Senate Budget and Fiscal Review—Scott Wiener, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Caroline Menjivar, Chair
Senator Susan Talamantes Eggman, Ph.D.
Senator Shannon Grove
Senator Richard D. Roth

Thursday, April 4th, 2024
9:30 am, or upon adjournment of session
1021 O Street – Room 1200

Consultant: Scott Ogus

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PUBLIC COMMENT

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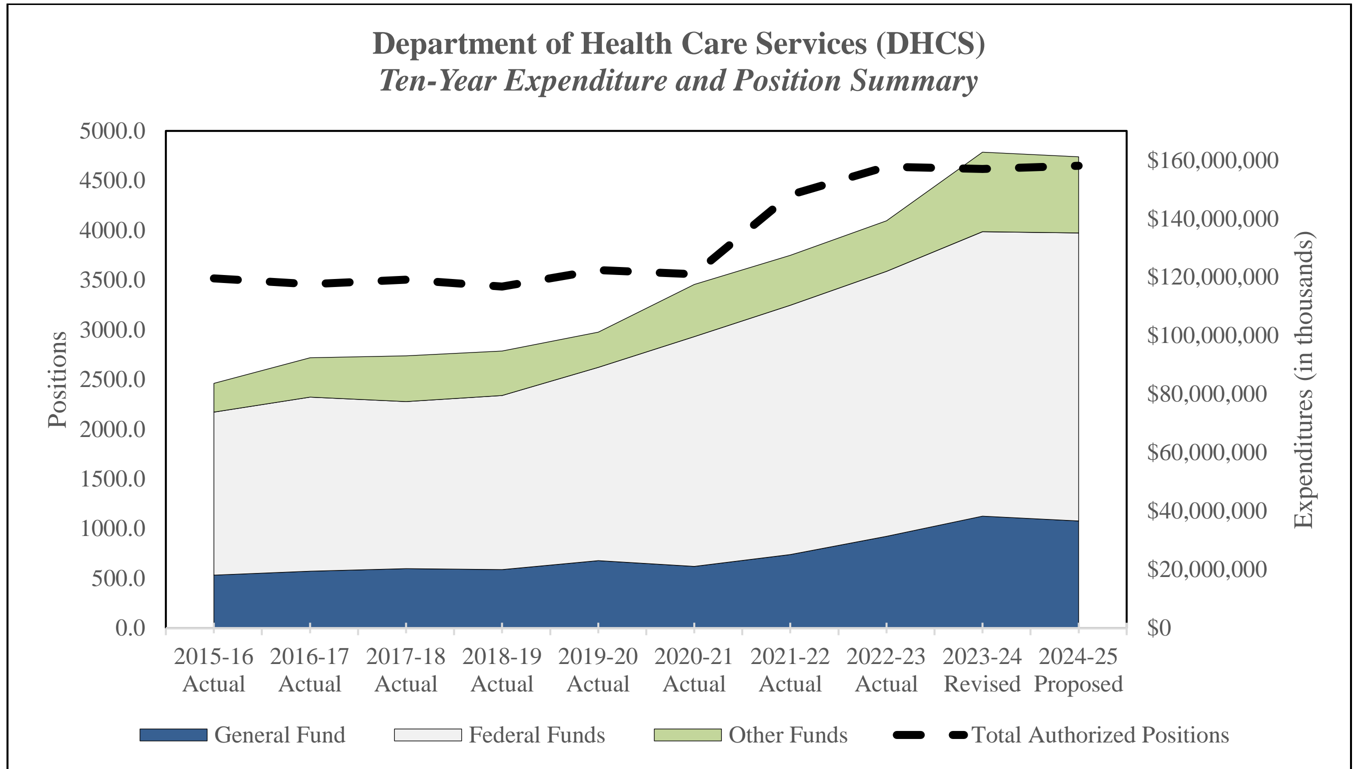
4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview



Department of Health Care Services - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	***2022-23 Actual***	***2023-24 Budget Act***	***2023-24 Revised***	***2024-25 Proposed***
General Fund	**$31,333,084**	**$38,265,892**	**$38,310,542**	**$36,627,052**
Federal Funds	**$90,676,953**	**$91,492,180**	**$97,201,892**	**$98,462,780**
Other Funds	**$17,234,019**	**$26,880,178**	**$27,217,614**	**$26,039,584**
Total Department Funding	**$139,244,056**	**$156,638,250**	**$162,730,048**	**$161,129,416**
Total Authorized Positions	**4640.5**	**4802.5**	**4617.5**	**4649.5**
Other Funds Detail:				
Breast Cancer Control Account (0009)	*$8,966*	*$8,142*	*$8,356*	*$8,114*
Childhood Lead Poisoning Prev Fund (0080)	*$0*	*$989*	*$989*	*$0*
DUI Program Licensing Trust Fund (0139)	*$522*	*$1,444*	*$1,462*	*$1,465*
Prop 99 - Hospital Services Acct (0232)	*$77,350*	*$70,115*	*$70,115*	*$72,477*

Prop 99 - Physician Services Acct (0233)	*$22,249*	*$19,901*	*$19,901*	*$20,693*
Prop 99 - Unallocated Acct (0236)	*$45,584*	*$44,022*	*$44,041*	*$46,290*
Narcotic Treatment Program Lic Fund (0243)	*$1,904*	*$1,903*	*$1,992*	*$2,502*
Perinatal Insurance Fund (0309)	*$27,421*	*$16,470*	*$23,379*	*$23,250*
Audit Repayment Trust Fund (0816)	*$0*	*$41*	*$41*	*$41*
Medi-Cal Inpatient Payment Adj Fund (0834)	*$133,845*	*$157,564*	*$115,193*	*$125,708*
Special Deposit Fund (0942)	*$74,369*	*$86,560*	*$65,568*	*$83,377*
Reimbursements (0995)	*$1,771,376*	*$2,005,103*	*$2,209,102*	*$2,270,873*
County Health Initiative Matching Fund (3055)	*$0*	*$174*	*$174*	*$174*
Children's Medical Services Rebate Fund (3079)	*$6,443*	*$3,700*	*$2,603*	*$2,556*
Mental Health Services Fund (3085)	*$2,858,428*	*$2,878,793*	*$2,290,660*	*$2,408,601*
Nondesignated Public Hospital Suppl Fund (3096)	*($601)*	*($152)*	*($38)*	*$5,333*
Private Hospital Supplemental Fund (3097)	*($10,088)*	*$223,717*	*$207,636*	*$73,384*
Mental Health Facility Licensing Fund (3099)	*$46*	*$373*	*$373*	*$373*
Residential and Outpatient Prog Lic Fund (3113)	*$7,846*	*$7,869*	*$8,581*	*$10,472*
Children's Health and Human Svcs Special Fund (3156)	*$297,152*	*$0*	*$175,439*	*$0*
Hospital Quality Assurance Revenue Fund (3158)	*$3,156,040*	*$5,913,927*	*$5,973,721*	*$4,209,673*
SNF Quality and Accountability Fund (3167)	*$25,967*	*$1,176*	*$1,176*	*$0*
Emergency Medical Air Transportation Fund (3168)	*$5,431*	*$8,724*	*$2,111*	*$0*
Long-Term Care Quality Assurance Fund (3213)	*$538,129*	*$471,515*	*$540,161*	*$539,546*
Healthcare Treatment Fund (3305)	*$423,167*	*$624,171*	*$768,665*	*$596,454*
Health Care Service Plan Fines/Penalties Fund (3311)	*$213*	*$12,487*	*$12,494*	*$12,495*
Medi-Cal Emergency Med Transport Fund (3323)	*$105,120*	*$57,809*	*$49,684*	*$49,433*
County Intervention Supp Svcs Subaccount LRF 2011 (3325)	*$0*	*$3,685*	*$3,685*	*$0*
Reversion Acct. Subacct., Mental Health Svcs Fund (3327)	*$2,970*	*$0*	*$0*	*$0*
Medi-Cal Drug Rebate Fund (3331)	*$2,861,652*	*$2,736,987*	*$2,872,071*	*$2,483,312*

Health Care Services Special Fund (3334)	*$2,065,534*	*$0*	*$0*	*$0*
YEPEITA - Cannabis Tax Fund (3350)	*$574,920*	*$340,425*	*$371,737*	*$341,306*
PACE Oversight Fund (3362)	*$0*	*$748*	*$0*	*$0*
Loan Repayment Acct, Healthcare Treatment Fund (3375)	*$35,223*	*$52,023*	*$55,581*	*$65,742*
Opioid Settlement Fund (3397)	*$70,948*	*$77,367*	*$81,485*	*$36,400*
California Emergency Relief Fund (3398)	*$1,014,728*	*$0*	*$10,972*	*$0*
988 State Suicide and BH Crisis Svcs Fund (3414)	*$0*	*$19,773*	*$19,773*	*$13,228*
Medi-Cal County BH Fund (3420)	*$0*	*$1,033,310*	*$971,944*	*$1,576,250*
Managed Care Enrollment Fund (3428)	*$0*	*$7,248,256*	*$7,873,000*	*$8,599,856*
Medi-Cal Provider Payment Reserve Fund (3431)	*$0*	*$1,020,956*	*$321,000*	*$1,095,167*
Global Payment Program Special Fund (8108)	*$1,009,692*	*$1,111,984*	*$1,314,355*	*$983,596*
DPH GME Special Fund (8113)	*$264,847*	*$261,308*	*$282,623*	*$281,354*
Suicide Prevention Vol Contribution Fund (8124)	*$0*	*$250*	*$250*	*$0*
Coronavirus Fiscal Recovery Fund of 2021 (8506)	*$226,281*	*$0*	*$0*	*$0*
Home- and Comm-Based Svcs ARP Fund (8507)	*($469,655)*	*$356,569*	*$445,559*	*$89*

