Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Melissa Hurtado
Senator Jeff Stone

Thursday, April 25, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

PUBLIC COMMENT

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4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Dental Services - Overview

Dental Services for Medi-Cal Beneficiaries. The budget includes $485.9 million ($200.2 million General Fund and $285.8 million federal funds) in 2018-19 and $993.3 million ($377.8 million General Fund and $615.5 million federal funds) in 2019-20 for base fee-for-service expenditures for dental services in the Medi-Cal program. The 2018-19 figures are net of a one-time underwriting savings adjustment of $514.2 million ($167.3 million General Fund and $346.9 million federal funds) from the program's contract with Delta Dental.

The budget also includes $80.9 million ($30.6 million General Fund and $50.3 million federal funds) in 2018-19 and $67.3 million ($26 million General Fund and $41.3 million federal funds) in 2019-20 for base dental services provided through dental managed care plans.

Dental Services Funding Summary			
Fiscal Year:	**2018-19**	**2019-20**	**CY to BY**
Dental Fee-for-Service			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$200,174,510	$377,767,700	$177,593,190
0890 – Federal Trust Fund	$285,754,490	$615,544,300	$329,789,810
Total Expenditures	**$485,929,000**	**$993,312,000**	**$507,383,000**
Dental Managed Care			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$30,619,010	$25,961,960	($4,657,050)
0890 – Federal Trust Fund	$50,307,990	$41,311,040	($8,996,950)
Total Expenditures	**$80,927,000**	**$67,273,000**	**($13,654,000)**

Background. Medi-Cal provides an array of dental benefits to eligible Medi-Cal beneficiaries including diagnostic, preventive, restorative, and endodontic services; periodontics; removable and fixed prosthodontics; maxillofacial prosthetics; implant services; oral and maxillofacial surgery; and orthodontic and adjunctive services. Children under age 21 receive the full scope of dental benefits. Adults had received a more limited set of services until January 2018, when full scope adult dental benefits were restored pursuant to the 2017 Budget Act. With some restrictions, Medi-Cal covers the following dental benefits for beneficiaries with full-scope, restricted-scope, or pregnancy related coverage, and those residing in a skilled nursing facility (SNF) or an intermediate care facility (ICF):

MEDI-CAL DENTAL BENEFITS BY ELIGIBILITY CATEGORY				
PROCEDURE	**Full Scope**	**Restricted Scope**	**Pregnancy Related**	**Residing in a Facility (SNF/ICF)**
Oral Evaluation (Under age 3)	**YES**	**NO**	**NO**	**YES**
Initial Exam (Age 3 and above)	**YES**	**NO**	**YES**	**YES**
Periodic Exam (Age 3 and above)	**YES**	**NO**	**YES**	**YES**
Prophylaxis	**YES**	**NO**	**YES**	**YES**
Fluoride	**YES**	**NO**	**YES**	**YES**
Restorative Services: Amalgams, Composites, Pre-fabricated Crowns	**YES**	**NO**	**YES**	**YES**
Laboratory Processed Crowns	**YES**	**NO**	**YES**	**YES**
Scaling and Root Planing	**YES**	**NO**	**YES**	**YES**
Full Mouth Debridement	**NO**	**NO**	**NO**	**YES**
Periodontal Maintenance	**YES**	**NO**	**YES**	**YES**
Anterior Root Canals	**YES**	**NO**	**YES**	**YES**
Posterior Root Canals	**YES**	**NO**	**YES**	**YES**
Partial Dentures	**YES**	**NO**	**YES**	**YES**
Full Dentures	**YES**	**NO**	**YES**	**YES**
Extractions/Oral and Maxillofacial Surgery	**YES**	**YES**	**YES**	**YES**
Emergency Services	**YES**	**YES**	**YES**	**YES**

Source: *California Medi-Cal Dental Services – 2018 Beneficiary Handbook (May 2018)*

DHCS provides dental services to Medi-Cal beneficiaries through two primary delivery systems:

1. Fee-for-Service – Most Medi-Cal beneficiaries receive dental benefits through the fee-for-service delivery system. The department contracts with an administrative services organization (ASO), Delta Dental, to provide administrative services for the Medi-Cal Dental Program including adjudication of claims, treatment authorization requests, and customer service for both providers and beneficiaries. The department also contracts with a fiscal intermediary (FI), DXC Technology, which manages the California Dental Medicaid Management Information System (CD-MMIS), which processes dental services claims.

