medicare & Medicaid Services (CMS), and covers most preventive, primary, and acute health care services and prescription drugs (including short nursing home stays). Medi-Cal is jointly state-federal funded, administered at the state level, and covers long-term stays in skilled nursing facilities, other home and community-based services, certain behavioral health services, and Medicare premiums and cost-sharing. For dually eligible individuals with high rates of chronic conditions and functional impairments, streamlined access to services across health and LTSS systems is critical. The fragmented Medicare/Medi-Cal fiscal arrangement does not incentivize providers and payers to effectively invest in services to meet individuals' needs and preferences.

Older individuals with multiple chronic conditions and/or functional limitations, people with disabilities, and residents of nursing facilities are often dually eligible. These individuals experience high rates of chronic illness, with many having long-term care needs and social risk factors. Nationally, 41 percent of dually eligible individuals have at least one mental health diagnosis, 49 percent receive LTSS, and 60 percent have multiple chronic conditions. Eighteen percent of dually eligible individuals report that they have "poor" health status, compared to 6 percent of other Medicare beneficiaries. In addition, dually eligible individuals are more likely to be from systematically and historically disadvantaged populations.

DHCS has taken steps to address integration for dually eligible beneficiaries, through the Cal MediConnect (CMC) demonstration, which integrates Medicare and Medi-Cal benefits. Further, as part of the CalAIM initiative, DHCS is planning to transition CMC beneficiaries to enroll in Dual Eligible Special Needs Plans (D-SNPs) as of January 1, 2023, which are Medicare Advantage plans designed to serve dually eligible individuals, similar to CMC plans. In future years, all Medi-Cal managed care plans will establish D-

SNPs, so that integrated care will be available to dually eligible beneficiaries throughout the state.

STAFF COMMENTS/QUESTIONS

DHCS:
Please present this proposal and respond to the following questions:

1. For what reasons has the administration not proposed trailer bill to establish this Office?

2. What are the key lessons learned from Cal MediConnect, and how will those lessons inform the work of this Office and future Medi-Cal policy?

3. Are there specific outcome metrics that DHCS has in mind to determine the effectiveness of the work of this Office? I.e., in the future, how will the state determine whether or not this proposed Office has been a good investment?

Staff Recommendation: Subcommittee staff recommends holding this item open to allow for more discussion and evaluation, and suggests the Subcommittee request the administration provide trailer bill to establish this Office in law. Short of any significant concerns being raised, staff recommends approval later this spring.

ISSUE 7: LOCAL EDUCATIONAL AGENCIES MEDI-CAL BILLING OPTION PROGRAM EXPANSION (SFL ISSUE 172)

PANEL 7 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

PANEL 7 – Q&A ONLY

Department of Health Care Services
- **Lindy Harrington**, Deputy Director, Health Care Financing
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

REQUEST

DHCS, Local Governmental Financing Division (LGFD) and Office of Legal Services (OLS), request 8.0 permanent positions and expenditure authority $2,238,000 ($1,119,000 General Fund (GF); $1,119,000 Federal Fund (FF)) in fiscal year (FY) 2021-22 for the expansion and improvement of school based health care. The request includes limited-term (LT) contract authority of $1,000,000 ($500,000 GF) in FY 2021-2022, and $1,000,000 ($500,000 GF) in FY 2022-23 to hire a contractor to help implement the expansion of the Local Educational Agencies Medi-Cal Billing Option Program (LEA BOP).

BACKGROUND

The LEA BOP reimburses LEAs (school districts, county offices of education, charter schools, community college districts, California State Universities, and University of California campuses) the federal share of the maximum allowable rate for approved services. In order to be reimbursed under LEA BOP, services must be medically-necessary, provided by qualified health service practitioners to Medi-Cal enrolled students, and provided under an individualize plan for the student, such as an Individualized Education Program or Individualized Family Service Plan.

The LEA BOP is an optional program in which the state's 1,039 LEAs can choose to participate in order to receive reimbursement for the federal share for direct medical services allowed under Medi-Cal. Currently, 602 LEAs participate in LEA BOP receiving approximately $130 million in federal funding annually. The 602 participating LEAs account for over five million of the six million public school children in California. LEAs pay for the services and are reimbursed the federal funds, at 50% of cost, for each individual service. Historically, DHCS administrative costs have been reimbursed by LEAs.

On April 27, 2020 the Centers for Medicare and Medicaid Services (CMS) approved California's Medicaid State Plan Amendment (SPA) 15-021 retroactively effective July 1, 2015. Back billing is permitted for all allowable services going back to July 1, 2015. This SPA expands access to federal Medicaid funds for LEAs through the following three primary changes: (1) incorporating a Random Moment Time Survey (RMTS) methodology into the cost settlement process, (2) adding new service practitioners and new services covered under the LEA BOP, and (3) expanding the population covered under the LEA BOP to include Medicaid beneficiaries outside of special education, including mandated screenings covered by an Individualized Health and Support Plan (IHSP) or a "Care Plan."

DHCS states that SPA 15-021's expanded services will encourage greater participation in the LEA BOP primarily because LEAs can now receive reimbursement for approved health services for all Medi-Cal enrolled students with an individualized plan, rather than just from a small sub-set of largely special education students.

LEAs have increasingly asked DHCS staff for more technical assistance, more trainings, and more guidance concerning the successful administration of the LEA BOP. DHCS currently aims to offer training every other month at stakeholder meetings, however with additional resources, DHCS plans to hold trainings monthly and more often if needed. With the additional resources, DHCS also plans to offer more specific trainings such as training specifically for small and rural LEAs. The present DHCS staff workload includes working closely with all of the participating LEAs to provide training and technical assistance, creating policies and procedures, working with CMS on updating provider manuals and SPAs, conducting outreach and education, working with the fiscal intermediary (FI) on creating logic based on policy, and partnering with DHCS' Audits and Investigation Division to review policy, align methodologies, and develop solutions to audit concerns and issues.

The Department requests 8.0 new permanent positions and resources to hire a contractor to assist in the development, implementation, and management of an outreach campaign. The contractor will develop and distribute outreach materials, provide trainings, provide technical assistance to participating and non-participating LEAs in regards to the benefits of LEA BOP participation and the expansion of the program, and train DHCS staff on how

to successfully maintain the outreach campaign.

The contractor will be selected in consultation with CDE and the executive director of the State Board of Education, and must have experience successfully working with K-12 education entities and will be responsible for developing, implementing, and managing an outreach campaign for the LEA BOP.

STAFF COMMENTS/QUESTIONS

DHCS:

1. Is this sufficient resources to provide the amount of TA that is wanted and needed by LEAs to be able to participate in this program successfully?

2. What is the difference between the new individualized plan (that is required for a student to access LEA-BOP services) and an IEP for special education students? What is the process required to develop an individualized plan?

3. Does any student qualify to have an individualized plan developed in order to receive LEA-BOP services?

Staff Recommendation: Subcommittee staff recommends holding this issue open to allow for additional discussion and evaluation.

ISSUE 8: BEHAVIORAL HEALTH QUALITY IMPROVEMENT PROGRAM (SFL ISSUE 174)

PANEL 8 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

County Behavioral Health Directors Association
- **Michelle Cabrera**, Executive Director

PANEL 8 – Q&A ONLY

Department of Health Care Services
- **Lindy Harrington**, Deputy Director, Health Care Financing
- **Kelly Pfeifer**, Deputy Director, Behavioral Health
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

County Behavioral Health Directors Association
- **Elia Gallardo**, Director, Government Affairs

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Sonal Patel**, Finance Budget Analyst

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

REQUEST

DHCS requests $940,000 ($470,000 General Fund; $470,000 Federal Fund) in FY 2021-22 and $913,000 ($457,000 General Fund; $456,000 Federal Fund) in FY 2022-23 to support the equivalent of 3.0 positions and contract resources to administer the Behavioral Health Quality Improvement Program (BH-QIP). The BH-QIP will assist county Mental Health Plans and county Drug Medi-Cal programs prepare for opportunities through the California Advancing and Innovating Medi-Cal (CalAIM).

The limited-term contract resources include $500,000 ($250,000 General Fund; $250,000 Federal Fund) in FY 2021-22 and in FY 2022-23 to provide technical assistance to counties.

DHCS also requests associated provisional language to Item 4260-101-0001, as follows:

Add provisions to Item 4260-101-0001:
18. (a) Notwithstanding any other law, of the funds appropriated in Schedule (3) of this item, $21,750,000 shall be available to implement the Behavioral Health Quality Improvement Program to assist county Mental Health Plans and county Drug Medi-Cal programs prepare for implementation of the applicable behavioral health components of the California Advancing and Innovating Medi-Cal initiative.
(b) The State Department of Health Care Services shall determine the methodology and distribution of the funds appropriated in this provision to those county Mental Health Plans or county Drug Medi-Cal programs it deems qualified.
(c) This provision and the Behavioral Health Quality Improvement Program shall be implemented only if, and to the extent that, the State Department of Health Care Services determines that associated federal financial participation under the Medi-Cal program is not jeopardized.
(d) Notwithstanding Chapter 3.5 (commencing with section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Service may implement, interpret, or make specific this provision, in whole or in part, by means of information notices or other similar instructions, without taking any further regulatory action.
(e) For purposes of implementing this provision, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

BACKGROUND

Within CalAIM and specific to behavioral health, the 2021-22 Governor's Budget includes resources to incentivize payment systems and IT systems changes to counties to:

- Convert county-level billing to Healthcare Common Procedure Coding System Level 1 codes;
- Update county IT systems for CalAIM changes in medical necessity determinations;
- Incorporate managed care and other utilization data from DHCS into county IS systems for care: and
- Automate data reporting.