Department of Health Care Services – *Changes to State Operations and Local Assistance*				
Fiscal Year:	**2022-23**	**2023-24 (CY)**	**2024-25 (BY)**	**CY to BY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$383,873,000	$553,313,000	$372,373,000	($180,940,000)
Federal Funds[1]	$553,737,000	$680,002,000	$579,550,000	($100,452,000)
Spec. Funds/Reimb	$537,950,000	$419,171,000	$343,937,000	($75,234,000)
Total Expenditures	**$1,475,560,000**	**$1,652,486,000**	**$1,295,860,000**	**($356,626,000)**
Total Positions	**4640.5**	**4617.5**	**4649.5**	**32.0**

LOCAL ASSISTANCE (*MEDI-CAL AND OTHER PROGRAMS)*				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$30,949,211,000	$37,757,229,000	$36,254,679,000	($1,502,550,000)
Federal Funds[1]	$90,143,216,000	$96,521,890,000	$97,883,230,000	$1,361,340,000
Spec. Funds/Reimb	$16,676,069,000	$26,798,443,000	$25,695,647,000	($1,102,796,000)
Total Expenditures	**$137,768,496,000**	**$161,077,562,000**	**$159,833,556,000**	**($1,244,006,000)**
[1]*Federal Funds include Funds 0890, 7502, and 7503.*				

Background. The Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering health care services to eligible individuals. DHCS programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost-effective manner. DHCS programs include:

- ***Medi-Cal.*** DHCS serves as the single state agency for Medi-Cal, California's Medicaid program. Medi-Cal is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 14.4 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low-income people with specific diseases. As of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level are also eligible for services in Medi-Cal.

- ***Children's Medical Services.*** Children's Medical Services coordinates and directs the delivery of health care services to low-income and seriously ill children and adults. Its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Child Health and Disability Prevention Program.

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations. Its programs include: Indian Health Program, Rural Health Services Development Program, Seasonal Agricultural and Migratory Workers Program, State Office of Rural Health, Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program, Small Rural Hospital Improvement Program, and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services***. As adopted in the 2011 through 2013 Budget Acts, DHCS oversees the delivery of community mental health and substance use disorder services, reflecting the elimination of the Departments of Alcohol and Drug Programs and Mental Health.

- ***Other Programs*****.** DHCS oversees family planning services, cancer screening services to low-income under-insured or uninsured women, and prostate cancer treatment services to low-income, uninsured men, through the Every Woman Counts Program, the Family Planning Access Care and Treatment Program, and the Prostate Cancer Treatment Program.

Legislative Oversight – Hearing Aid Coverage for Children Program (HACCP). Oversight of Prior Budget Investment – Hearing Aid Coverage for Children Program. In 2019, the Legislature approved

AB 598 (Bloom), the Let California Kids Hear Act, which would have required health care service plans and health insurers to cover hearing aids and related services for children ages zero to 17. The Newsom Administration requested the Legislature withdraw the bill from engrossing and enrolling with the promise of another solution to the problem of insufficient access to hearing aids for children in the commercial health insurance market. The 2020 Budget Act included one position and General Fund expenditure authority of $400,000 in 2020-21, $15.1 million in 2021-22, and $14.5 million annually thereafter to provide hearing aids and associated services to uninsured children up to 600 percent of the federal poverty level, beginning July 1, 2021. DHCS implemented the Hearing Aid Coverage for Children Program (HACCP), which covers children ages zero to 17 who do not have coverage for hearing aids and related services. HACCP utilizes the Medi-Cal fee-for-service delivery system, including the associated fee-for-service reimbursement rates, to provide hearing aids and related services for this population.

During budget subcommittee hearings in 2022, advocates reported that only 44 children had been enrolled in HACCP and seven had received hearing aids. The advocates reported many parents were unable to find a pediatric provider in their county that had opted into HACCP, as the limited scope of care and low reimbursement rates were a barrier to provider participation in the program. As a result, the 2022 Budget Act included General Fund expenditure authority of $10 million in 2022-23 for the program, and the Legislature adopted provisional budget bill language to clarify eligibility for the program to include children with outside health insurance coverage with a coverage limit of $1,500 or less for hearing aids.

During 2023, advocates reported similarly low participation rates in HACCP for both providers and children receiving hearing aids. The May 2023 Medi-Cal Local Assistance Estimate reported the program spent $302,830 in 2022-23 and was estimated to spend $1.5 million in 2023-24, despite the $14.5 million ongoing resources approved by the Legislature in the 2020 Budget Act. These reduced expenditures were due to a paucity of utilization of services in the program, primarily due to lack of access to providers. The November 2023 Estimate reflects an expected increase of expenditures to $2.6 million in 2024-25, which is still significantly below the originally estimated expenditure need for a program that provides services to a meaningful proportion of this population of deaf and hard of hearing children. The November 2023 Estimate also includes General Fund expenditure authority of $4 million in 2023-24 and $3.7 million in 2024-25 for administration of the program, which is significantly higher than the cost of services actually delivered to children.

The Legislature, recognizing the failure of HACCP to improve access to hearing aids for deaf and hard of hearing children, approved SB 635 (Menjivar), which would have implemented a hearing aid and related coverage mandate in the commercial market, similar to the original provisions of AB 598 in 2019. Governor Newsom vetoed SB 635, and the Governor's veto message included the following commitments:

"[I]mproving access to hearing aids for children is a priority for my Administration. We can, and we must, do better for these children and their families as we implement HACCP. To this end, I am directing my Administration to explore increases to Medi-Cal provider payments with the goal of incentivizing additional provider participation in HACCP, increasing access for youth in need of hearing aids.

In addition, DHCS has developed a comprehensive plan to increase provider participation and program enrollment. These improvements will enable HACCP to reach and serve more children, which is our shared goal.

Specifically, in the next six months, DHCS will take a variety of steps to help patients maximize benefits, including: (1) partnering with other state entities to promote participation and awareness of HACCP, (2) completing translations for HACCP related materials into 18 languages, (3) implementing a streamlined annual eligibility renewal process to simplify provider enrollment, (4) conducting outreach to Medi-Cal providers not yet participating in HACCP to support their participation, (5) hosting quarterly webinars with providers and stakeholders, and (6) continuing to identify potential service improvements and strategies to increase program success."

In addition to these commitments, the Administration's proposed reimbursement rate increases related to the managed care organization (MCO) tax includes increased reimbursement to audiologists participating in HACCP. These proposed reimbursement rate increases are currently pending before the Legislature.

Subcommittee Staff Comment. This is an informational item.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of DHCS programs and budget.

2. Please provide the following information regarding the HACCP:

    a. Number of children that have received hearing aids by fiscal year through HACCP.
    b. How reimbursement rates for hearing aids and related services compare to both the fee-for-service delivery system, and the California Children's Services program.
    c. How many additional providers have enrolled in HACCP in 2023-24.

3. Please describe the components of the DHCS HACCP Action Plan, particularly those included in the addendum that was prompted by the Governor's SB 635 veto message.

4. The November 2023 Medi-Cal Estimate assumes the increase in HACCP expenditures is due to enrollment ramp-up. How many additional children is DHCS expecting to enroll in HACCP in 2024-25? How many additional providers?

5. Are Kaiser providers enrolled to provide services in the HACCP? If not, what are the barriers to Kaiser participation in HACCP and what is DHCS doing to mitigate those barriers and ensure Kaiser participates?

6. Has DHCS conducted a geographic analysis of participating HACCP providers to determine whether the population of children in need of HACCP services is within a reasonable distance of a provider?

7. If the Legislature approves the MCO tax targeted rate increase proposal related to audiologists, how would the overall reimbursement through HACCP compare to other programs, like CCS, or to commercial insurance? Which codes would be impacted?

Issue 2: November 2023 Medi-Cal Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2023 Medi-Cal Local Assistance Estimate includes $157.5 billion ($37.3 billion General Fund, $95.8 billion federal funds, and $24.4 billion special funds and reimbursements) for expenditures in 2023-24, and $156.6 billion ($35.9 billion General Fund, $97.6 billion federal funds, and $23.2 billion special funds and reimbursements) for expenditures in 2024-25.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2023-24 (CY)**	**2024-25 (BY)**	**CY to BY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$35,625,728,000	$34,348,774,000	($1,276,954,000)
Federal Funds	$90,205,377,000	$92,313,489,000	$2,108,112,000
Special Funds/Reimbursements	$24,271,407,000	$23,099,536,000	($1,171,871,000)
Total Expenditures	**$150,102,512,000**	**$149,761,799,000**	**($340,713,000)**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$1,547,873,000	$1,400,413,000	($147,460,000)
Federal Funds	$5,127,437,000	$4,859,255,000	($268,182,000)
Special Funds and Reimbursements	$137,683,000	$69,323,000	($68,360,000)
Total Expenditures	**$6,812,993,000**	**$6,328,991,000**	**($484,002,000)**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$157,428,000	$164,008,000	$6,580,000
Federal Funds	$418,906,000	$383,408,000	($35,498,000)
Special Funds and Reimbursements	$33,000	$11,000	($22,000)
Total Expenditures	**$576,367,000**	**$547,427,000**	**($28,940,000)**
TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$37,331,029,000	$35,913,195,000	($1,417,834,000)
Federal Funds	$95,751,720,000	$97,556,152,000	$1,804,432,000
Special Funds and Reimbursements	$24,409,123,000	$23,168,870,000	($1,240,253,000)
Total Expenditures	**$157,491,872,000**	**$156,638,217,000**	**($853,655,000)**

Caseload. In 2023-24, the budget assumes annual Medi-Cal caseload of 14.8 million, an increase of 582,900 beneficiaries, or 4.1 percent, compared to assumptions in the 2023 Budget Act. The department estimates 92.6 percent of Medi-Cal beneficiaries, or 13.7 million, will receive services through the managed care delivery system while 7.4 percent, or 1.1 million, will receive services through the fee-for-service delivery system.