2. Dental Managed Care - The department contracts with six dental managed care plans that provide dental care to approximately 832,000 Medi-Cal beneficiaries in Sacramento and Los Angeles counties. These plans are regulated by the Department of Managed Health Care and licensed under the Knox-Keene Act. The department contracts with Access Health Plan, Health Net and Liberty Health Plan to provide dental benefits in both Sacramento and Los Angeles. In Sacramento, approximately 418,000 beneficiaries are mandatorily enrolled in one of three geographic managed care plans, while in Los Angeles approximately 414,000 beneficiaries voluntarily enroll in one of three prepaid health plans.

2014 Audit Found Low Children's Dental Utilization and Provider Reimbursement. In 2014, the California State Auditor performed an audit of Medi-Cal dental services which found several weaknesses in the program's operation that limited children's access to dental care. In particular, the audit reported the following:

1. Children's utilization rate of dental services, 43.9 percent, was 12th worst among states submitting data to CMS in 2013. The utilization rate is defined as the percentage of beneficiaries having one dental procedure performed during the year.
2. While the availability of dental providers was adequate on a statewide basis, many counties had insufficient providers, with five counties reporting no providers at all.
3. California's provider reimbursement rates for the 10 most common dental procedures were only 35 percent of the national average in 2011.
4. The department had not performed annual reimbursement rate reviews, as required by law, between 2001 and 2011.
5. The department had not enforced provisions of its contract with Delta Dental designed to improve outreach and increase utilization of services.

The audit also observed that provider surveys suggest that low provider participation is based in part on the program's low reimbursement rates compared to national averages.

The audit made 24 specific recommendations for improvements, including but not limited to: 1) establishing assessment criteria for beneficiary utilization and provider participation; 2) developing procedures for identifying areas with low utilization or provider participation; 3) simplifying administrative processes for providers; 4) monitoring beneficiary utilization, access and enrollment; 5) resumption of annual review of reimbursement rates; 6) requiring Delta Dental to provide additional dental services in underserved areas, either in fixed facilities or mobile clinics; and 7) requiring Delta Dental to develop a dental outreach and education program each year.

Annual Dental Reimbursement Rate Review. After the 2014 audit, DHCS resumed its annual review of dental reimbursement rates in Medi-Cal. The most recent report was released in August 2018 for the 2015-16 and 2016-17 fiscal years. The report found that in 2015-16, for the 25 most frequent utilized procedure codes, Medi-Cal paid an average of 105.3, 99.2, 76.5, and 62.9 percent of Illinois, Florida, New York, and Texas Medicaid Program's dental fee schedules, respectively. For 2016-17 the overall averages were 109, 91.5, 78.7, and 64.3 percent of Illinois, Florida, New York, and Texas Medicaid Program's dental fee schedule, respectively. The report also found a decrease in providers rendering Medi-Cal dental services, from 9,527 in calendar year 2008 to 8,270 in calendar year 2016, a decrease of 13.2 percent.

Dental Outreach. The audit also recommended the department enforce and enhance its contract with Delta Dental to conduct outreach to Medi-Cal beneficiaries to improve utilization of dental services. One of the primary findings of the audit was that more than 50 percent of children had not visited a dentist in the preceding 12 months.

In its 2016 ASO contract, DHCS implemented several new outreach requirements for Delta Dental. Delta was required to:

- Adhere to DHCS established baseline target rates for utilization for precedent to payment items.
- Implement provider and beneficiary services to provide education in addition to dental services in clinics.
- Target all areas in the state for outreach, focusing on underserved areas/subpopulations.
- Increase utilization by selected adults, such as for systemic disease conditions.
- Maximize beneficiary awareness of the Medi-Cal Dental Program, information about the covered benefits available to them, and the tools at their disposal to schedule appointments and/or receive other assistance.
- Establish four major goals around the annual dental visit, increase of preventive dental services for children, increase of sealants, and annual increases to precedent to payment items.
- Utilize and promote the use of evidence-based and age-appropriate preventive procedures, including fluoride varnish and dental sealants.
- Help families understand the importance of dental benefits and how to access dental services.
- Develop American Dental Association (ADA) compliant education for parents on the need to bring children in for their first dental visit by age one.
- Develop all beneficiary materials in both English and all threshold languages and assure that all written materials are at no higher than a sixth grade reading level.
- Develop material to inform parents/guardians, medical providers, other governmental and non-governmental organizations, and community advocates on key information to promote oral health and the utilization of dental services under the Medi-Cal Dental Program.
- For children, EPSDT Services must include identifying and contacting families of children who are due for a dental screening, examination, preventive visit, and those who have missed such visits, and assist them in scheduling any necessary appointments.