BH-QIP is modeled after the successful Delivery System Reform Incentive Program, Public Hospital Redesign and Incentives in Medi-Cal, and Public Hospital Quality Improvement programs.

The table below describes the state operations by the proposed position-equivalent.

Table 1
Position Equivalent Workload Description

Division	Request (Equivalent Positions)	Workload Description
Community Services Division (CSD)	1.0 Research Data Specialist II (RDS II)	To redesign performance outcome reports and provide data related technical assistance to counties on new reporting functions.
Medi-Cal Behavioral Health Division (MCHBD)	1.0 Health Program Specialist I (HPS I)	To design BH-QIP and its implementation process, and act as a county liaison for programmatic and/or clinical related technical assistance.
Local Governmental Financing Division (LGFD)	1.0 Associate Government Program Analyst (AGPA)	To assist MCBHD and CSD staff with fiscal management and oversee accurate county payments for meeting milestones.

County behavioral health programs serve as both managed care plans and clinical provider networks, and their size and complexity of their role in Medi-Cal has grown over the last decade. County behavioral health programs conduct a number of activities required by the federal managed care rules, many of which represent new requirements. Behavioral health providers are also newer to the practices of data collection, performance measurement, and reporting.

County behavioral health programs have historically depended upon categorical grant funding to enhance their infrastructure and as a result face technology challenges, including manual data reporting systems and inconsistent coding and billing systems. Although the CalAIM Initiative is designed to create the right environment for change, including simplifying state requirements, integrating mental health (MH) and substance use disorder (SUD) contracting, and reforming how the state pays counties (and how the counties pay providers), many counties do not yet have the tools to function in this environment, according to DHCS. The BH-QIP proposes to provide counties with the means to prepare for the changes to come.

Counties will implement the BH-QIP in the following domains:

1. Payment Reform
    a. Convert county-level billing to Healthcare Common Procedure Coding System (HCPCS) Level 1 codes.

b. Make system changes to transition from a Certified Public Expenditure to an Intergovernmental Transfers reimbursement method.
c. Make system changes to update claiming rates.

2. Update county IT systems for CalAIM changes in medical necessity determinations.
a. Adopt a standardized screening tool.
b. Adopt a standardized transition of care tool.
c. Adopt standardized assessment domains.

3. Incorporate Managed Care and other Utilization Data from DHCS into county IT systems of care.

4. Automate data reporting and/or electronic health record (EHR) systems as needed.

2021-22 Governor's Budget Local Assistance Proposal
(Dollars in thousands)

Program Budget	2021-22	2022-23	2023-24
Start-Up Costs[1]	14,000	0	0
Incentive Payments to Counties[2]	7,750	32,125	32,125
Total by Fiscal Year	21,750	31,125	32,125

[1] Each of the 56 county behavioral health programs would receive $250,000 General Fund in start-up costs.
[2] Incentive payments amounts will be recalibrated every year over the three years commensurate with actual county speeds of achieving all stated goals. Late reports, data and payments lags expected well into FY 2023-24.

STAFF COMMENTS/QUESTIONS

DHCS:
Please present this proposal and respond to the following questions:

1. What gives you the confidence that this proposal contains sufficient resources to address the needs of all 58 counties to be prepared for the successful implementation of CalAIM behavioral health provisions?

CBHDA:
Please provide feedback to this proposal and respond to the following questions:

1. Do you recommend changes to this proposal?

2. Do you believe that this proposal, with this level of resources, will enable the state to provide the technical assistance and support that all 58 counties will need?

Staff Recommendation: Subcommittee staff recommends holding this item open to allow for more discussion and evaluation of the proposal.

ISSUE 9: BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE PROGRAM (SFL ISSUES 175 AND 195) AND INCREASE ACCESS TO STUDENT BEHAVIORAL HEALTH SERVICES (GB BCP) UPDATES

PANEL 9 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

Mental Health Services Oversight and Accountability Commission
- **Toby Ewing**, Executive Director

County Behavioral Health Directors Association
- **Michelle Cabrera**, Executive Director

PANEL 9 – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director, Behavioral Health
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

County Behavioral Health Directors Association
- **Elia Gallardo**, Director, Government Affairs

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Sonal Patel**, Finance Budget Analyst

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

PROPOSALS

The Governor's Budget includes $750 million General Fund for the Behavioral Health Continuum Infrastructure Program and $400 million ($200 million General Fund; $200 million federal fund) for the Increase Access to Student Behavioral Health Services BCP, both of which were heard in this Subcommittee on February 22, 2021.

The Governor's Spring Finance Letter includes a BCP for state operations resources to support the Behavioral Health Continuum Infrastructure Program, as described here:

DHCS requests $2,191,000 General Fund in fiscal year (FY) 2021-22 and $2,155,000 General Fund in FY 2022-23 and in FY 2023-24 to administer the Behavioral Health Continuum Infrastructure Program (BH-CIP). This funding would be shifted from the $750 million one-time General Fund in local assistance proposed in the 2021 Governor's Budget. DHCS also requests corresponding provisional language.

The requested resources include limited-term contract authority of $1,500,000 General Fund annually from FY 2021-22 to FY 2023-24 to provide training and technical assistance to counties on real estate acquisition and rehabilitation, to conduct outreach and education activities, and to develop and manage the contracting process.

BACKGROUND

2021-22 Governor's Budget BH-CIP Proposal

To support counties and tribal entities with one-time investments in behavioral health infrastructure, the 2021-22 Governor's Budget includes the BH-CIP that provides $750 million in local assistance grants to counties and tribal entities to efficiently and cost-effectively acquire and rehabilitate real estate assets. The BH-CIP will allow California counties to expand the community continuum of behavioral health treatment facilities, allowing individuals to live and be treated in a stable environment which leads to better health and behavioral health outcomes. This will include the addition of at least 5,000 beds, units, or rooms to expand such capacity. County and tribal entities are required to provide in-kind funding or property equal to or greater than 25 percent of the total award, commit to own and operate the behavioral health treatment facilities, and maintain a long-term commitment to operating the facility for at least 30 years.

BH-CIP funding may be used to expand capacity for the following types of facilities, including but not limited to:
Crisis Intervention, Stabilization and Crisis Residential.

- Residential Treatment.
- Day Rehabilitation.
- Day Treatment Intensive or Partial Hospitalization with Housing Supports.
- Adult Residential Care Facilities/Board and Care Facilities.
- Room and Board with Intensive Outpatient Services.
- Peer Respite and Shared Housing.

DHCS reports that California counties face a behavioral health continuum infrastructure deficit. For example, inpatient psychiatric bed capacity in California is 21 beds/100,000 people whereas experts estimate 50 beds/100,000 people are needed to meet the need across the state. In a 2017 study (using 2014 data that has not yet been updated), California had among the lowest inpatient psychiatric bed capacity in the country. Only about 2,600 subacute mental health treatment beds are licensed in California6 and the

number of Substance Use Disorder (SUD) treatment facilities has decreased by 13 percent over the last three years (down to 874 licensed facilities in 2020 compared to 1,009 in 2018).

Several drivers contribute to this mismatch of supply and demand: high California real estate costs; “not in my backyard” mentality and zoning restrictions; and difficulty accessing low-income housing, resulting in growing homelessness which in turn can lead to increasing numbers of people with severe mental illness requiring residential care. Additionally, the restrictive federal interpretation of limitations of federal funding for patient care provided in Institutions for Mental Disease (IMDs) results in the denial of federal Medicaid funding for many treatment facilities. This results in increased costs to county behavioral health programs to pay for such placements when needed, preventing county behavioral health departments and county-contracted providers from building financial reserves that could otherwise allow for significant infrastructure investments.

Funding for and responsibility of most behavioral health treatment services and infrastructure was shifted from the state to counties as part of the 1991 and 2011 Realignment to provide a minimum level of funding for behavioral health services and flexibility for counties to maintain funding reserves and to make long-term investments in infrastructure. Additionally, the Mental Health Services Act authorizes counties to use a portion of local annual funding to enhance the infrastructure needed to support the behavioral health system, which includes developing facilities to meet increased needs of the local mental health system. Other county funding may also be used to support the behavioral health continuum infrastructure.

2021-22 Governor’s Budget Increase Access to Behavioral Health Services

This proposal seeks to implement a $389.0 million ($194.5 million GF, $194.5 million FF) local assistance incentive program through Medi-Cal Managed Care Plans, in partnership with schools and county behavioral health departments, to increase the number of K-12 students receiving preventive, early intervention, and behavioral health services from school-affiliated behavioral health providers.