In 2024-25, the budget assumes annual Medi-Cal caseload of 13.8 million, a decrease of one million beneficiaries, or 6.8 percent, compared to the revised caseload estimate for 2023-24. The department estimates 95.1 percent of Medi-Cal beneficiaries, or 13.1 million, will receive services through the managed care delivery system while 4.9 percent, or 672,381, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The November 2023 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

Current Year (2023-24) Savings **–** The Estimate includes total expenditures of $157.5 billion ($37.3 billion General Fund, $95.8 billion federal funds, and $24.4 billion special funds and reimbursements) for the Medi-Cal program in 2023-24, a 0.5 percent decrease in General Fund expenditures compared to the assumptions included in the 2023 Budget Act. According to DHCS, the primary drivers of these decreased General Fund expenditures are as follows:

- *Managed Care Organization (MCO) Tax*. $738.3 million General Fund savings from changes to assumptions for impacts from the MCO tax including accounting for the impact of changes to COVID-19 federal matching funds and updating the timing of revenue collections relative to costs to managed care plans.
- *Proposition 56 Provider Payments*. $184.7 million General Fund savings from updated estimates of the need to replace declining Proposition 56 tobacco tax revenue with General Fund to continue supplemental Medi-Cal provider payments.
- *Prescription Drug Rebates*. $135.1 million General Fund savings due to transfers from the Medi-Cal Drug Rebate Fund to support the General Fund.
- *Impacts of Federal Deferrals*. $102.2 million General Fund savings due to updated estimates of deferral repayment and resolution assumptions from the federal Centers for Medicare and Medicaid Services (CMS).
- *Shift of Timing of Payments*. $70.8 million General Fund savings that is the net result in the following shifts of payments from 2022-23 into 2023-24: 1) $115 million repayment to CMS related to in-home supportive services from the Coordinated Care Initiative, and 2) $185.8 million transfer from the previous MCO tax to the General Fund.
- *Designated State Health Programs*. $56.1 million General Fund savings due to federal assistance provided through the state's 1115 Demonstration Waiver for Designated State Health Programs shifting from 2022-23 to 2023-24, as well as claiming an additional quarter of claims for the new California Reproductive Health Access Demonstration (CalRHAD).
- *Various Other Changes*. $37.1 million General Fund savings for various other changes to the Medi-Cal program.

These savings are partially offset by the following increases in General Fund costs:

- *Medi-Cal Redeterminations*. $499 million General Fund costs from updated assumptions related to redeterminations of eligibility for Medi-Cal after the end of the COVID-19 public health emergency's continuous coverage requirement.
- *Federal Repayment for State-Only Populations*. $481.5 million General Fund costs due to differences in the final repayment amounts owed to the federal Centers for Medicare and Medicaid Services for federal matching funds paid for populations in state-only programs.
- *Changes in Multi-Year Expenditures*. $70.4 million General Fund costs due to changes in spending levels for programs implemented over multiple years, including Behavioral Health Bridge Housing, the Behavioral Health Continuum Infrastructure Program, Providing Access and Transforming Health, the Children and Youth Behavioral Health Initiative, and the California Advancing and Innovating Medi-Cal Initiative.
- *Respiratory Syncytial Virus (RSV) Vaccines*. $61.4 million General Fund costs due to administration of the recently approved vaccine for RSV for Medi-Cal beneficiaries.
- *COVID-19 Vaccines*. $16.4 million General Fund costs due to decreased federal support and federal matching funds for the purchase and administration of COVID-19 vaccines.

<u>Budget Year (2024-25) Adjustments</u> – The Estimate includes total expenditures of $156.6 billion ($35.9 billion General Fund, $97.6 billion federal funds, and $23.2 billion special funds and reimbursements) for the Medi-Cal program in 2024-25, a 3.8 percent decrease compared to the revised General Fund expenditure assumptions for 2023-24. According to DHCS, the primary drivers of these increased General Fund expenditures are as follows:

- *Expiration of One-Time Expenditures*. $4 billion General Fund savings due to one-time expenditures not continuing in 2024-25 including: state-only claiming, CalAIM Behavioral Health Payment Reform, reconciliations for the Coordinated Care Initiative, support for Los Angeles County for justice-involved populations, various legislative priorities, temporary expansion of county eligibility funding, and start-up funding for the CARE Act.
- *Medi-Cal Redeterminations*. $2.3 billion General Fund savings from updated assumptions related to redeterminations of eligibility for Medi-Cal after the end of the COVID-19 public health emergency's continuous coverage requirement.
- *Changes in Multi-Year Expenditures*. $692.9 million General Fund savings due to changes in spending levels for programs implemented over multiple years, including Behavioral Health Bridge Housing, the Behavioral Health Continuum Infrastructure Program, Providing Access and Transforming Health, the Children and Youth Behavioral Health Initiative, and the California Advancing and Innovating Medi-Cal Initiative.
- *Managed Care Organization (MCO) Tax*. $502.9 million General Fund savings from changes to assumptions for impacts from the MCO tax including accounting for the impact of changes to COVID-19 federal matching funds and updating the timing of revenue collections relative to costs to managed care plans.
- *Delay of Behavioral Health Bridge Housing*. $235 million General Fund savings from a proposed delay of the final round of Behavioral Health Bridge Housing grants from 2024-25 until 2025-26
- *Delay of Behavioral Health Continuum Infrastructure Program*. $140.4 million General Fund savings from a proposed delay of Behavioral Health Continuum Infrastructure Program grants from 2024-25 until 2025-26.

These savings are partially offset by the following increases in General Fund costs:

- *Expansion of Medi-Cal Regardless of Immigration Status*. $1.6 billion General Fund costs due to the full-year impact of implementation of the Medi-Cal expansion to all income-eligible individuals age 26 to 49, regardless of immigration status.
- *Base Managed Care Costs*. $886.3 million General Fund costs due to increases in base capitation payments to Medi-Cal managed care plans to support health care services for Medi-Cal beneficiaries.
- *Phase-out of COVID-19 Enhanced Federal Match*. $750.1 million General Fund costs due to the phase-out of the enhanced federal match made available during the COVID-19 public health emergency.
- *Impacts of Federal Deferrals*. $706.5 million General Fund costs due to updated estimates of deferral repayment and resolution assumptions from the federal Centers for Medicare and Medicaid Services (CMS).
- *Hospital Quality Assurance Fee Program*. $702.9 million General Fund costs due to one-time repayment of postponed payments for children's health care coverage under the Hospital Quality Assurance Fee Program.
- *Growth in Medicare Costs*. $461.1 million General Fund costs related to growth in costs of Medicare coverage for Medi-Cal beneficiaries enrolled in both Medicare and Medi-Cal, as well as other Medicare-related costs.
- *Prescription Drug Rebates*. $388.8 million General Fund costs due to lower than expected savings from prescription drug rebates in the Medi-Cal program, and the depletion of the Medi-Cal Drug Rebate Fund reserves for 2023-24.
- *Behavioral Health Bridge Housing Funding Shift*. $265 million General Fund costs due to shifting existing support for Behavioral Health Bridge Housing from the Mental Health Services Fund (MHSF) to the General Fund due to shortfalls in estimated MHSF revenue.
- *Assisted Living Waiver Expansion*. $141.9 million General Fund costs due to ongoing support for expansion of the Assisted Living Waiver, which had previously been supported by the federal Home- and Community-Based Services Spending Plan.
- *Proposition 56 Provider Payments*. $123.1 million General Fund costs from updated estimates of the need to replace declining Proposition 56 tobacco tax revenue with General Fund to continue supplemental Medi-Cal provider payments.
- *Base Fee-for-Service Costs*. $121.7 million General Fund costs due growth in fee-for-service costs for health care services provided to Medi-Cal beneficiaries, particularly increases in costs for pharmacy.
- *Reproductive Health Waiver*. $100 million General Fund costs related to the implementation of the California Reproductive Health Access Demonstration (CalRHAD).
- *Community Assistance, Recovery, and Empowerment (CARE) Act*. $65.3 million General Fund costs related to implementation of the Community Assistance, Recovery, and Empowerment (CARE) Act.
- *Elimination of Asset Limit*. $47.2 million General Fund costs related to the elimination of the asset limit for determination of eligibility for the Medi-Cal Aged and Disabled Program.
- *COVID-19 Vaccines*. $42.2 million General Fund costs due to decreased federal support and federal matching funds for the purchase and administration of COVID-19 vaccines.
- *Respiratory Syncytial Virus (RSV) Vaccines*. $34.1 million General Fund costs due to administration of the recently approved vaccine for RSV for Medi-Cal beneficiaries.
- *Designated State Health Programs*. $19.2 million General Fund costs due to claiming of one fewer quarter for the CalRHAD demonstration as a designated state health program.