In addition to these requirements for Delta Dental, the department has conducted its own outreach activities. In particular, the department identified beneficiaries between 0 and 3 years of age that had not had a dental visit in the preceding 12 months. The department mailed each of these beneficiaries' parents or legal guardians information about the importance of early dental visits and encouraged them to take their children to see a dental provider. According to DHCS, after its mailing campaign that began in January 2015, 29 percent of children whose families received a letter subsequently scheduled a dental visit.

1115 Waiver – Medi-Cal 2020 Dental Transformation Initiative. Effective January 2016, the federal Centers for Medicare and Medicaid Services approved California's 1115 Demonstration Waiver, known as Medi-Cal 2020. Through the Medi-Cal 2020 Waiver, DHCS is implementing four dental "domains", collectively referred to as the Dental Transformation Initiative (DTI), to improve the quality of care and increase utilization of dental services. The four domains of the DTI program are:

1. Increase Preventive Services Utilization for Children - This domain aims to increase the statewide proportion of children ages one through 20 enrolled in Medi-Cal who receive a preventive dental service in a given year. The domain's goal is to increase the utilization amongst children by at least 10 percent over a five year period. DHCS offers financial incentives for dental service office locations that increase delivery of preventive oral care to Medi-Cal eligible children.

According to DHCS, Domain 1 costs for incentive payments to providers for increasing preventive services over the baseline will be $60.2 million ($30.1 million General Fund and $30.1 million federal funds) in 2018-19 and $76.9 million ($38.5 million General Fund and $38.5 million federal funds) in 2019-20.

2. Caries Risk Assessment and Disease Management – Under this domain, dental providers receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under.

   According to DHCS, Domain 2 costs for caries risk assessment and disease management will be $3.7 million ($1.8 million General Fund and $1.8 million federal funds) in 2018-19 and $4.1 million ($2 million General Fund and $2 million federal funds) in 2019-20.

3. Increase the Continuity of Care - This domain aims to encourage continuity of care among Medi-Cal beneficiaries age 20 and under. Dental provider service office locations receive an incentive payment for maintaining continuity of care for enrolled child beneficiaries for two, three, four, five, and six year continuous periods. Incentive payments are made annually.

   According to DHCS, Domain 3 costs for incentive payments for continuity of care will be $11.9 million ($5.9 million General Fund and $5.9 million federal funds) in 2018-19 and $18.1 million ($9 million General Fund and $9 million federal funds) in 2019-20.

4. Local Dental Pilot Programs (LDPPs) –15 LDPPs were approved, although two have been withdrawn, to address one or more of the previous three domains through alternative programs, using strategies focused on rural areas, including local case management initiatives and education partnerships. DHCS requires LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three domains. No more than 25 percent of the annual DTI funding is allocated to this domain.

   According to DHCS, Domain 4 costs for LDPPs will be $39.5 million ($19.7 million General Fund and $19.7 million federal funds) in 2018-19 and $50.1 million ($25 million General Fund and $25 million federal funds) in 2019-20.

Restoration of Adult Dental Benefits. AB 5 X3 (Evans), Chapter 20, Statutes of 2009, Third Extraordinary Session, discontinued optional dental benefits in the Medi-Cal program for adults including full denture procedures and "restore but not replace" procedures. Adults retained some limited sets of services that were federally required. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, restored partial adult optional dental benefits beginning in May 2014. The restored benefits include examinations; radiographs/photographic images; prophylaxis; fluoride treatments; amalgam and composite restorations; stainless steel, resin, and resin window crowns; anterior root canal therapy; complete dentures, including immediate dentures; and complete denture adjustments, repairs and relines. The 2017 Budget Act restored the remaining full scope adult dental benefits effective January 1, 2018.

Proposition 56 Funds Supplemental Reimbursement for Certain Dental Services. Proposition 56, approved by voters in 2016, increased the excise tax rate on cigarettes by $2 per pack, with an equivalent increase on other tobacco products, including electronic cigarettes. After allocations for administration, auditing, and backfills of other revenue streams, Proposition 56 requires 82 percent of remaining funds be transferred to the Healthcare Treatment Fund to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services in the Medi-Cal program. The 2018 Budget Act included up to $210 million of Proposition 56 revenues for increased supplemental reimbursement of dental providers in Medi-Cal.