Additionally, to incentive funds to be provided by the state, partnerships are encouraged to maximize all available additional funding sources, including but not limited to, School-Based MediCal Administrative Activities, Mental Health Services Act, Mental Health Student Services Act, and Local Control Funding Formula funds.

To implement this program, DHCS requests one-time $11,014,000 ($5,507,000 General Fund (GF) and $5,507,000 Federal Fund (FF)) in fiscal year (FY) 2021-22, available over four years, to support the equivalent of 12.0 positions.

SEIU Requests:

SEIU is requesting changes to both proposals, as follows:

"$750M Infrastructure Investment Should Also Go Towards Increased Staffing & IT Systems Improvements"

- Require counties to utilize at least 25 percent of the investment and incentive funds to expand the staffing capacity of locally available behavioral health services offered at county-operated sites that employ the expertise of county employees.
- Allow the 25 percent to be used to support existing behavioral health workforce training and development programs.
- Require that part of this funding go towards increasing behavioral health staffing as "existing workforce levels are not actually meeting current needs/demands for services. Furthermore, once these additional "brick and mortar" facilities and bed capacities are created, they will need additional staffing."
- Require funding to be used for improving and connecting existing IT systems in California's county-based behavioral health care delivery system.

"$389M Student Behavioral Health Initiative Should Be Shifted to County Behavioral Health Departments and Workers Instead of Managed Care Plans"

- Shift funding from managed care health plans to the County Behavioral Health Departments, specifically to the County Mental Health Plans because:
  - "Counties have established relationships with local schools and school districts, and we should capitalize on that knowledge and expertise.
  - California needs to improve its Medi-Cal network adequacy capabilities. For example, according to the annual network certification for specialty mental health conducted by the DHCS, only 13 of the County Mental Health Plans fully passed the required certification, while 43 conditionally passed and will require ongoing State monitoring and corrective action plans for remediation."

STAFF COMMENTS/QUESTIONS

DHCS:

Please provide a brief presentation on both the county infrastructure and school-based services proposals, and related BCPs, and respond to the following questions:

1. Is the state engaged in a behavioral health services gap analysis? If yes, please describe, and if not, would this not be justified?

2. Please provide reactions and feedback to SEIU's requests for changes to both proposals.

3. Once CalAIM payment reform is implemented, would these types of incentive payments (proposed for managed care plans) paid to counties qualify for federal matching funds? If yes, when would you estimate payment reform being in place?

4. For what reasons are the school-based incentive payments limited to K-12, and not also proposed for higher education?

5. Please share the administration's vision and strategy for integrating these proposals into the investment the state has already made into the Mental Health Students Services Act.

6. What accountability measures are built into the school-based proposal to ensure that managed care plans utilize the funds to address appropriate and effective school-based needs?

7. Which proposals in the Governor's Budget do you believe most significantly seek to make behavioral health services more accessible to the homeless population?

8. Under the MHSA, the State mandates that counties spend a majority of Community Services and Supports funding on Full Service Partnerships, which results in more than $900 million annually. FSP programs are intended to serve Californians with the greatest mental health needs with the most comprehensive levels of community-based care available. Are counties consistently following this expenditure requirement, and how would the Governor's infrastructure proposal leverage this existing investment?

OAC:
Please provide any general feedback and recommended changes you have to these proposals, and respond to the following questions:

1. Do you agree that managed care plans should play a significant role in ensuring that children have good access to behavioral health services?

2. Do you have other recommendations on how the Medi-Cal program can increase access to behavioral health services, for both children and the homeless population?

3. Should the state invest more in mobile crisis services for kids/families?

4. In addition to building long-term infrastructure to address the behavioral health needs of children/youth, what urgent/immediate interventions should the state consider supporting to address widespread trauma resulting from the pandemic?

CBHDA:
Please provide any general feedback and recommended changes you have to these proposals, and respond to the following questions:

1. What are the biggest challenges faced by counties in addressing the state's behavioral health needs, and how are those addressed by the Governor's Budget?

2. What major investments do you believe are missing from the Governor's Budget that would significantly improve access to behavioral health services for vulnerable populations (namely children and homeless)?

3. In addition to building long-term infrastructure to address the behavioral health needs of children/youth, what urgent/immediate interventions should the state consider supporting to address the widespread trauma resulting from the pandemic?

Staff Recommendation: Subcommittee staff recommends holding these proposals open to allow for additional discussion and evaluation. Staff also recommends the Subcommittee approve of these proposals later in the spring, and give serious consideration to approving of additional investments in county services, school-based partnerships and services, and mobile crisis services.

ISSUE 10: MENTAL HEALTH SERVICES ACT FLEXIBILITIES (TBL)

PANEL 10 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director and State Medicaid Director, Health Care Programs

Mental Health Services Oversight and Accountability Commission
- **Toby Ewing**, Executive Director

County Behavioral Health Directors Association
- **Michelle Cabrera**, Executive Director

PANEL 10 – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director, Behavioral Health
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

County Behavioral Health Directors Association
- **Elia Gallardo**, Director, Government Affairs

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Sonal Patel**, Finance Budget Analyst

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

PROPOSAL

DHCS proposes trailer bill to extend certain temporary adjustments to the Mental Health Services Act (MHSA) through June 30, 2022 to increase funding flexibility for counties to respond to the COVID-19 public health emergency. This proposal was included on the Subcommittee's "non-discussion" agenda on February 22, 2021, and is being included again here to allow for a presentation and discussion on this issue, as well as a presentation of requested changes by CBHDA.

BACKGROUND

The MHSA was enacted by California voters in 2004, which established a one percent income tax on personal income in excess of $1 million per year to expand and transform California's mental health system of care for those with a mental illness and their families. The MHSA addresses a broad continuum of prevention, early intervention, and treatment service needs, as well as the necessary infrastructure, technology and training elements that effectively support the system. MHSA funds are distributed to counties by the State Controller's Office on a monthly basis for the five funding components, which are: Prevention and Early Intervention (PEI), Community Services and Supports (CSS), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technology Needs (CFTN).

As part of the 2020 Budget Act, AB 81 (Budget Committee, Chapter 13, Statutes of 2020) was enacted to allow specified temporary flexibilities for counties with respect to the MHSA requirements due to the COVID-19 public health emergency. Specifically, AB 81:

- Authorizes counties to spend down their local MHSA prudent reserves, as opposed to submitting a request to DHCS as required through regulation (Welfare and Institutions Code (WIC) Section 5847(i)).

- Authorizes counties to spend funds within CSS program component regardless of category restrictions to meet local needs (WIC Section 5892(b)(3)).

- Authorizes counties to use their existing approved Three-Year Plan or Annual Update to expend local MHSA funds through 2020-21, if a county behavioral health director certifies to DHCS that they were unable to submit their new Three-Year Plan due to COVID-19-related reasons (WIC Section 5847(h)(1)).

- Extends the reversion deadline for unspent county funds subject to reversion as of July 1, 2019, and July 1, 2020, to July 1, 2021 (WIC Section 5892(i)).

- Authorizes DHCS to implement, interpret, or make specific the temporary flexibilities provided during the PHE by means of all-county letters or other instructions without taking further regulatory action (WIC Section 5847(j)).

As the public health emergency continues, counties continue to provide urgently needed mental health services at the same level or above to meet demand, especially outreach and engagement services not covered by other funding sources. In order to support these efforts to help meet local needs, DHCS proposes to extend the current flexibilities (as outlined above) for an additional year, *with the exception of the reversion period*. DHCS'

proposal also includes uncodified language that would declare that the proposal is in furtherance of the MHSA and make the provisions of the proposal severable.

Stakeholder Request:

A coalition of stakeholders and advocacy organizations, led by the County Behavioral Health Directors Association, urge the Governor and Legislature to approve of suspending the reversion of unspent funds for another year, until July 1, 2022. According to CBHDA, the pandemic has made it more difficult for counties to secure approved 3-year innovation plans and plan updates. Unlike the other key components of MHSA county expenditures, innovation plans and updates must be approved by the Mental Health Services Oversight and Accountability Commission. According to CBHDA,

> *"Although in 2020, the MHSOAC worked diligently to expand their capacity to address Innovation approvals, the MHSOAC has expressed concerns with their capacity to address a large volume of expected submissions of Innovation projects before the end of the current fiscal year. This situation, which has been exacerbated by the pandemic, will result in funds potentially being subject to reversion, due to insufficient time to secure MHSOAC approval for Innovation projects."*

STAFF COMMENTS/QUESTIONS

DHCS:

Please present this proposed trailer bill, and respond to the following questions?

1. For what reasons did you choose to not extend the suspension on reversion of unspent funds?

2. What do you know about the status of unspent MHSA funds, and funds that would be subject to reversion by June 30, 2021, by each county, and how spending was affected by the pandemic?