- *Various Other Changes*. $19.4 million General Fund costs for various other changes to the Medi-Cal program.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open as updated estimates of caseload and expenditures will be provided at the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the significant General Fund changes in the Medi-Cal program in the 2023-24 and 2024-25 fiscal years.

Issue 3: November 2023 Family Health Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2023 Family Health Local Assistance Estimate includes $247.2 million ($215.3 million General Fund, $5.2 million federal funds, and $26.7 million special funds and reimbursements) for expenditures in 2023-24, and $250.9 million ($218.9 million General Fund, $5.5 million federal funds, and $26.5 million special funds and reimbursements) for expenditures in 2024-25.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2023-24 (CY)**	**2024-25 (BY)**	**CY to BY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$83,876,000	$92,633,000	$8,757,000
Special Funds/Reimbursements	$6,522,000	$6,508,000	($14,000)
County Funds [non-add]	[$87,437,000]	[$96,181,000]	[$8,744,000]
Total CCS Expenditures	**$90,398,000**	**$99,141,000**	**$8,743,000**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$125,762,000	$120,742,000	($5,020,000)
Special Funds and Reimbursements	$453,000	$529,000	$76,000
Total GHPP Expenditures	**$126,215,000**	**$121,271,000**	**($4,944,000)**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$5,639,000	$5,554,000	($85,000)
Federal Funds	$5,212,000	$5,468,000	$256,000
Special Funds and Reimbursements	$19,699,000	$19,443,000	($256,000)
Total EWC Expenditures	**$30,550,000**	**$30,465,000**	**($85,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$215,277,000	$218,929,000	$3,652,000
Federal Funds	$5,212,000	$5,468,000	$256,000
Special Funds and Reimbursements	$26,674,000	$26,480,000	($194,000)
County Funds [non-add]	[$87,437,000]	[$96,181,000]	[$8,744,000]
Total Family Health Expenditures	**$247,163,000**	**$250,877,000**	**$3,714 ,000**

Background. The Family Health Estimate forecasts the current and budget year local assistance expenditures for three state-only funded programs that provide services for low-income children and adults with special health care needs who do not qualify for enrollment in the Medi-Cal program.

The programs included in the Family Health Estimate are:

- **California Children's Services (CCS)**: The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 183,956 in 2023-24, a decrease of 4,565 or 2.4 percent, compared to the 2023 Budget Act. The budget estimates Medi-Cal CCS caseload of 173,299 in 2024-25, a decrease of 10,657 or 5.8 percent, compared to the revised 2023-24 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 11,978 in 2023-24, a decrease of 156 or 1.3 percent, compared to the 2023 Budget Act. The budget estimates state-only CCS caseload of 14,142 in 2024-25, an increase of 2,164 or 18.1 percent compared to the revised 2023-24 estimate.
- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington's, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal. GHPP costs for Medi-Cal eligible individuals are reflected in the Medi-Cal Local Assistance Estimate
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal GHPP caseload of 939 in 2023-24, an increase of 3 or 0.3 percent, compared to the 2023 Budget Act. The budget estimates Medi-Cal GHPP caseload of 958 in 2024-25, an increase of 19 or two percent, compared to the revised 2023-24 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 676 in 2023-24, an increase of two or 0.3 percent, compared to the 2023 Budget Act. The budget estimates state-only GHPP caseload of 675 in 2023-24, a decrease of one or 0.1 percent, compared to the revised 2023-24 estimate.
- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).
  Caseload Estimate: The budget estimates EWC caseload of 17,683 in 2023-24, a decrease of 2,878 or 14 percent, compared to the 2023 Budget Act. The budget estimates EWC caseload of 17,868 in 2024-25, an increase of 185 or one percent compared to the revised 2023-24 estimate.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the significant changes in Family Health Estimate programs in the 2023-24 and 2024-25 fiscal years.

2. Please provide a status update of the transition plan for the Child Health and Disability Program (CHDP)?

Issue 4: CalAIM Enhanced Care Management and Community Supports

Legislative Oversight and Panel Discussion – CalAIM Enhanced Care Management and Community Supports. The subcommittee would like to explore the implementation of the California Advancing and Innovating Medical (CalAIM) Enhanced Care Management (ECM) benefit and community supports services. In particular, the subcommittee would like to examine how Medi-Cal beneficiaries are determined eligible for the ECM benefit and community supports services. In addition, the subcommittee would like to discuss how DHCS and Medi-Cal managed care plans conduct outreach to providers and consumers to ensure both are aware of the ECM benefit and community supports services available under CalAIM.

CalAIM – A Whole Person-Centered Transformation of the Medi-Cal Program. The California Advancing and Innovating Medi-Cal (CalAIM) initiative is an ambitious effort to incorporate evidence-based and evidence-informed investments in prevention, case management, and non-traditional services into the Medi-Cal program. Many of these investments were piloted during the state's previous 1115 Waiver, Medi-Cal 2020, and CalAIM incorporates many of these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for Medi-Cal managed care plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD), and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity.

CalAIM represents a significant transformation of the health care delivery systems that provide physical health, behavioral health, and oral health care services to Medi-Cal beneficiaries. However, CalAIM also represents an opportunity to build into the foundations of the Medi-Cal program an incentive structure that achieves a healthier Medi-Cal population with a comprehensive, whole-person approach that addresses the social determinants of health and avoids cross-cutting impacts and cost shifts to other state or local social service and public safety agencies. While CalAIM contains the broad outlines of building such a foundation, the Legislature continues to work with the Administration to carefully evaluate the implementation of each component of CalAIM to ensure these program changes are consistent with the values of a publicly-supported health care program.

Recent Budget Investments and Trailer Bill to Support CalAIM Implementation. During the fall of 2019, the Newsom Administration released its comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program, which would ultimately become known as CalAIM. Due to the pandemic, the Administration delayed implementation of CalAIM in the 2020-21 fiscal year. The Administration returned to its implementation planning for CalAIM in the 2021 Budget Act, which included 69 positions and expenditure authority of $1.6 billion ($675.7 million General Fund and $954.7 million federal funds). The Legislature also approved trailer bill language to authorize implementation of CalAIM in the health omnibus, AB 133 (Committee on Budget), Chapter 143, Statutes of 2021. (*Codified in Article 5.51, commencing with Section 14184.100, of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code*)

The 2022 Budget Act included expenditure authority of $1.1 billion ($458.6 million General Fund, $624.9 million federal funds, and $60.4 million special funds and reimbursements) in 2021-22 and $3.1 billion ($1.2 billion General Fund, $1.8 billion federal funds, and $100.2 million special funds and reimbursements) in 2022-23, and the Legislature approved additional trailer bill language, to support implementation of the CalAIM initiative. The 2022 Budget Act also included state operations resources of 97 positions and expenditure authority of $107.8 million ($53.9 million General Fund and $53.9 million federal funds) to support state operations for the implementation of the components of the CalAIM initiative.

CalAIM Implemented Through New Federal Waiver Authority. CalAIM transitions many of Medi-Cal's existing programs into managed care benefits under a new 1915(b) Waiver, maintains some programs under the previous 1115 Waiver authority, and makes other changes through amendments to the Medicaid State Plan. The federal Centers for Medicare and Medicaid Services (CMS) approved California's 1115 Waiver and 1915(b) Waiver applications implementing CalAIM reforms on December 29, 2021. Both Waivers are approved until December 31, 2026. While the managed care authorities provided by the two Waivers are similar, there are key differences. For example, while 1115 Waivers require budget neutrality (federal expenditures must not be greater under the Waiver than they would have been without the Waiver), 1915(b) Waivers only require the demonstration of cost effectiveness and efficiency (actual expenditures cannot exceed projected expenditures)[1]. This distinction allows for the provision of certain non-traditional community supports services that would previously have been required to undergo a more difficult accounting of savings to the state and federal governments.

Enhanced Care Management. The Governor's January budget includes expenditure authority of $992.4 million ($374.4 million General Fund and $618 million federal funds) in 2023-24 and $1 billion ($393.1 million General Fund and $648.9 million federal funds) in 2024-25 to support the new enhanced care management benefit, implemented beginning on January 1, 2022. Under its previous 1115 Waiver authority, Medi-Cal 2020, DHCS implemented Whole Person Care pilot programs to coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. The 25 approved WPC pilots targeted services to individuals with chronic conditions, with behavioral health needs, experiencing or at-risk of homelessness, or who are justice-involved. The pilots provided eight categories of service to these individuals, including: 1) outreach, 2) care coordination, 3) housing support, 4) peer support, 5) benefit support, 6) employment assistance, 7) sobering centers, and 8) medical respite.

Beginning January 1, 2022, CalAIM expanded the Whole Person Care delivery concept statewide through implementation of a mandatory enhanced care management (ECM) benefit and voluntary community supports benefits delivered by Medi-Cal managed care plans in each county. ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Medi-Cal beneficiaries with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high touch, and person-centered. Medi-Cal beneficiaries are eligible for ECM if they are included in one of the following populations of focus:

[1] MACPAC. "Features of federal Medicaid managed care authorities". January 2016.