In an effort to increase provider participation, DHCS began providing supplemental payments to dental providers of 40 to 60 percent of the dental Schedule of Maximum Allowances (SMA), or fixed supplemental payment amounts, for certain dental services. According to DHCS, the services included the following claiming (CDT) codes in the following procedural categories:

Type of Procedure	# of Specific CDT codes	Supplemental Payment Amount or Percent of SMA
Restorative	35 CDT codes	40 percent
Endodontic	18 CDT codes	40 percent
Prosthetic	76 CDT codes	40 percent
Oral and Maxillofacial Surgery	111 CDT codes	40 percent
Adjunctives	15 CDT codes	40 percent
	2 CDT codes	60 percent
	1 CDT Code (D9220)	$148.65
	1 CDT Code (D9221)	$110.99
Visits and Diagnostics	5 CDT codes	20 percent
	1 CDT Code (D0120)	$30.00
	1 CDT Code (D0145)	$39.00
	1 CDT Code (D0150)	$41.00
	1 CDT Code (D0350)	$3.60
	1 CDT Code (D0230)	$1.05
Preventive	1 CDT Code (D1110)	$50.00
	1 CDT Code (D1206)	$12.00
	1 CDT Code (D1208)	$9.00
Orthodontics	10 CDT codes	40 percent
Periodontics	3 CDT codes	40 percent

The budget includes $510.1 million ($194.4 million Proposition 56 funds and $315.7 million federal funds) in 2018-19 and $546.6 million ($216.6 million Proposition 56 funds and $330 million federal funds) in 2019-20.

Current Status of Provider Participation and Dental Utilization. According to data provided by DHCS in its two most recent quarterly reports for the 1115 Waiver, which includes DTI, children's preventive utilization was 45.2 percent as of July 2018 and had increased slightly to 45.4 percent as of November 2018. Between July 2018 and December 2018, the number of rendering dental providers in fee-for-service grew from 10,270 to 10,479 and service offices grew from 5,780 to 5,815. Between July

2018 and November 2018, the number of rendering providers in Geographic Managed Care dental plans grew from 268 to 399 and service offices grew from 118 to 158. During the same period, the number of rendering providers in the Prepaid Health Plans in Los Angeles grew from 1,930 to 2,112 and service offices grew from 874 to 1,043. Also during the same period, the number of safety net clinics decreased from 565 to 556.

According to DHCS' most recent fee-for-service performance measures report, 22.8 percent of adults 21 and over had an annual dental visit between July 2017 and June 2018. 13.7 percent of adults 21 and over used a preventive service during that period. 48.7 percent of continuously covered adults 21 and over utilized a dental service in the prior three years. These data include the first six months of the restoration of full adult dental benefits and the implementation of Proposition 56 supplemental provider payments for dental services approved in the 2017 Budget Act.

Proposals for Investment and Program Changes. Several stakeholders have proposed the following investments or program changes for dental services in Medi-Cal:

Trailer Bill Language Clarifying Establishment of Patients for Clinics – The Children's Partnership and a coalition of ten other organizations request trailer bill language to clarify the provisions of AB 1174 (Bocanegra), Chapter 662, Statutes of 2014, that states that federally qualified health centers (FQHCs) and rural health clinics (RHCs) are allowed to establish a patient through store-and-forward teledentistry for the purposes of billing so that a virtual dental home (VDH) can operate as intended, as efficiently as possible in community settings. FQHCs and RHCs are a critical source of care for underserved communities and have been extremely successful at implementing the VDH. However, FQHCs and RHCs must establish an individual as a patient before they can bill for services. This simple budget language clarification request would allow the provision of safe and quality dental care to children and adults in community settings through the Virtual Dental Home.

Silver Diamine Fluoride Coverage in Denti-Cal – The California Dental Association (CDA) requests resources to add silver diamine fluoride as a Medi-Cal dental benefit. According to CDA, dental caries remain the most common, yet preventable, chronic disease of children. Application of silver diamine fluoride is one of the most promising approaches in dental care to arrest dental caries. Silver diamine fluoride is being used in a very limited fashion in California's Dental Transformation Initiative but is not a dental benefit covered by Medi-Cal. It is a painless topical medication that can provide enormous benefit and eliminate the need for more extensive restorative procedures. Modernizing the dental benefits offered under Medi-Cal provides vulnerable patients with expanded quality of care as part of an overall comprehensive dental treatment plan and has the potential to reduce state costs.