OAC:

Please provide any feedback you have on the administration's trailer bill proposal and to CBHDA's requested changes to the trailer bill, and respond to the following questions:

1. Please respond to CHBDA's assertions that the OAC's innovation plan approval process is too slow and cumbersome.

2. What do you know about the status of unspent MHSA funds by counties, and how spending was affected by the pandemic?

CBHDA:

Please present the changes you are requesting to the administration's mental health flexibilities trailer bill and the justification for those changes, and respond to the following questions:

1. What do you know about the status of unspent MHSA funds by counties, and how spending was affected by the pandemic?

2. What makes spending innovation funds particularly challenging for counties?

3. If MHSA reversion requirements are not suspended for an additional year, how much MHSA funding would revert? What percentage of those funds are innovation funding and what fiscal years are they from?

Staff Recommendation: Subcommittee staff recommends holding this item open to allow for additional discussion and evaluation.

NON-PRESENTATION ITEMS

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 11: MEDI-CAL PROGRAM INTEGRITY DATA ANALYTICS (SFL ISSUE 167)

REQUEST

DHCS, Audits and Investigations (A&I), requests one-year limited-term (LT) contract expenditure authority of $6,885,000 ($1,130,000 General Fund (GF); $5,755,000 Federal Fund (FF)) in fiscal year (FY) 2021-22 to extend funding for the Medi-Cal Program Integrity Data Analytics (MPIDA) service.

BACKGROUND

Extending funding for MPIDA will provide DHCS with new data models that specifically target two heightened risk areas: COVID-19 services and pharmacy claims transitioning from managed care to fee-for-service (FFS).

In addition, one year of extended funding will support the following services that aid DHCS in identifying fraud, waste, and abuse in Medi-Cal:

- Provides access to numerous proprietary databases to gain additional information about Medi-Cal providers and beneficiaries.

- Matches eligibility records with four proprietary data sources to identify individuals that should not be enrolled in Medi-Cal.

- Provides case management functionality that efficiently organizes all investigative activities including the development of leads, investigative activities, referrals to law enforcement and regulatory agencies, and the issuance of administrative sanctions.

STAFF COMMENTS/QUESTIONS

This is a spring proposal that has not been heard by the Subcommittee before. No questions or concerns have been raised by stakeholders.

Staff Recommendation: Subcommittee staff recommends likely approval, but holding this item open now to allow for additional evaluation and stakeholder input.

ISSUE 12: INTEROPERABILITY FEDERAL FINAL RULE COMPLIANCE (SFL ISSUE 168)

REQUEST

DHCS requests funding for 5.0 existing permanent positions, one-year limited-term (LT) contract funding, and expenditure authority of $2,854,000 ($713,000 General Fund (GF); $2,141,000 Federal Fund (FF)) in fiscal year (FY) 2021-22 and $737,000 ($184,000 GF; $553,000 FF) in FY 2022-23 and ongoing. The requested resources are needed to plan for and support DHCS compliance with the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) for Health Information Technology's Interoperability and Patient Access Rule (CMS-9115-F).

Below is a summary of LT contract dollars being requested in FY 2021-22:

Product/Effort	Duration	Contract Amounts
Interoperability Compliance Business Analyst	1-year LT	$250,000
Interoperability Compliance Business Analysis Team	1-year LT	$400,000
Interoperability Compliance Change Management and Business Process Design Team	1-year LT	$400,000
Interoperability Compliance Technical Team	1-year LT	$1,250,000
Total		**$2,300,000**

The 5.0 existing permanent positions were previously approved via BCP IMD15-01 "OHIT Staffing – Technical Assistance Program" in FY 2015-16. The Health Information Technology for Economic and Clinical Health (HITECH) workload and funding from that BCP will be ending September 2021. The positions were previously funded as 10% Health Care Services Plan Fines and Penalties Fund and 90% FF. This BCP proposes to redirect those existing positions to new workload related to the Interoperability and Patient Access Rule (CMS-9115-F).

BACKGROUND

Within DHCS, the Health Information Management Division (HIMD) is responsible for the Medi-Cal Promoting Interoperability Program (PIP), formerly known as the Medi-Cal Electronic Health Record Incentive Program. The PIP was originally authorized under the federal 2009 HITECH Act, which incentivized providers and hospitals to adopt and "meaningfully use" electronic health records (EHRs). A large part of the intent of "meaningful use" was to improve interoperability – the ability of different health information systems to exchange information with each other – by requiring program participants to electronically share specific patient data.

The HITECH programs, including the Medi-Cal PIP, are coming to an end in fall 2021, with close out activities through January 2024. However, CMS continues to advance interoperability requirements through new regulations. In May 2020, the Interoperability and Patient Access Final Rule (CMS-9115-F) was published in the Federal Register. 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.

The new policies provide patients access to their health information and move the healthcare system toward greater interoperability. As such, DHCS must plan for the implementation of technical solutions and also provide planning support to contracted plans and providers.

Given its prioritized response to the COVID-19 public health emergency, DHCS will not meet the July 1, 2021 deadline for the Patient Access API and will be submitting a planned approach to CMS. DHCS is submitting this budget proposal to obtain resources to plan and begin supporting compliance with the requirements. DHCS will be submitting an Advance Planning Document (APD) to CMS that describes the approach and requests enhanced federal funds for the resources in this proposal.

STAFF COMMENTS/QUESTIONS

This is a spring proposal that has not been heard by the Subcommittee before. No questions or concerns have been raised by stakeholders.

Staff Recommendation: Subcommittee staff recommends likely approval, but holding this item open now to allow for additional evaluation and stakeholder input.

ISSUE 13: MANAGED CARE PLAN STATEWIDE PROCUREMENT (SFL ISSUE 169)

REQUEST

DHCS, Managed Care Operations Division (MCOD) and Managed Care Quality and Monitoring Division (MCQMD), requests 11.0 permanent positions, four-year limited-term (LT) resources equivalent to 7.0 positions, and expenditure authority of $2,672,000 ($1,336,000 General Fund (GF); $1,336,000 Federal Fund (FF)) for fiscal year (FY) 2021-22, $2,510,000 ($1,255,000 GF; $1,255,000 FF) in FY 2022-23 through FY 2024-25 and $1,554,000 ($777,000 GF; $777,000 FF) in FY 2025-26 and ongoing to support the statewide Managed Care Program (MCP) procurement effort.

BACKGROUND

The Managed Care Delivery System has expanded into all 58 counties over the last 27 years. Various MCP model types operate throughout the 58 counties. The Two Plan Model type, where a commercial plan can operate, began in 1993. Currently there are 36 counties where a commercial health plan operates as a MCP in the county. Within the 36 counties that operate one commercial plan, a Local Initiative (LI) Plan operates in 15 of those counties as well. Additionally, 22 counties operate a County Organized Health System (COHS) Plan.

The MCP Procurement offers DHCS the opportunity to restructure and update the current MCP contract for all plans within all 58 counties while also requiring commercial plans to participate in the Request for Proposal (RFP) procurement process in order to operate in the county as a MCP. Upon completion of the procurement for commercial plan contracts, DHCS will incorporate the same contract requirements into its contracts with LI and COHS plans.

To-date, DHCS has not re-procured within the counties where commercial plans operate. In support of the MCP Statewide procurement, DHCS will be procuring commercial plans in the 36 counties where commercial health plans currently operate and provide services.

With an overall focus on quality outcomes and reducing health disparities, the DHCS MCP procurement, in alignment with the California Advancing and Innovating Medi-Cal (CalAIM) Initiative, also aims to restructure and update all Managed Care Plan contracts. Additionally, the MCP Procurement will focus on requirements and evaluation criteria highlighting increased access to care and care coordination and will aim to drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

STAFF COMMENTS/QUESTIONS

This is a spring proposal that has not been heard by the Subcommittee before. No questions or concerns have been raised by stakeholders.

Staff Recommendation: Subcommittee staff recommends likely approval, but holding this item open now to allow for additional evaluation and stakeholder input.

ISSUE 14: PROVIDER APPLICATION AND VERIFICATION FOR ENROLLMENT (PAVE) (SFL ISSUE 171)

REQUEST

DHCS, Enterprise Technology Services (ETS) in partnership with the Provider Enrollment Division (PED), requests one-year limited-term (LT) contract funding in the amount of $7,168,000 ($1,792,000 General Fund (GF); $5,376,000 Federal Fund (FF)) in fiscal year (FY) 2021-22 for enhancements (change requests) to the Provider Application and Validation for Enrollment (PAVE) system, including functionality to support provider enrollment activities within DHCS.

BACKGROUND

PAVE is a Commercial Off-the-Shelf (COTS) software that automates DHCS' Medi-Cal provider enrollment processes and serves as the enterprise platform for provider enrollment activities. PAVE is currently in maintenance and operations (M&O) status and is used to process and track provider enrollment for most Medi-Cal providers. PAVE provides a secure, web-based portal for providers to submit their applications and maintain accurate, up-to-date information. PAVE is also used by DHCS to establish and monitor on-going compliance with enrollment requirements by providers. PAVE improves access to enrollment services, facilitates ease of use, and adds efficiencies to enrollment processes that are critical to supporting the timely enrollment of providers. DHCS reports that business rules within the application have also resulted in a decreased number of deficient applications being submitted, improving the average processing time significantly.