- *Individuals and Families Experiencing Homelessness.* (1) Adult individuals who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes or decreased utilization of high-cost services; or (2) children, youth, and families with members under 21 years of age who are experiencing homelessness, sharing the housing of other persons, or living in other short-term housing or a hospital without a safe place to be discharged.
- *Individuals at Risk for Avoidable Hospitalization or Emergency Department Utilization.* (1) Adults with five or more avoidable emergency department visits, or three or more unplanned hospital or short-term skilled nursing facility stays in a six month period; or (2) children and youth with three or more avoidable emergency department visits, or two or more unplanned hospital or short-term skilled nursing facility stays in a 12 month period.
- *Individuals with Serious Mental Illness or Substance Use Disorder Needs.* (1) Adults with serious mental illness (SMI) or substance use disorders (SUD) eligible for specialty mental health services or the Drug Medi-Cal program, with at least one complex social factor influencing their health (e.g. food, housing, or economic insecurity; history of Adverse Childhood Experiences, former foster youth, justice-involvement), and are at high risk for institutionalization, overdose and/or suicide; use crisis services, emergency departments, urgent care, or inpatient stays as the primary source of care; experienced two or more emergency department or hospital visits due to SMI or SUD in the past 12 months; or are pregnant or post-partum; or (2) any children and youth eligible for specialty mental health services or the Drug Medi-Cal program.
- *Individuals Transitioning From Incarceration.* (1) Adults transitioning or transitioned from a correctional facility within the past 12 months with at least one of the following conditions: mental illness, SUD, chronic or significant clinical condition, intellectual or developmental disability, traumatic brain injury, human immunodeficiency virus (HIV), pregnant or postpartum; or (2) children and youth transitioning or transitioned from a youth correctional facility within the past 12 months.
- *Individuals at Risk for Long-Term Care Institutionalization.* Adults living in the community who meet skilled nursing facility level of care criteria or require lower-acuity skilled nursing; are actively experiencing at least one complex social or environmental factor influencing their health; and are able to reside continuously in the community with wraparound supports.
- *Nursing Facility Residents Seeking Community Transition.* Adults residing in nursing facilities who desire to transition back to the community, are likely to make a successful transition, and able to reside continuously in the community.

ECM requires Medi-Cal managed care plans and their contracted ECM providers to deliver the following core services:

- *Outreach and Engagement.* Medi-Cal managed care plans are required to develop comprehensive outreach policies and procedures that can include, but are not limited to:
  - Attempting to locate, contact, and engage Medi-Cal beneficiaries who have been identified as good candidates to receive ECM services, promptly after assignment to the plan.
  - Using multiple strategies for engagement including in-person meetings, mail, email, texts, telephone, community and street-level outreach, follow-up if presenting to another partner in the ECM network, or using claims data to contact other providers the beneficiary is known to use.
  - Using an active and progressive approach to outreach and engagement until the beneficiary is engaged.

  - Documenting outreach and engagement attempts and modalities.
  - Utilizing educational materials and scripts developed for outreach and engagement.
  - Sharing information between the managed care plan and ECM providers to assess beneficiaries for other programs if they cannot be reached or decline ECM.
  - Providing culturally and linguistically appropriate communications and information to engage members.
- *Comprehensive Assessment and Care Management Plan.* Medi-Cal managed care plans must conduct a comprehensive assessment and develop a comprehensive, individualized, person-centered care plan with beneficiaries, family members, other support persons, and clinical input. The plan must incorporate identified needs and strategies to address those needs, such as physical and developmental health care, mental health care, dementia care, SUD services, long-term services and supports (LTSS), oral health services, palliative care, necessary community-based and social services, and housing.
- *Enhanced Coordination of Care.* Enhanced coordination of care includes coordination of the services necessary to implement the care plan. This coordination could include:
  - Organizing patient care activities in the care management plan
  - Sharing information with the care team and family members or support persons.
  - Maintaining regular contact with providers, including case conferences
  - Ensuring continuous and integrated care, with follow-up with primary care, physical and developmental health care, mental health care, SUD treatment, LTSS, oral health care, palliative care, necessary community-based and social services, and housing.
- *Health Promotion.* Medi-Cal managed care plans must provide services to encourage and support lifestyle choices based on healthy behavior, such as: identifying and building on successes and support networks, coaching, strengthening skills to enable identification and access to resources to assist in managing or preventing chronic conditions, smoking cessation or other self-help recovery resources, and other evidence-based practices to help beneficiaries with management of care.
- *Comprehensive Transitional Care.* Medi-Cal managed care plans must provide services to facilitate transitions from and among treatment facilities, including developing strategies to avoid admissions and readmissions, planning timely scheduling of follow-up appointments, arranging transportation for transitional care, and addressing understanding of rehabilitation and self-management activities and medication management.
- *Member and Family Supports.* Medi-Cal managed care plans must ensure the beneficiary and family or support persons are knowledgeable about the beneficiary's conditions, including documentation and authorization for communications, providing a primary point of contact for the beneficiary and family or support persons, providing for appropriate education of the beneficiary and family or support persons, and ensuring the beneficiary has a copy of the care plan and how to request updates.
- *Coordination of and Referral to Community and Social Support Services.* Medi-Cal managed care plans must ensure any present or emerging social factors can be identified and properly addressed, including determining appropriate services to meet needs such as housing or other community supports services, and coordinating and referring beneficiaries to available community resources and following up to ensure services were provided.

The ECM phase-in schedule was based on which counties implemented Home Health Programs and Whole Person Care pilots under the 1115 Waiver, and for certain populations of focus. As of July 1, 2023, all counties must provide ECM services to all populations of focus.

Community Supports. The Governor's January budget includes expenditure authority of $237 million ($74.4 million General Fund and $162.6 million federal funds) in 2023-24 and $248.8 million ($78.1 million General Fund and $170.7 million federal funds) in 2024-25 to support implementation of community supports services. Community supports are services or service settings that Medi-Cal managed care plans may offer as a medically appropriate, cost-effective alternative to Medi-Cal eligible services or settings. Provision of community supports is voluntary for Medi-Cal managed care plans to provide and voluntary for Medi-Cal beneficiaries to receive. Plans may change their election of which community supports they provide every six months. The community supports plans may provide include the following:

- Housing Transition Navigation Services – These services assist beneficiaries with obtaining housing and include assessing a beneficiary's housing needs, developing a housing support plan, navigating housing options and applications, assisting with advocacy and securing available income and housing subsidy resources, assisting with reasonable accommodation and move-in readiness, and coordinating necessary environmental modifications.
- Housing Deposits – These services assist beneficiaries with securing or funding one-time housing services that do not constitute room and board including security deposits, setup fees or deposits for utilities or other services, first month coverage of utilities, first and last month's rent if required for occupancy, health and safety services such as pest eradication or cleaning upon moving in, and medically necessary adaptive aids and services such as air conditioners or air filters.
- Housing Tenancy and Sustaining Services – These services assist beneficiaries in maintaining safe and stable tenancy after housing is secured including early identification and intervention for behaviors that may jeopardize housing, education and training on rights and responsibilities of tenants and landlords, coordination and assistance to maintain relationships with landlords and resolve disputes, advocacy and linkage to community resources to prevent eviction, health and safety visits, unit habitability inspections, and training for independent living and life skills.
- Short-Term Post-Hospitalization Housing – These services may include supported housing in an individual or shared interim housing setting and are designed to assist beneficiaries who are homeless and who have high medical or behavioral health needs with the opportunity to continue their recovery immediately after exiting an inpatient hospital, substance abuse or mental health treatment facility, custody facility, or recuperative care.
- Recuperative Care (Medical Respite) – These services provide short-term residential care for beneficiaries who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, the service would include interim housing with a bed and meals with ongoing monitoring of the beneficiary's condition. The service may also include limited or short-term assistance with activities of daily living, coordination of transportation to post-discharge appointments, connection to other necessary health and human services benefits or housing, or stabilizing case management relationships and programs.
- Caregiver Respite – These services provide relief to caregivers of beneficiaries who require intermittent temporary supervision and may be provided by the hour on an episodic basis, by the day or overnight, or include services that attend to the beneficiary's basic self-help needs or other activities of daily living.
- Day Habilitation Programs – These services assist beneficiaries in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the beneficiary's natural environment. These services may include training or assistance with the use of public transportation, personal skills development in conflict resolution, community participation, developing and

maintaining interpersonal relationships, daily living skills, community resource awareness (e.g. police, fire, other local services), selecting and moving into a home, locating and choosing suitable housemates, locating household furnishings, settling disputes with landlords, managing personal financial affairs, managing needs for personal attendants, dealing with and responding to governmental agencies and personnel, asserting rights through self-advocacy, and coordinating health and human services benefits.