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 utilization rates for primary preventive dental services for both children and adults in the Medi-Cal program.

2. Please describe current outreach efforts by DHCS and the ASO to improve children's utilization of preventive dental services.

3. Please describe current outreach efforts by DHCS and the ASO to improve adult utilization of preventive dental services since the restoration of the full dental benefit.

Issue 2: Medi-Cal Pharmacy Services

Governor's Executive Order on Prescription Drug Purchasing. On January 7, 2019, the Governor issued Executive Order N-01-19, ordering state departments to implement several directives intended to reduce the cost of prescription drugs for both public and private purchasers.

1. *Transition of Medi-Cal Prescription Drug Benefits to Fee-For-Service.* The Executive Order directs the Department of Health Care Services (DHCS) to take all necessary steps to transition all pharmacy services currently provided by Medi-Cal managed care plans into the Medi-Cal fee-for-service delivery system. The transition, which would be completed by January 2021, is intended to create additional negotiating leverage on behalf of the state's 13.2 million Medi-Cal beneficiaries. According to the Administration, this transition would standardize the Medi-Cal drug benefit, reduce confusion among beneficiaries without sacrificing quality or outcomes, and result in hundreds of millions of dollars in additional savings beginning in the 2021-22 fiscal year. There are no savings or transition costs for this purpose reflected in the Governor's January budget for the 2019-20 fiscal year.

2. *Statewide Review of Drug Purchasing Initiatives.* The Executive Order directs DHCS, in consultation with the California Pharmaceutical Collaborative (CPC), to review all state purchasing initiatives and consider additional options to maximize the state's bargaining power, including the Medi-Cal program. The review, which may include recommended changes to state law or other procurement or reimbursement processes, will be completed by July 12, 2019.

3. *Prioritization of Drugs and Implementation of Bulk Purchasing Arrangements.* The Executive Order directs the Department of General Services (DGS), in collaboration with the CPC, to develop a prioritized list of prescription drugs for future bulk purchasing initiatives or for renegotiation of existing purchasing arrangements with manufacturers. The prioritization would be based on the level of competition for the drug in the marketplace and consideration of the 25 highest-cost drugs. The department will provide a written report to the Governor's Office by March 15, 2019.

   Once DGS and the CPC have developed a prioritized list, these two entities will develop and implement bulk purchasing arrangements for high-priority drugs. The department will encourage local governments to participate in the bulk purchasing arrangement through proactive outreach and will provide a written status report to the Governor's Office by April 12, 2019. The Executive Order also directs DGS and the CPC to develop a framework for private purchasers, such as small businesses, health plans, and the self-insured to opt into the state bulk purchasing program. DGS will provide a written report recommending any necessary legislative changes to the Governor's Office by May 17, 2019.

Prescription Drug Coverage in California. While recent health reform efforts have led to significant expansions of health insurance coverage in California and across the United States, a complementary goal of these health reform efforts has also been to reduce the growth of health care costs. One of the primary drivers of rising health care costs has been the growth in the price of prescription drugs, which in 2017 accounted for approximately one out of every ten dollars in national health care expenditures.[1] Employer-based health plans experience even higher expenditures for prescription drugs, which make up 19 percent of employer-based health spending.[2]

According to the federal Centers for Medicare and Medicaid Services (CMS), California has experienced average annual growth in prescription drug expenditures of seven percent between 1991 and 2014, with total expenditures rising from $7.7 billion in 1991 to $36.9 billion in 2014.[3]

Medi-Cal, which covers 13.2 million low-income Californians, is one of the largest purchasers of prescription drugs in the state. The Governor's January budget estimates that Medi-Cal will spend $1.4 billion in 2018-19 and $2 billion in 2019-20 on prescription drugs in the fee-for-service delivery system. These figures are net of rebates provided by manufacturers under state and federal drug rebate programs (see *Prescription Drug Rebates in Medi-Cal*) and do not include drugs purchased on behalf of Medi-Cal beneficiaries by managed care plans.