PAVE is currently used to process and track provider enrollment for the following provider types: ambulatory surgical clinics, audiologists, blood banks, certified acupuncturists, certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists, chiropractors, clinical laboratories, diabetes prevention, dispensing opticians, Drug Medi-Cal clinics and medical directors and licensed professionals, heroin detox, exempt-from-licensure clinics, transportation, hearing aid dispensers, licensed clinical social workers, licensed marriage and family therapists, licensed midwives, occupational therapists, ocularists, optometrists, orthotists, out of state hospitals, pharmacies, physical therapists, physician assistants, physicians, podiatrists, portable imaging, prosthetists, psychologist, respiratory care practitioner, speech language pathologists, and tribal health services.

DHCS intends to expand the use of PAVE to other provider types, including Family-Planning, Access, Care, and Treatment (F-PACT), Diabetes Prevention Program (DPP), and Dental providers. In addition, DHCS intends to make program integrity enhancements to the provider enrollment process. These enhancements will collect information from providers regarding their affiliations with other providers that have been sanctioned in Medicare and or other Medicaid programs. All of these enhancements are part of PAVE M&O.

STAFF COMMENTS/QUESTIONS

This is a spring proposal that has not been heard by the Subcommittee before. No questions or concerns have been raised by stakeholders.

Staff Recommendation: Subcommittee staff recommends likely approval, but holding this item open now to allow for additional evaluation and stakeholder input.

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ISSUE 15: COSMETIC FRAGRANCE AND FLAVOR INGREDIENT RIGHT TO KNOW ACT OF 20202 IMPLEMENTATION (SB 312) (SFL ISSUE 224)

REQUEST

CDPH, Center for Healthy Communities, Occupational Health Branch, requests $26,000 General Fund in 2021-22 and $52,000 ongoing General Fund to pay for costs associated with changes, maintenance, and operation of an existing database needed to accommodate the mandates of SB 312 (Leyva, Chapter 315, Statutes of 2020).

BACKGROUND

The California Safe Cosmetics Program (CSCP) was created within CDPH by the California Safe Cosmetics Act of 2005. Manufacturers of cosmetics whose total sales exceed $1 million in California are required to report to the CSCP any products that contain intentionally added ingredients that have been identified by authoritative bodies as known or suspected carcinogens, reproductive or developmental toxicants. The CSCP maintains an online reporting system used by reporting companies and a searchable database which provides the public with access to the information reported by cosmetics manufacturers if not identified as trade secrets. As of December 5, 2020, there were 581 companies that had reported 86,198 products containing one or more ingredients linked to cancer or reproductive or developmental harm.

SB 312 establishes the Cosmetic Fragrance and Flavor Ingredient Right to Know Act of 2020. Commencing January 1, 2022, the bill requires an increase in the number and types of hazardous ingredients that manufacturers of cosmetic products sold in the state must report to CDPH. SB 312 requires these manufacturers to provide the CSCP with a list of each reportable fragrance or flavor ingredient included in their cosmetic products, and a list of each fragrance allergen that is present in the product in specific concentrations. Commencing January 1, 2022, the bill also requires CDPH to post a list of those fragrance flavor ingredients in reported cosmetic products and their associated health hazards on the CSCP existing database of cosmetic product information.

Historically, the CSCP budget has had no dedicated funds for ongoing database maintenance, which must be performed by staff in the Information Technology Services Division (ITSD) and paid for by the program. In 2019-20, in response to a stakeholder proposal, CSCP received a one-time, $1 million funding augmentation for a major database update that was completed in June 2020. The 2019-20 augmentation also included funding that added three positions (Research Scientist Supervisor I, Health Program Specialist II, and Staff Services Analyst) to CSCP, who will be able to absorb

the non-IT portions of the new workload associated with SB 312 mandates. However, CDPH states that the program cannot absorb the new, ongoing IT costs related to SB 312 implementation.

STAFF COMMENTS/QUESTIONS

This is a spring proposal that has not been heard by the Subcommittee before. No questions or concerns have been raised by stakeholders.

Staff Recommendation: Subcommittee staff recommends likely approval, but holding this item open now to allow for additional evaluation and stakeholder input.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 16: INCREASED INVESTIGATION WORKLOAD (SFL ISSUE 068)

REQUEST

DSH requests $337,000 General Fund in fiscal year (FY) 2021-22 and $266,000 annually thereafter to support the reclassification of 20.0 Hospital Police Officer (HPO) positions to Investigators.

BACKGROUND

Each hospital within DSH has an allocation of protective services staff operating under the Department of Police Services (DPS). DPS has jurisdiction over all criminal activity and violations of any laws or administrative policies on hospital grounds and are therefore responsible for the investigation of those crimes and/or allegations of misconduct. Investigative functions at the hospitals are conducted by the Office of Special Investigations (OSI). The Office of Law Enforcement Services (OLES) within the California Health and Human Services (CHHS) Agency provides independent and contemporaneous oversight of investigations conducted by departments within CHHS. As such, DSH is required to report specific types of incidents to OLES for the determination of whether the allegations warrant OLES monitoring of the departmental investigation.

Investigators operate under the OSI, however as a resolution to increased workloads, urgency of completion and statutory deadlines for completion of investigations, DSH implemented the Detective Units. This specialized unit was supported by the county district attorneys to ensure bifurcation of cases (administrative versus criminal) was implemented.

Detective Unit

- Hospital police detectives within the detective unit are responsible for pursuing criminal cases that arise from law violations involving patients and staff. Criminal cases are generated from officers' preliminary reports and the detectives follow the case from the evidence gathering phase through the submission of the case to the district attorney's office for prosecution.

Office of Special Investigations

- Investigators within the OSI are responsible for pursuing administrative cases involving allegations of staff misconduct as well as investigations involving

employee's adherence to facility policies and rules. The investigators are responsible for determining when allegations of staff misconduct warrant an internal investigation, for completing the investigation, for making appropriate recommendations of corrective actions to the hiring authority for disposition and for submitting cases to the District Attorney for prosecution if a case is determined to also be criminal in nature.

It is the intent of DSH to reclassify 20.0 existing HPO positions to that of an Investigator. DSH explains that current workload being completed is at a level more consistent with the duties of an Investigator classification.

STAFF COMMENTS/QUESTIONS

This is a spring proposal that has not been heard by the Subcommittee before. No questions or concerns have been raised by stakeholders.

Staff Recommendation: Subcommittee staff recommends likely approval, but holding this item open now to allow for additional evaluation and stakeholder input.

ISSUE 17: STATEWIDE LIGATURE RISK SPECIAL REPAIR FUNDING EXPENDITURE AUTHORITY (SFL ISSUE 069)

REQUEST

DSH requests authority, through provisional language, in fiscal year (FY) 2021-22 and annually thereafter until 2026-27, to extend the encumbrance and expenditure authority for ligature risk special repair funding authorized in the 2020 Budget Act.

BACKGROUND

DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily census of 6,143 and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

The 2020 Budget Act included funding to mitigate ligature risks within four of The Joint Commission (TJC) accredited state hospitals. This is necessary to meet standards for acute psychiatric hospitals required by the Centers for Medicaid and Medicare Services (CMS), and to maintain TJC accreditation at these four state hospitals. Funding is implemented across seven years as outlined below:

- Year One, 2020-21: $5,257,000 General Fund
- Year Two, 2021-22: $5,257,000General Fund
- Year Three, 2022-23: $8,409,000 General Fund
- Year Four, 2023-24: $8,409,000 General Fund
- Year Five, 2024-25: $15,415,000 General Fund
- Year Six, 2025-26: $15,415,000 General Fund
- Year Seven, 2026-27: $15,415,000 General Fund

Provisional language is needed to address the challenges in completing the purchase or fabrication of ligature retrofit materials and labor and hiring issues that necessitate an extended timeline for the required retrofits.

Budget Bill Provisional Language:

The following Budget Bill Provisional Language is being proposed:

Item 4440-011-0001
14. Of the amount appropriated in Schedule (2), $5,257,000 shall be expended for ligature risk special repair projects at Atascadero, Metropolitan, Napa, and Patton state hospitals. The amount allocated shall be available for encumbrance or expenditure until June 30, 2024.

STAFF COMMENTS/QUESTIONS

This is a spring proposal that has not been heard by the Subcommittee before. No questions or concerns have been raised by stakeholders.

Staff Recommendation: Subcommittee staff recommends likely approval, but holding this item open now to allow for additional evaluation and stakeholder input.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 18: MENTAL HEALTH SERVICES FUND LIQUIDATION PERIOD EXTENSIONS – COUNTY MENTAL HEALTH INNOVATION PLANNING (SFL ITEM 22) AND TRIAGE PERSONNEL GRANT PROGRAM (SFL ITEM 23)

REQUEST

Innovation Planning

The Mental Health Services Oversight and Accountability Commission (OAC) requests an extension to the time period to liquidate $400,000 in encumbrances from Item 4560-001-3085, Budget Act of 2018, to support County Mental Health Innovation Planning.