- Nursing Facility Transition/Diversion to Assisted Living Facilities – These services assist beneficiaries to live in the community or avoid institutionalization by transitioning to a Residential Care Facility for Elderly and Adult (RCFE) or Adult Residential Facility (ARF). These services, which do not include room and board, may include assessing housing needs and presenting options, assessing onsite service needs at the RCFE or ARF, assisting in securing a residence, communicating with facility administration and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other in-lieu-of services necessary for stable housing.
- Nursing Facility Transition to a Home – These services assist beneficiaries to live in the community and avoid institutionalization by transitioning to a private residence. These services, which do not include room and board, may include assessing housing needs and presenting options, assisting in securing housing, communicating with landlords and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other ILOS necessary for stable housing.
- Personal Care and Homemaker Services – These services assist beneficiaries with activities of daily living such as bathing, dressing, toileting, ambulation, or feeding. These services also assist beneficiaries with instrumental activities of daily living such as meal preparation, grocery shopping and money management. These services are provided in addition to any approved In-Home Supportive Services (IHSS) benefits approved by the county or during any IHSS waiting period.
- Environmental Accessibility Adaptations (Home Modifications) – These services provide physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a beneficiary, or enable the beneficiary to function with greater independence in the home. Adaptations may include installation of ramps and grab-bars, doorway widening for beneficiaries who require a wheelchair, installation of stair lifts, bathroom or shower accessibility, installation of specialized electric or plumbing systems to accommodate medical equipment or supplies, installation and testing of a Personal Emergency Response System for beneficiaries who are alone for significant parts of the day without a caregiver and otherwise require routine supervision.
- Medically-Supportive Food/Meals/Medically Tailored Meals – These services help beneficiaries achieve nutrition goals at critical times to help them regain and maintain their health and may include meals delivered to the home immediately following discharge from a hospital or nursing facility, or medically-tailored meals provided to the beneficiary at home to meet the unique dietary needs of a chronic condition.
- Sobering Centers – These services provide a safe, supportive environment to become sober for individuals found to be publicly intoxicated and who would otherwise be transported to an emergency department or jail. These services also include medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, homeless care support services, and screening and linkage to ongoing supportive services.
- Asthma Remediation – These services are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function

in the home without acute asthma episodes that could result in emergency utilization or hospitalization. These services would include allergen-impermeable mattress and pillow dustcovers, high-efficiency particulate air filtered vacuums, integrated pest management, de-humidifiers, air filters, other moisture-controlling interventions, minor mold removal and remediation, ventilation improvements, asthma-friendly cleaning products and supplies, and other interventions identified to be medically appropriate and cost-effective.

As of March 2024, the availability of community supports in each county, or future date of implementation are as follows:

- Housing Transition Navigation Services
  - **Currently Available – All 58 Counties**: As of January 2024, all Medi-Cal managed care plans in all 58 counties offer housing transition navigation services.

- Housing Deposits
  - **Currently Available – All 58 Counties**: As of January 2024, all Medi-Cal managed care plans in all 58 counties offer housing deposits.

- Housing Tenancy and Sustaining Services
  - **Currently Available – All 58 Counties**: As of January 2024, all Medi-Cal managed care plans in all 58 counties offer housing tenancy and sustaining services.

- Short-Term Post-Hospitalization Housing
  - **Currently Available – 53 Counties**: As of January 2024, Medi-Cal managed care plans in 53 counties offer short-term post-hospitalization housing.
  - **Beginning July 1, 2024 – 5 Counties**: Calaveras, Inyo, Madera, Mono, San Mateo

- Recuperative Care (Medical Respite)
  - **Currently Available – 58 Counties**: As of January 2024, Medi-Cal managed care plans in all 58 counties offer recuperative care (medical respite).

- Caregiver Respite
  - **Currently Available – 58 Counties**: As of January 2024, Medi-Cal managed care plans in all 58 counties offer caregiver respite.

- Day Habilitation Programs
  - **Currently Available – 32 Counties**: As of January 2024, Medi-Cal managed care plans in 32 counties offer day habilitation programs.
  - **Beginning July 1, 2024 – 9 Counties**: Marin, Mariposa, Napa, San Mateo, Santa Cruz, Solano, Sonoma, Ventura, Yolo
  - **Not Available – 17 Counties:** Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity

- Nursing Facility Transition/Diversion to Assisted Living Facilities
  - **Currently Available – 38 Counties**: As of January 2024, Medi-Cal managed care plans in 38 counties offer nursing facility transition/diversion to assisted living facilities.

- **<u>Not Available – 20 Counties</u>:** Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Nevada, Plumas, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Tehama, Trinity

- <u>Nursing Facility Transition to a Home</u>
  - **<u>Currently Available – 38 Counties</u>**: As of January 2024, Medi-Cal managed care plans in 38 counties offer nursing facility transition to a home.
  - **<u>Not Available – 20 Counties</u>:** Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Nevada, Plumas, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Tehama, Trinity

- <u>Personal Care and Homemaker Services</u>
  - **<u>Currently Available – All 58 Counties</u>**: As of January 2024, Medi-Cal managed care plans in all 58 counties offer personal care and homemaker services.

- <u>Environmental Accessibility Adaptations (Home Modifications)</u>
  - **<u>Currently Available – 40 Counties</u>**: As of January 2024, Medi-Cal managed care plans in 40 counties offer environmental accessibility adaptations (home modifications).
  - **<u>Not Available – 18 Counties</u>:** Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Tehama, Trinity

- <u>Medically-Supportive Food/Meals/Medically Tailored Meals</u>
  - **<u>Currently Available – 57 Counties</u>**: As of January 2024, 57 counties have a Medi-Cal managed care plan that offers medically-supportive food, meals, and medically tailored meals.
  - **<u>Beginning July 1, 2026</u>:** Butte

- <u>Sobering Centers</u>
  - **<u>Currently Available – 27 Counties</u>**: As of January 2024, Medi-Cal managed care plans in 27 counties offer sobering centers.
  - **<u>Beginning July 1, 2024 – 5 Counties</u>**: Calaveras, Inyo, Madera, Mono, Ventura
  - **<u>Not Available – 26 Counties</u>**: Butte, Colusa, Contra Costa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mariposa, Mendocino, Modoc, Napa, Nevada, Plumas, San Mateo, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo

- <u>Asthma Remediation</u>
  - **<u>Currently Available – 30 Counties</u>**: As of January 2024, Medi-Cal managed care plans in 30 counties offer asthma remediation.
  - **<u>July 1, 2024 – 8 Counties</u>**: Marin, Mariposa, Napa, San Mateo, Santa Cruz, Solano, Sonoma, Yolo
  - **<u>Not Available – 20 Counties</u>:** Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Nevada, Plumas, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Tehama, Trinity

Managed Care Plan Incentives. The Governor's January budget includes expenditure authority of $600 million ($300 million General Fund and $300 million federal funds) in 2023-24 and $300 million ($150

million General Fund and $150 million federal funds) in 2024-25 for managed care plan incentives. Beginning January 1, 2022, Medi-Cal managed care plans were eligible for incentive payments for investing in expanding and improving delivery of ECM and community supports. Federal regulations allow a percentage above a Medi-Cal managed care plans capitation payment to be allocated for quality improvement programs. To receive incentive payments, Medi-Cal managed care plans must improve delivery system infrastructure, build provider capacity for ECM and community supports services, and achieve certain quality benchmarks.

Medi-Cal Providing Access and Transforming Health (PATH). The Governor's January budget includes expenditure authority of $1 billion ($426.5 million General Fund, $523.2 million federal funds, and $95.3 million special funds and reimbursements) in 2023-24 and $478.8 million ($207.4 million General Fund, $239.4 million federal funds, and $32 million special funds and reimbursements) in 2024-25 for the Medi-Cal Providing Access and Transforming Health (PATH) initiative. The Medi-Cal PATH initiative is intended to provide a smooth transition between current 1115 Waiver pilots and statewide services and capacity building, including for effective pre-release care and coordination with justice agencies. PATH funding will support the transition from Whole Person Care pilots to ECM and community supports, including funding for counties, community-based organizations, and other providers to build the capacity and infrastructure necessary for these new statewide services. In addition, PATH funding will help ensure jails and prisons are ready for service delivery for the justice-involved, including mandatory Medi-Cal applications; behavioral health referrals, linkages, and warm hand-offs from county jails to Medi-Cal managed care plans and county behavioral health departments; "in reach" services up to 90 days prior to release, and the re-entry ECM benefit available in January 2023. PATH funding will also support workforce development for the homeless and home- and community-based services systems of care, including outreach, training in evidence-based practices, information technology for data sharing, and training stipends.

Panel Discussion. The subcommittee has invited the following panelists to discuss their experience with delivering the ECM benefit and community supports services:

- **Katie Andrew,** Dir. of Govt. Affairs, Quality & Behavioral Health, Local Health Plans of California
- **Ruth Lopez Novodo**, Managed Care Director, El Proyecto del Barrio, Inc.
- **Jessica Cervin,** Case Management Department Manager, Sacramento Native American Health Center
- **Linda Nguy,** Associate Director of Policy Advocacy, Western Center on Law and Poverty

Subcommittee Staff Comment—This is an informational item.

Questions. The subcommittee has requested DHCS and invited panelists to respond to the following:

DHCS:

1. Please provide a brief overview and update of implementation of the enhanced care management benefit (ECM) and community supports services in CalAIM, including the following information, if available:
   a. Number of ECM providers in the state
   b. Most common types of entities that are enrolled as ECM providers
   c. Number of unique Medi-Cal beneficiaries that receive the ECM benefit on an annual basis.

   d. Status of plan uptake of each of the community supports, including most common and least common services offered statewide.
   e. Number of Medi-Cal beneficiaries that receive one or more community supports services annually.
   f. Most common and least common community supports services received by Medi-Cal beneficiaries.

2. Please describe the process for determining beneficiary eligibility for ECM or community supports services.

3. How are beneficiaries determined to be part of one of the populations of focus? Do plans have any flexibility in offering ECM or community supports services to beneficiaries outside of these populations or who do not meet eligibility criteria, but would benefit from these services?

4. Does the department have flexibility to implement additional populations of focus, or is there a need for a statutory change?

5. Has the department observed any challenges with beneficiaries accessing ECM or community supports services in any parts of the state? If so, what is the most common barrier?