The 2018 and 2019 Budget Acts included a total of $5 million one-time Mental Health Services Fund (MHSF) collectively to support contract costs for technical assistance to the counties in developing their MHSF Innovation Plans, with a focus on Incompetent to Stand Trial patient diversion. The OAC's contractor identified a subcontractor, but later learned the entity was not legally eligible to provide subcontracting services. The contractor is currently negotiating with an alternative subcontractor. Extending the liquidation authority for an additional year provides needed time to finalize the subcontract.

Triage Personnel Grant Program

The OAC also requests that Item 4560-494 be added to extend the period to liquidate $5.9 million in encumbrances from Item 4560-101-3085, Budget Act of 2018, to support the Triage Personnel Grant Program. The Program provides competitive grants to counties to support crisis services for individuals with mental health needs. Extending the liquidation period provides additional time for grantees to complete work delayed due to COVID-19 impacts, including difficulty hiring and retaining staff, challenges accessing and engaging clients using a remote telecommunications platform, and finalizing subcontracts.

Proposed Budget Bill Provisional Language

4560-494—Reappropriation, Mental Health Oversight and Accountability Commission. Notwithstanding any other law, the period to liquidate encumbrances of the following citations is extended as specified below.

3085—Mental Health Services Fund

(1) $400,000 in Item 4560-001-3085, Budget Act of 2018. Available for liquidation until June 30, 2022.

(2) $5,900,000 in Item 4560-101-3085, Budget Act of 2018. Available for liquidation until June 30, 2023.

STAFF COMMENTS/QUESTIONS

This is a spring proposal that has not been heard by the Subcommittee before. No questions or concerns have been raised by stakeholders.

Staff Recommendation: Subcommittee staff recommends likely approval, but holding this item open now to allow for additional evaluation and stakeholder input.

4800 COVERED CALIFORNIA

ISSUE 19: HOSPITAL DISCHARGE DATA SHARING (SFL TBL)

REQUEST

This proposed trailer bill would require OSHPD to make hospital discharge data available to Covered California to improve accuracy of annual premium rate setting. The proposed provisions protect patients' rights to confidentiality, and require Covered California to provide the Governor and Legislature with a report detailing the impact of these requirements on Covered California, including the impact on health plan premium rates offered through the state exchange, by August 1, 2023.

BACKGROUND

This trailer bill is intended to improve the accuracy of annual premium rate setting. As described by Covered California, utilization and risk mix analyses are an essential part of carrier pricing. Covered California enrolls one-third of its membership anew each year, and there is substantial competition and migration between plans during renewal. The high rate of turn-over means that a prior year's population may be very different from the new population. Yet, carriers are expected to set rates for the next year only a few months after the current year's open enrollment has closed—not allowing enough time for much actual claims experience to accumulate. Thus, carriers are operating with very limited information about a large segment of their population. Covered California explains that this lack of information leads to incorrect pricing and additional business risk, which is bad for both consumers and carriers. The importance of getting early insight into the potential health risk profile of a new cohort—and how it compares to the market average—is heightened given the implementation of risk adjustment under the federal Affordable Care Act, under which the federal Centers for Medicare & Medicaid Services must make transfer payments across carriers based on how their own enrolled risk profile compares to that of other issuers in the market. A marketplace that can help plans understand their relative risk position earlier in the process can potentially help all plans price more accurately.

OSHPD maintains comprehensive data on nearly all inpatient health care facility discharges that occur in the state each year. The utilization and diagnosis information on these datasets contain the information needed to construct a risk profile analysis of each "new" cohort of Covered California enrollees.

Through a research effort conducted in collaboration with the University of California, San Francisco and DHCS in 2014, Covered California helped to demonstrate that the OSHPD patient discharge data could be a valuable tool to help carriers understand their risk mix

in a way that protects patient privacy and maintains the confidentiality of the rate-setting process. By linking the data with Covered California enrollment information, comprehensive risk profiling was conducted and shared back with plans on an aggregated confidential basis to inform their rate proposals for 2015.

The data is important for various analyses undertaken by Covered California's Plan Management Division, as it assesses the experience of state exchange enrollees in relation to other state initiatives, such as the effort to reduce unnecessary C-sections, and potentially to allow for better assessment of how to ensure continuity of care for new consumers as they transition from other sources of coverage. The data also can shed light onto the risk profile of those who enroll in Covered California compared to those who remain uninsured, including analysis by race, age, and gender—a component of Covered California's efforts to reduce health disparities.

Covered California will protect this data in accordance with state and federal privacy and information security-related laws and standards which govern all the sensitive information within its custody or under its control. These include the privacy and information security standards enacted in accordance with 45 CFR §155.260, as well as the California Information Practice Act (Cal. Civil Code § 1798 et. seq.). The privacy and information security-related standards which Covered California has enacted to fulfill 45 CFR §155.260 consist of the 351 individual security and privacy-related requirements arising under the Minimum Acceptable Risk Standards for State Exchanges, or "MARSE", which is applicable to any and all CalHEERS data. Consequently, data obtained from OSHPD will always be subject to these same individual privacy and information security-related standards.

The proposed trailer bill language can be found here:

https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/358

STAFF COMMENTS/QUESTIONS

This is a spring proposal that has not been heard by the Subcommittee before. No questions or concerns have been raised by stakeholders.

Staff Recommendation: Subcommittee staff recommends likely approval, but holding this item open now to allow for additional evaluation and stakeholder input.

ACTION-ONLY ISSUES

The following items have been heard already by the Subcommittee, or are of a technical nature, and are recommended for approval.

0530 California Health and Human Services Agency			
Issue	**Proposal Name**	**Proposal Description**	**Staff Comments and Recommendations**
January Budget Proposals			
20	Administrative Resources for Implementation of SB 852 (the California Affordable Drug Manufacturing Act of 2020)	Proposes a one-time appropriation of $2 million General Fund in Fiscal Year 2021-22 for consulting services, with expenditure authority until Fiscal Year 2022-23, and position authority for one FTE position ($197,000 General Fund in 2021-22 and $184,000 General Fund ongoing) to support implementation of SB 852 (Pan, Chapter 207, Statutes of 2020), the California Affordable Drug Manufacturing Act of 2020.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** March 8, 2021

4120 Emergency Medical Services Authority			
Issue	**Proposal Name**	**Proposal Description**	**Staff Comments and Recommendations**
January Budget Proposals			
21	Community Paramedicine or Triage to Alternate Destination Act of 2020 (AB 1544)	Proposes $2.3 million General Fund over three years beginning in 2021-22 to implement AB 1544 (Gipson, Gloria, Chapter 138, Statutes of 2020), the Community Paramedicine or Triage to Alternate Destination Act of 2020, which would authorize a local emergency medical services agency to develop and seek approval for a program that provides the various community paramedic or triage paramedic services.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021
22	Office of Legislative, Regulatory and External Affairs and Legal Office Increased Workload	Proposes $286,000 General Fund ongoing and two permanent positions, to meet the increased workload within the Office of Legislative, Regulatory and External Affairs (LEA) to coordinate external affairs; public	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021

		engagement related to emergency preparedness and disaster response and mitigation; and intergovernmental communications in support of EMSA's lead role under California's Emergency Support Function 8 (ESF-8) – Public Health and Medical. The requested resources will also address increased workload within the Legal Office associated with mandated reporting tasks, AB 434 (Baker, Chapter 780, Statutes of 2017) compliance, and creation of content and ongoing workload associated with implementation of EMSA's intranet.	
23	Regional Disaster Medical Health Response Local Assistance	Proposes $365,000 General Fund ongoing, to improve regional disaster medical and health mitigation, preparedness, response and recovery by permanently funding an additional three (3) local Regional Disaster Medical Health Specialist in three California Governor's Office of Emergency Services Mutual Aid regions.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021

4140 Office of Statewide Health Planning and Development			
Issue	**Proposal Name**	**Proposal Description**	**Staff Comments and Recommendations**
January Budget Proposals			
24	Administrative Support Services	Requests a net-zero adjustment to the OSHPD's total special funds (increase of $6,000 Hospital Building Fund, $31,000 Health Data and Planning Fund, $4,000 Mental Health Services Fund, and decrease of $41,000 Health Facility Construction Loan Insurance Fund) to support administrative services related to accounting and human resources. The implementation of the Fi$Cal system has resulted in increased time needed for various processes.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021

25	Reimbursements for Health Care Payments Data Program	Requests $5,009,000 in reimbursement authority to the General Fund for Fiscal Year 2021-22, $5,316,000 in 2022-23, $4,736,000 in 2023-24, and $4,743,000 in 2024-25. Reimbursement authority will enable OSHPD to use federal funds to support the Health Care Payments Data (HPD) System through the end of the Project Approval Lifecycle process. HPD costs eligible for federal funds include state staff and services, operating expenses, and contracted services.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021
26	SB 17 Attorney Fees	Requests $457,000 in 2021-22 and $567,000 in 2022-23 from the California Health Data and Planning Fund to support State Office of the Attorney General (AG) fees for legal services provided to OSHPD associated with Chapter 603, Statutes of 2017 (SB 17). OSHPD also requests provisional language providing increased expenditure authority in the case that 2021-22 attorney fees exceed the amount in this request.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021
Spring Proposals			
27	Reappropriation of Federal Funds for State Loan Repayment Program	Requests a reappropriation of up to $31,000 in federal funds, to support the State Loan Repayment Program due to a grant contract breach. OSHPD has federal authority to encumber the funds in 2021-22.	**Staff Recommendation:** Approve as proposed.
28	Mental Health Services Fund Extension of Encumbrance Liquidation Period	Proposes to extend the period to liquidate encumbrances for $700,000 (Prop. 63 funds) for the Peer Personnel Program, for one grantee needing additional time to fulfill the service grant agreement as a result of COVID. OSHPD anticipates that more grantees also will need additional time.	**Staff Recommendation:** Approve as proposed.
29	Technical Adjustment – Correct Program Number	Requests that Item 4140-001-0001 be amended to correctly reflect the program number	**Staff Recommendation:** Approve as proposed.