6. How does the department independently, or in collaboration with plans, provide outreach and technical assistance to providers to ensure they are aware of the benefits and services available to their patients under CalAIM?

7. How does the department independently, or in collaboration with plans, provide outreach and education to Medi-Cal beneficiaries to ensure they are aware of the benefits and services available under CalAIM?

8. How are the department or plans tracking outcomes for Medi-Cal beneficiaries receiving ECM and community supports? Are there any data available to characterize the impact on high-need beneficiaries of the implementation of these benefits and services?

9. While the expiration of the CalAIM Waiver is more than two years away, are there any lessons learned from the experience of ECM and community supports so far that might inform changes to the program in the next iteration of the Waiver beginning in 2027?

Local Health Plans

1. Please describe the local plans' experience in implementing the ECM benefit, and standing up community supports.

2. How do local plans identify which of their members are eligible for ECM or community supports services? Specifically, how to local plans identify members that are in a population of focus, and at a sufficiently high risk level to be eligible for either ECM or community supports services?

3. What kind of outreach is conducted by local plans to ensure members know which services are available and to connect them with providers of those services?

4. What type of case management is available to members who are not quite high-risk enough to qualify for ECM, but are still in need of some case management services or other navigation?

5. Do local plans have any discretion to determine a member eligible for ECM or community supports if the member doesn't strictly qualify under existing eligibility criteria, but would likely benefit from receiving one of these services?

6. What has been the local plans' experience in standing up provider networks for non-traditional community supports services, including housing, medically tailored meals, environmental/asthma remediation, etc..? Have there been any challenges with provider enrollment, rate development, or reimbursement processes?

7. For the community supports services local plans are providing, are the provider networks generally sufficient to provide these services to members everywhere in a plan's coverage area?

8. What kind of outreach or technical assistance do local plans offer to providers to ensure they know the services available for their patients, how to connect patients with those services, and generally how to navigate administrative requirements to ensure their patients are receiving all of the services they need?

<u>Clinic Providers (El Proyecto Del Barrio, Inc., and Sacramento Native American Health Center)</u>

1. Please describe the benefits and services under CalAIM provided by your clinic providers.

2. How do the Medi-Cal managed care plans in your area refer their members for enhanced care management or community supports services?

3. Were there any challenges enrolling as a provider of these benefits or services, or with the rate-setting or reimbursement process?

4. Have DHCS or the plans provided any outreach or technical assistance to your clinic providers to ensure they know what services are available under CalAIM for their patients?

5. Have your clinic providers experienced any challenges connecting patients to ECM or community supports services? What are the most common barriers?

6. Have your clinic providers encountered patients that, in their view would likely benefit from ECM or community supports services, but did not meet eligibility criteria?

7. Has the availability of these benefits and services allowed your clinics to better serve patients in the community compared with services provided prior to CalAIM?

8. What types of other benefits or services that address the social determinants of health are you able to connect your patients to under CalAIM?

Consumer Advocates (Western Center on Law and Poverty)

1. Please describe WCLP's view of how ECM and community supports services in CalAIM impact health care consumers' access to care that addresses the whole person.

2. Are consumers experiencing challenges accessing these new benefits and services? What are the most common barriers experienced by consumers that prevent them from receiving ECM or community supports?

3. Do DHCS or Medi-Cal managed care plans work with community partners like WCLP to perform outreach and education activities to ensure consumers know what services are available under CalAIM?

4. Has WCLP observed any disparities in the delivery of ECM or community supports services to certain communities? If so, are these disparities general across these services, or specific to a certain set of services?

5. What recommendations do you have for how DHCS or the plans could improve the reach of CalAIM, improve how consumers access ECM and community supports services, and ensure consumers get the care they need?

Issue 5: Funding Transition to State Operations for CalAIM MLTSS and D-SNP Integration

Budget Change Proposal – Governor's Budget. DHCS requests to shift expenditure authority of $6.6 million ($3.3 million General Fund and $3.3 million federal funds) for three years from local assistance to state operations. If approved, this shift would allow DHCS to align technical assistance contracts for the California Advancing and Innovating Medi-Cal (CalAIM) Managed Long-Term Services and Supports (MLTSS) and Dual-Eligible Special Needs Plan (D-SNP) integration with other technical assistance contracts managed by DHCS.

Multi-Year Funding Request Summary		
Fund Source	**2024-25**	**2025-26***
State Operations:		
0001 – General Fund	$3,300,000	$3,300,000
0890 – Federal Trust Fund	$3,300,000	$3,300,000
Local Assistance:		
0001 – General Fund	($3,300,000)	($3,300,000)
0890 – Federal Trust Fund	($3,300,000)	($3,300,000)
Total Funding Request:	**$0**	**$0**

* Shift of resources continues through 2026-27.

Background. Under CalAIM, DHCS made several changes to the delivery system for long-term services and supports (LTSS) that built upon the state's duals demonstration project, the Coordinated Care Initiative (CCI). CalAIM has moved the state toward aligned enrollment in a Medi-Cal managed care plan and a dual-eligible special needs plan (D-SNP) operated by one integrated organization. In the seven CCI demonstration counties, all Medi-Cal beneficiaries in a Cal MediConnect plan transitioned to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product, beginning January 1, 2023. Aligned enrollment will occur in all non-CCI counties by 2026. Dual-eligible beneficiaries already in a non-aligned D-SNP (not affiliated with their managed care plan) will be allowed to maintain their enrollment, but new enrollment in non-aligned D-SNPs will be closed.

DHCS will require all D-SNPs to use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. D-SNPs would be required to: 1) develop and use integrated member materials, 2) include consumers in existing advisory boards, 3) establish joint contract management team meetings for aligned D-SNPs and managed care plans, 4) include dementia specialists in care coordination efforts, and 5) coordinate carved-out LTSS benefits including in-home supportive services (IHSS), MSSP, and other home- and community-based services waiver programs.

As part of this transition, the Medi-Cal Estimate has included expenditure authority of $6.6 million ($3.3 million General Fund and $3.3 million federal funds) to support contractor activities for project management, technical assistance, policy development support, stakeholder engagement meetings and documents, and provider, member and health plan outreach.

Fund Transition Request. DHCS requests to shift expenditure authority of $6.6 million ($3.3 million General Fund and $3.3 million federal funds) for three years from local assistance to state operations. If approved, this shift would allow DHCS to align technical assistance contracts for the California

Advancing and Innovating Medi-Cal (CalAIM) Managed Long-Term Services and Supports (MLTSS) and Dual-Eligible Special Needs Plan (D-SNP) integration with other technical assistance contracts managed by DHCS.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: Managed Care Capitation Payment Systems Support

Budget Change Proposal – Governor's Budget. DHCS requests five positions and expenditure authority of $926,000 ($233,000 General Fund and $693,000 federal funds) in 2024-25, and $881,000 ($221,000 General Fund and $660,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to provide ongoing support to the Capitation Payment Management System (CAPMAN) and Electronic Accounting Management Interface (EAMI) systems that manage capitation payments in the Medi-Cal program.

Multi-Year Funding Request Summary		
Fund Source	**2024-25**	**2025-26***
0001 – General Fund	$233,000	$221,000
0890 – Federal Trust Fund	$693,000	$660,000
Total Funding Request:	**$926,000**	**$881,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and resources ongoing after 2025-26.

Background. According to DHCS, in 2011, 3 million Medi-Cal beneficiaries were enrolled in Medi-Cal managed care. The November 2023 Medi-Cal Local Assistance Estimate assumes 2024-25 Medi-Cal caseload of 13.8 million, with 95.1 percent, or 13.1 million, receiving services through the managed care delivery system. Medi-Cal managed care plans provide for Medi-Cal covered benefits and services for their enrolled members and receive a per member per month capitation payment that is actuarially determined to cover the expected costs of beneficiaries' care.

DHCS reports that the Medi-Cal program has significantly expanded and changed in the last 12 years due to the federal Affordable Care Act, state and federal regulations and statutory changes, as well has DHCS initiatives to improve the beneficiary experience, such as the California Advancing and Innovating Medi-Cal (CalAIM) initiative. These expansions and changes have led to significant increases in complexity for payments made to Medi-Cal managed care plans.

The Capitation Payment Management System (CAPMAN) calculates monthly capitation payment amounts, generates premium payment transactions, generates enrollment and disenrollment transactions, and allows Medi-Cal managed care plans to reconcile payments received against members they have enrolled. According to DHCS, in 2022 programs requested 92 change requests, but the Business Operations Technology Services Division (BOTSD) only has staff capacity to manage 52 change requests. DHCS reports BOTSD receives an average of 50 new change requests annually, but needs additional staff to clear the backlog of change requests to a manageable amount.

Staffing and Resource Request. DHCS requests five positions and expenditure authority of $926,000 ($233,000 General Fund and $693,000 federal funds) in 2024-25, and $881,000 ($221,000 General Fund and $660,000 federal funds) annually thereafter to provide ongoing support to the Capitation Payment Management System (CAPMAN) and Electronic Accounting Management Interface (EAMI) systems that manage capitation payments in the Medi-Cal program. Specifically, DHCS requests the following positions:

Business Operations Technology Services Division – Five positions

- **One Information Technology Specialist (ITS) II** position and **four ITS I** positions would provide information technology support for the CAPMAN system; meet additional workload of changes, operations support, monitoring, and reporting; aid in addressing stakeholder change requests, product support inquiries, and audit processes; and be responsive to product support requests, audits, and data-related inquiries.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 7: Medi-Cal Drug Rebate Special Fund Reserve Shift

General Fund Budget Solution – Governor's Budget. DHCS requests to transfer reserves balances in the Medi-Cal Drug Rebate Fund of $135.1 million in 2023-24 and $27.6 million in 2024-25 to the General Fund. This transfer is intended to address the state's General Fund shortfall.