		"3855" for Health Care Information and Quality Analysis in Schedule (3) of the item, due to a typo in the Governor's Budget.	
30	Technical Adjustment – Change Program Name from "Alzheimer's" to "Geriatric" Care Workforce Programs	Requests to retitle the "Alzheimer's Health Care Workforce Program" to "Geriatric Care Workforce Program" to more appropriately describe program activities proposed in the Governor's Budget.	**Staff Recommendation:** Approve as proposed.
31	Technical Adjustment – Annual Reimbursement	Requests that Item 4140-101-0143 be amended by increasing reimbursements by $400,000 to correctly reflect reimbursements due to a technical computing error.	**Staff Recommendation:** Approve as proposed.

4150 Department of Managed Health Care			
Issue	**Proposal Name**	**Proposal Description**	**Staff Comments and Recommendations**
January Budget Proposals			
32	Health Coverage: Mental Health or Substance Use Disorders (SB 855)	Proposes 5 positions and $1,500,000 Managed Care Fund in 2021-22, 5.5 positions and $1,345,000 in 2022-23 and annually thereafter to review and enforce mental health and substance use disorder treatment coverage mandates on health plans as specified pursuant to SB 855 (Weiner, Chapter 151, Statutes of 2020).	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** March 8, 2021
33	Risk-Based or Global Risk Provider Arrangement Pilots (AB 1124)	Proposes limited-term expenditure authority of $413,000 in 2021-22, $401,000 in 2022-23 through 2024-25, $332,000 in 2025-26, and $342,000 in 2026-27 from the Managed Care Fund to create two pilot programs, one in Northern California and one in Southern California, to permit a qualifying voluntary employees' beneficiary association (VEBA) or trust fund to enter into capitation payment agreements with qualified providers while being exempt from licensure under the Knox-Keene Health	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** March 8, 2021

		Care Service Plan Act of 1975 for no more than four years as specified pursuant to AB 1124 (Maienschein, Chapter 266, Statutes of 2020).	

4260 Department of Health Care Services			
Issue	**Proposal Name**	**Proposal Description**	**Staff Comments and Recommendations**
January Budget Proposals			
34	AB 1705 Ground Emergency Medical Transportation (GEMT) Public Provider Intergovernmental Transfer (IGT) Program	Requests 5.0 permanent positions and expenditure authority of $715,000 ($358,000 Federal Fund (FF); $357,000 Reimbursement Fund (RF)) in fiscal year (FY) 2021-22 and $670,000 ($335,000 FF; $335,000 RF) in FY 2022-23 and ongoing to implement and continue the ongoing workload of the new Ground Emergency Medical Transportation Public Provider Intergovernmental Transfer Program pursuant to AB 1705 (Bonta, Chapter 544, Statutes 2019).	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** March 8, 2021
35	Behavioral Health Plan 274 Expansion Project	requests two-year limited-term expenditure authority of $1,080,000 ($108,000 General Fund; $972,000 Federal Fund) in fiscal year 2021-22 and in FY 2022-23 to support contract costs for the provision of technical assistance to counties during the expansion of X12 274 Health Provider Directory to behavioral health plans. The system expansion is required to meet federal network adequacy requirements.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 22, 2021
36	California Community Transitions (SB 214)	Requests three-year limited-term (LT) resources equivalent to 3.0 positions and expenditure authority of $432,000 General Fund in fiscal year 2021-2022 and $405,000 GF in FY 2022-2023 and FY 2023-2024. The LT resources are needed to	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** March 8, 2021

		implement and maintain the workload created by the passage of SB 214 (Dodd, Chapter 300, Statutes of 2020) California Community Transitions Program.	
37	Limited-Term Workload Extension	Requests limited-term (LT) extension of LT resources equivalent to 38.0 positions and expenditure authority of $8,702,000 ($3,081,000 General Fund; $5,621,000 Federal Fund) in fiscal year 2021-22 to address the continuing workloads for: • California Community Transitions (CCT) Demonstration Project • Federal Managed Care Regulations • 1115 Waiver Extension Medi-Cal 2020 • Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements • Medi-Cal Health Enrollment Navigators • Robert F. Kennedy Workers Medical Plan	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** March 8, 2021
38	Conversion of Limited-Term Positions to Permanent	Requests the conversion of 62.5 limited-term resources to permanent positions and expenditure authority of $9,455,000 ($3,176,000 General Fund; $5,603,000 Federal Fund; $676,000 Hospital Quality Assurance Revenue Fund) in fiscal year 2021-22 and ongoing to address the following ongoing workload: □ Federal Managed Care Regulations □ Legal Support for Ongoing Waiver Activities □ Health Care Reform Financial Reporting □ Private Hospital Directed Payment (PHDP) Program □ Medi-Cal Eligibility Systems Staffing	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** March 8, 2021

39	Mental Health Services Assisted Outpatient Treatment (AB 1976)	Requests $288,000 General Fund in fiscal year (FY) 2021-22 and $270,000 General Fund in FY 2022-23 and in FY 2023-24 to implement the Assisted Outpatient Treatment (AOT) program pursuant to AB 1976 (Eggman, Chapter 140, Statutes 2020). Per AB 1976, DHCS is statutorily mandated to provide training and technical assistance, provide an annual data analysis, track AOT program implementation for all 58 California Counties and submit an annual legislative report.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 22, 2021
40	Substance Use Disorder Recovery Residences (SB 406)	Requests 4.0 permanent positions and expenditure authority of $594,000 General Fund in fiscal year (FY) 2021-22 and $558,000 General Fund in FY 2022-23 and ongoing to implement SB 406 (Pan, Chapter 302, Statutes 2020) by taking action on complaints against disclosed recovery residences, associated with a licensed residential substance use disorder treatment facility or certified program, that provide licensable services without first obtaining licensure or certification from DHCS.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 22, 2021
41	Restoration of Adult OTC Cough/Cold and Acetaminophen Drug Benefit Trailer Bill	Proposes trailer bill language to restore over-the-counter acetaminophen and cough and cold products as Medi-Cal benefits. DHCS expects a reduction in annual Medi-Cal expenditures of $21 million ($7.8 million General Fund and $13.2 million federal funds) due to the replacement of more costly opioids, prescription pain relievers, and other prescription cough	**Staff Recommendation:** Adopt placeholder trailer bill. **Heard in Sub 1:** March 8, 2021 The proposed trailer bill language can be found here: https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/309

		treatments with these less costly over-the-counter options.	
42	Medi-Cal Screening for Misuse of Opioids and Other Drugs Trailer Bill	Proposes trailer bill to repeal the statutory December 31, 2021 suspension date for Medi-Cal adult primary care screenings, brief intervention, and referral for treatments of misuse of opioids and other drugs because it is a federally required Medicaid State Plan benefit for all adults as of June of 2020.	**Staff Recommendation:** Adopt placeholder trailer bill. **Heard in Sub 1:** February 22, 2021 The proposed trailer bill language can be found here: https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/312
43	Strengthening Coordination of Benefits and Post-Payment Recovery Trailer Bill	Proposes trailer bill language to clarify requirements for third-party commercial health insurance carriers to share data with DHCS of post-payment recovery and coordination of benefits. DHCS considers this to be technical, non-controversial, clean-up trailer bill.	**Staff Recommendation:** Adopt placeholder trailer bill. **Heard in Sub 1:** March 8, 2021 The proposed trailer bill language can be found here: https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/314
44	Medi-Cal Coverage of Continuous Glucose Monitors	Requests expenditure authority of $10.9 million ($3.8 million General Fund and $7.1 million federal funds) to add continuous glucose monitoring (CGM) systems as a Medi-Cal benefit for beneficiaries with Type 1 diabetes who demonstrate medical necessity, beginning January 1, 2022.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** March 8, 2021
January Proposals Modified in the Spring			
45	Medi-Cal Enterprise System Modernization	The January budget requests two-year limited-term (LT) expenditure authority of $22,279,000 ($4,016,000 General Fund (GF); $18,263,000 Federal Fund (FF)) in fiscal year (FY) 2021-	**Staff Recommendation:** Approve as proposed in the Spring Finance Letter. **Heard in Sub 1:** March 8, 2021

		22 and $1,275,000 ($128,000 GF; $1,147,000 FF) in FY 2022-23 to continue support of critical IT modernization efforts. DHCS and CMS have changed their approach from focusing on individual IT systems to focusing on the entire Medicaid Enterprise System, where Medicaid Management Information System (MMIS) and Eligibility and Enrollment (E&E) systems efforts are handled in coordination as Medi-Cal Enterprise Systems. The SFL requests a decrease of $1,788,000 in General Fund and an increase of $1,788,000 in federal funds as an update to this proposal.	

4265 California Department of Public Health			
Issue	**Proposal Name**	**Proposal Description**	**Staff Comments and Recommendations**
January Budget Proposals			
46	Adjustment to Support Infectious Disease Modeling	Requests one-time General Fund expenditure authority of $450,000 in 2021-22, and encumbrance or expenditure authority until June 30, 2023, to support infectious disease modeling activities as a part of the urgent COVID-19 pandemic response by increasing internal capacity to conduct, oversee, and utilize high-quality data modeling to inform public health emergency decisions and to participate in the COVID-19 Modeling and Analytics Consortium.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021
47	COVID-19 Workplace Outbreak Reporting (AB 685)	Requests three positions and $677,225 General Fund appropriation in Fiscal Year 2021-22 and ongoing to create a new program to manage COVID-19 workplace outbreak reporting, as mandated by AB 685 (Reyes, Chapter 84, Statutes of 2020).	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021

48	Medical Breach Enforcement Section (MBES) Expansion	Requests 17 positions and $2.6 million from the Licensing and Certification Program Fund in 2021-22 and ongoing, to expand the MBES. By expanding MBES and centralizing the investigation workload, CHCQ will free up clinical staff in the field offices from investigating any privacy breach intakes, thus allowing them to redirect their time to workload of a more clinical nature.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021
49	Skilled Nursing Facility Staffing Requirements Compliance (AB 81)	Requests six positions and $939,000 from the Licensing and Certification Program Fund in 2021-22 and ongoing, to implement provisions of AB 81 (2020 budget trailer bill) affecting the Quality and Accountability Supplemental Payment Program. AB 81 increased the fines for SNFs that fail to meet staffing requirements and granted appeal rights to SNFs that are non-compliant with staffing requirements for one day.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021
50	Support for Alzheimer's Disease Awareness, Research, and Training	Requests $17 million General Fund ($10.2 million in Local Assistance and $6.8 million in State Operations) in 2021-22, available to be spent over a three-year period, to support Alzheimer's Disease Program activities that include: Grants focused on disproportionately impacted populations; public awareness campaign; caregiver training programs; California Blue Zone challenge grants; and a statewide standard of dementia care.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021
51	Timely Investigation of Caregivers	Requests seven positions and $1 million from the Licensing and Certification Program Fund in 2021-22 and ongoing, to improve the timeliness of investigations of complaints against caregivers.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 8, 2021

January Proposals Modified in the Spring			
52	Books for Low-Income Children	Requests one-time General Fund expenditure authority of $5 million in Local Assistance in 2021-22 for an early childhood literacy program for Women, Infants and Children (WIC) participants.	**Staff Recommendation:** Approve as proposed in the Spring Finance Letter. **Heard in Sub 1:** February 8, 2021

4440 Department of State Hospitals			
Issue	**Proposal Name**	**Proposal Description**	**Staff Comments and Recommendations**
January Proposals			
53	Increased Court Appearances and Public Records Act Requests	Requests $777,000 General Fund in Fiscal Year (FY) 2021-22 and in FY 2022-23 to support 5.5 two-year limited term (LT) positions for the Legal Division (LD) to address the sustained increase in workload of court hearings at which DSH attorneys are required to appear throughout the state and the sustained increase in workload of Public Records Act (PRA) requests to which DSH must respond.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 22, 2021
54	Medical and Pharmaceutical Billing System	Requests $794,000 General Fund in Fiscal Year (FY) 2021-22 and $774,000 annually in FYs 2022-23, 2023-24 and 2024-25 to support 1.0 permanent position and contract resources equivalent to 2.0 consultants. The resources will be used to enhance system functionality for the Cost Recovery System (CRS) to capture, bill and recover eligible patient cost-of-care reimbursements until DSH has successfully implemented an Electronic Health Record.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 22, 2021
55	Metropolitan: Consolidation of police Operations	Requests $22,024,000 Public Buildings Construction Fund for the construction phase of the Metropolitan: Consolidation of Police Operations project. The request will allow for the consolidation of hospital police	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 22, 2021

		services into a single location and include the demolition of seismically deficient buildings.	
56	One-Time Deferred Maintenance Allocation	Requests one-time $15 million General Fund, available over three years, to address critical deferred maintenance, special repairs/replacement, and regulatory compliance projects at DSH's five hospitals. The planned projects include those related to fire and life safety, critical infrastructure, and any facilities modernization required to complete major repairs and systems replacements.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 22, 2021
57	Patient Education	Requests 3.0 permanent positions and $352,000 General Fund in Fiscal Year (FY) 2021-22 and ongoing to expand patient education services at DSH-Coalinga. DSH's goal is to offer comparable education services for DSH-Coalinga patients as it does at its other hospitals and improve patient outcomes.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 22, 2021
58	Protected Health Information Permanent Implementation	Requests $986,000 General Fund in Fiscal Year (FY) 2021-22 and FY 2022-23 to extend 8.0 limited-term positions for an additional two years to continue processing of invoices and payments from external medical providers containing Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and consolidating DSH's financial operations into a single budget unit.	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 22, 2021
59	Skilled Nursing Facility Infection Preventionists (AB 2644)	Requests $350,000 General Fund in Fiscal Year (FY) 2021-22 and ongoing for 2.0 permanent positions to establish Infection Preventionists at DSH-Metropolitan and DSH-Napa in accordance with requirements set forth in AB 2644 (Wood, Chapter 287, Statutes of 2020).	**Staff Recommendation:** Approve as budgeted. **Heard in Sub 1:** February 22, 2021
60	Statewide: Enhanced Treatment Units	Requests a supplemental appropriation of $3,792,000	**Staff Recommendation:**

		General Fund to fund increased construction costs for the Statewide Enhanced Treatment Unit (ETU) at DSH-Atascadero and DSH-Patton. The additional funds are necessary to complete construction of the project.	Approve as budgeted. **Heard in Sub 1:** February 22, 2021
January Proposals Modified in the Spring			
61	Coalinga: Hydronic Loop Replacement	The January request was for $50,528,000 General Fund for the construction phase of the DSH-Coalinga Hydronic Loop Replacement project. This project replaces the severely corroded and deteriorated below grade hydronic loop piping system with a completely new hydronic loop piping system which will efficiently provide domestic hot water and heating to the facilities including patient occupied buildings. The spring proposal requests a decrease of $23,069,000 General Fund for the construction phase, based on the Department of General Services (DGS) updated cost estimate. DSH and DGS evaluated alternative system options for the project and selected a specialized hydronic loop plastic piping system which reduced the construction costs in both labor and material costs. This system is expected to deliver the required protection from the corrosive soil thereby providing both longevity and short-term and long-term cost savings.	**Staff Recommendation:** Approve as proposed in the Spring Finance Letter. **Heard in Sub 1:** February 22, 2021
Spring Proposals			
62	Atascadero: Potable Water Booster Pump System - Reappropriation	Requests a reappropriation of $229,000 General Fund for the working drawings of the Atascadero: Potable Water Booster Pump System. The project includes installing a potable water booster pump system to serve the DSH-Atascadero. The	**Staff Recommendation:** Approve as proposed.

		reappropriation is necessary to address project delays driven by the Covid-19 Pandemic. Working drawings funding for the project was appropriated by the 2020 Budget Act with the authority set to expire June 30, 2021. Re-appropriation will allow DSH to complete the working drawings phase of the project and proceed to construction in Fiscal Year 2022-23.	
63	Relocation to the Clifford L. Allenby Building – Phase 3	Request General Fund (GF) authority of $9.2 million in FY 2021-22 and $8.9 million ongoing to offset the increased rental costs of $7.7 million for CHHS, DDS, and DSH in the new state building. In addition, DSH requests 2.0 permanent position authority to provide technology support to CHHS and DDS requests $1.5 million and limited-term funding equivalent to 1.0 position in FY 2021-22, $1.1 million and limited-term funding equivalent to 1.0 position in FY 2022-23, and $1.0 million ongoing to address the services and equipment necessary for occupancy in the new Clifford L. Allenby Building located at 1215 O Street in Sacramento.	**Staff Recommendation:** Approve as proposed.