Multi-Year Funding Request Summary		
Fund Source	**2023-24**	**2024-25**
0001 – General Fund	$135,084,000	$27,562,000
3331 – Medi-Cal Drug Rebate Fund	($135,084,000)	($27,562,000)
Total Funding Request:	**$0**	**$0**

Background. The federal Omnibus Budget Reconciliation Act of 1990 established the Medicaid Drug Rebate Program, which requires drug manufacturers to pay rebates to state Medicaid programs for drugs dispensed to Medicaid beneficiaries. These rebates are shared between states and the federal government according to the relevant federal matching rate for the beneficiaries to whom the drugs were dispensed. In addition to the federal rebate program, California law requires DHCS to enter into contracts with drug manufacturers to provide supplemental rebates for drugs dispensed to Medi-Cal beneficiaries in the fee-for-service delivery system or enrolled in county organized health systems (COHS). These rebates are in addition to those received through the federal rebate program. In 2010, the federal Affordable Care Act further extended eligibility for the federal rebate program to drugs dispensed to beneficiaries enrolled in non-COHS Medi-Cal managed care plans.

In the past, when rebates were first received, the funding split between the General Fund and federal funds was unknown and the initial funding credited back assuming a 50 percent federal match until reconciled with actual claims data. The timing of these later adjustments varied, and shifted from one fiscal year to another. For example, federal reimbursement was never remitted for drug rebates on claims between April 2015 and June 2016. For this period and the period between January and March 2017, DHCS remitted several one-time repayments to the federal government related to the higher federal matching rate for Affordable Care act beneficiaries after reconciliation of actual claims data. The 2017 Budget Act reflected a federal repayment of $487.3 million in 2016-17. The 2018-19 January budget included an additional federal repayment of $303.1 million in 2017-18 and offsetting savings of $280.7 million in 2018-19. The 2019-20 January budget includes additional rebates of $390 million for 2018-19. This uncertainty of when drug rebates are received and adjusted posed challenges for the department's overall fiscal management.

The 2019 Budget Act included trailer bill language to establish the Medi-Cal Drug Rebate Fund to manage the impact on the department's General Fund cash flow due to the uncertain timing of drug rebates and funding adjustments. The fund allows for a specific amount to be budgeted and transferred to offset General Fund expenditures in the Medi-Cal program. DHCS reports it typically targets a reserve in the fund of $220 million. If additional rebates are received, the department is able to validate the rebates and have increased flexibility on the timing of the impact to the General Fund, reducing volatility in Medi-Cal General Fund expenditures. The fund is continuously appropriated to DHCS for expenditure in the Medi-Cal program and the authorizing trailer bill language authorized the State Controller to use the funds for cash flow loans to the General Fund.

General Fund Budget Solution. DHCS requests to transfer reserves balances in the Medi-Cal Drug Rebate Fund of $135.1 million in 2023-24 and $27.6 million in 2024-25 to the General Fund. This transfer is intended to address the state's General Fund shortfall.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal

2. What is the rationale for transferring this fund balance to the General Fund, rather than allowing for a General Fund loan?

Issue 8: Clinic Workforce Stabilization Payments – Trailer Bill Language

General Fund Budget Solution and Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to authorize cancellation of the transfer of $14.9 million of unspent clinic workforce stabilization payments to HCAI for clinic workforce development programs. This proposal is intended to address the state's General Fund shortfall.

Background. The 2022 Budget Act included General Fund expenditure authority of $70 million, available until June 30, 2024, and the Legislature approved trailer bill language, to provide retention payment of up to $1,000 to eligible clinic workers. Based on estimates that the number of clinic workers eligible for payments would not encumber the entire $70 million allocation, the trailer bill language adopted by the Legislature included a provision that would transfer the remaining, unspent balance of the funds to HCAI to support clinic workforce development programs. The programs eligible for this funding include teaching health center residency programs, the State Loan Repayment Program, the Allied Healthcare Scholarship Program, the Allied Healthcare Loan Repayment Program, nurse practitioner postgraduate workforce training slots, or physician assistant postgraduate workforce training slots.

General Fund Budget Solution and Trailer Bill Language. DHCS proposes trailer bill language to authorize cancellation of the transfer of $14.9 million of unspent clinic workforce stabilization payments to HCAI for clinic workforce development programs. This proposal is intended to address the state's General Fund shortfall. The trailer bill language would delete the provisions of Section 14199.72 of the Welfare and Institutions Code that govern the transfer of unspent clinic workforce stabilization payments to HCAI.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 9: Eliminate Two-Week Checkwrite Hold Buyback

General Fund Budget Solution – Governor's Budget. DHCS requests to eliminate the planned buyback of the two-week hold on fee-for-service Medi-Cal payments each June until the following fiscal year. If approved, this proposal would result in General Fund savings of $532.5 million in 2024-25 and is intended to address the state's General Fund shortfall.

Background. The 2022 Budget Act included expenditure authority of $795.8 million ($309.4 million General Fund and $486.3 million federal funds) to eliminate the two-week hold on provider checkwrites that occurs during the last two weeks of the fiscal year. This practice was adopted during the 2006-07 fiscal year as a budget solution to address a General Fund shortfall. Because Medi-Cal is budgeted on a cash basis of accounting, delaying checkwrites for two weeks resulted in one-time savings in that fiscal year by moving costs into the subsequent fiscal year. As the program has grown since adoption of this savings proposal, the cost to reverse it has grown, as well.

The 2023 Budget Act delayed elimination of the checkwrite delay until 2024-25, resulting in $378 million General Fund savings to address the General Fund shortfall in the 2023-24 fiscal year. For 2024-25, DHCS requests to eliminate the planned buyback entirely. The department indicates it may revisit this issue if the state's General Fund condition improves.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal

Issue 10: Proposals for Investment

Proposals for Investment. The subcommittee has received the following proposals for investment:

For presentation:

- **Medi-Cal Outreach and Enrollment for Older Adults Project.** The California Coverage and Health Initiatives request expenditure authority of $20 million ($10 million General Fund and $10 million federal funds) in 2024-25, 2025-26, and 2026-27 to continue to provide enrollment assistance to older adults. The project's work began in April 2022, and the current funding for the Medi-Cal Outreach and Enrollment for Older Adults will end on June 30, 2024. This budget request is meant to continue the funding of the program. With the expiration of the current funding, the vulnerable populations that are presently being served under the project, including dual-eligible seniors and older adults regardless of immigration status, will no longer be able to benefit from the program. This includes receiving outreach about the health care coverage, information about enrollment, as well as how to utilize services under this grant that allow them to maximize their coverage. Additionally, a significant number of individuals that are currently dual eligible but are not currently enrolled will not have access to the services and will not benefit from the program. The populations served under this grant face multiple health-related social needs, including housing insecurity, food insecurity, poverty, and limited English proficiency. With this budget request, the project can continue this crucial work and expand its reach throughout a greater number of California counties.

- **Medi-Cal Coverage for Dental Implants.** The California Alliance for Retired Americans request expenditure authority and trailer bill language to add coverage for medically necessary dental implants as a benefit in the Medi-Cal program. Currently, single tooth implants are not a benefit of the Medi-Cal Dental Program, unless a beneficiary has an exception medical condition such as cancer of the mouth, severe loss of upper and lower jaw bone, skeletal deformities, or traumatic destruction of jaw, face, or head. All others in need of an implant are required to pay for it out of pocket. Families on Medi-Cal are already at the poverty threshold, so have no means to pay thousands of dollars out of pocket for a dental procedure that should be a covered benefit under Medi-Cal. The lack of accessible dental services across California means everyday Californians who are suffering from less dire, but no less significant, dental issues are simply having teeth removed without having that tooth replaced. This request would be an important step toward ensuring fair and equitable access to dental services for all Californians.

Not for presentation:

- **Multi-Year Continuous Medi-Cal Enrollment for Young Children 0-5.** A coalition of 8 children's and consumer advocacy organizations requests expenditure authority of $20 million ($10 million General Fund and $10 million federal funds) in 2024-25 and $40 million ($20 million General Fund and $20 million federal funds) annually thereafter to implement multi-year continuous Medi-Cal enrollment for children ages 0-5 authorized in the 2022 Budget Act. SB 189 (Committee on Budget and Fiscal Review), Chapter 189, Statutes of 2022 amended the policy to require a Department of Finance determination in the spring of 2024 that General Fund money over the multiyear forecast is available to support the provision of a General Fund augmentation for the State Department of Health Care Services to implement continuous Medi-Cal enrollment for children ages zero through 4 years,

inclusive, subject to federal approvals. In addition to receiving this determination, to become operational by the January 2025 start date, the policy must be funded. This will require funding and submission of a request for federal approval. If California delays submitting this federal request until this summer or later, it runs the risk of an unfavorable federal review should federal administrations change. This request would remove the language requiring a determination in the spring of 2024 that General Fund money over the multiyear forecast is available to support the provision of a General Fund augmentation for the State Department of Health Care Services to implement continuous Medi-Cal enrollment for children ages zero through 4 years and direct DHCS to submit the federal waiver.