Many other California state entities are impacted by high prescription drug spending. Total prescription drug costs for state employees and retirees covered by the California Public Employee Retirement System (CalPERS) were $1.25 billion for Basic Plans and $880.1 million for Medicare plans in 2017.[4] Other state entities prescription drug expenditures in the 2015-16 fiscal year were as follows:

Prescription Drug Expenditures by Various State Departments, 2015-16[5]	
Department	Expenditures
CA Dept. of Corrections Rehabilitation: California Correctional Health Care Services	$239,454,095
Department of State Hospitals	$34,895,455
Department of Developmental Services	$8,539,096
California State Universities	$3,569,905
CA Dept. of Corrections and Rehabilitation: Division of Juvenile Justice	$275,695

[1] Centers for Medicare and Medicaid Services. "National Health Expenditures 2017 Highlights". https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf. Accessed February 9, 2019.

[2] Peterson-Kaiser Health System Tracker. "Retail drugs as a share of national health spending and as a share of employer health benefits, 2017".

[3] Centers for Medicare and Medicaid Services. "Health expenditures by state of residence: summary tables, 1991-2014. Table 8: Total All Payers State Estimates by State of Residence (1991 - 2014) - Drugs and Other Non-durable Products".

[4] CalPERS Pension and Health Benefits Committee. "Board Agenda Item 5c: Prescription Drugs Utilization and Cost Trends". September 25, 2018.

[5] Legislative Analyst's Office. "Department of General Services' Efforts to Control State Prescription Drug Spending". (Handout - Assembly Health Committee. February 14, 2017).

High-Cost Specialty Drugs Dramatically Increase Costs for Public Health Care Programs. One of the primary drivers in the growth of overall prescription drug expenditures is the high cost of specialty drugs. According to a Health Affairs Blog post from May 2016, specialty drugs account for a disproportionate share of overall drug spending and have a corresponding effect on spending growth. In fact, spending on specialty medicines was responsible for 73 percent of overall medicine spending growth over the past five years. Approval of these drugs by the federal Food and Drug Administration, along with the requirement of public health care programs to cover approved, medically necessary prescription drugs have placed enormous fiscal and programmatic pressures on these programs in recent years. In particular, the emergence of Sovaldi and Harvoni, specialty drugs developed by Gilead Sciences, which effectively cure individuals infected with hepatitis C, illustrate the potential for unexpected skyrocketing costs to public health programs. In response to these costs, the 2015-16 Governor's January budget reserved $300 million for the combined impact of hepatitis C treatment on California's public health programs including Medi-Cal, the Department of State Hospitals, and the California Department of Corrections and Rehabilitations. Medi-Cal implemented a supplemental capitation payment for hepatitis C treatment for Medi-Cal managed care beneficiaries. The Governor's January budget estimates Medi-Cal will spend a total of $400.9 million in 2018-19 and $359.3 million in 2019-20 for hepatitis C treatment for managed care beneficiaries.

While hepatitis C treatment is one of the more well-known instances of high-cost specialty drugs that impact public health care programs, the population with hepatitis C is relatively small. Several other specialty drugs have been approved, or are nearing approval that could target much larger populations. Specialty drugs treating high cholesterol or other common conditions could result in increased expenditures dramatically higher than those experienced for hepatitis C treatments. The prices of specialty drugs are also growing dramatically. For example, the Memorial Sloan Kettering Cancer Center reported that the median launch price of new cancer agents doubled in the last decade, from $4,500 per month to more than $10,000 per month. Similarly, the launch prices of new multiple sclerosis drugs increased from $8,000 to $12,000 per year in the 1990s to $50,000 to $65,000 per year today. Specialty drugs also often experience substantial price growth every year they are on the market. For example, the AARP Public Policy Institute's December 2016 Rx Price Watch report found that the retail prices of specialty drugs widely used by older Americans increased by almost 11 percent in 2013.

Generic Drugs Also Subject to Sharp Price Increases. Significant price increases are not limited to specialty drugs. Prices for drugs that have been on the market for decades have also seen inexplicable increases. For example, over the past 20 years, the price of human insulin produced by two major manufacturers – Eli Lilly and Novo Nordisk – rose 450 percent after accounting for inflation, according to a 2016 Washington Post analysis of data from Truven Health Analytics. A single 10-milliliter vial of Eli Lilly's Humalog insulin, which is less than a month's supply for many adults, was listed at $254.80 in 2016, compared with $20.82 in 1996.

Prescription Drug Rebates in Medi-Cal. 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. However, managed care drug utilization is not eligible for state supplemental rebates.

The Governor's January budget includes General Fund savings from drug rebates of approximately $1.6 billion in 2018-19 and $1.4 billion in 2019-20 through the federal rebate program, state supplemental rebate program, from managed care beneficiaries, and beneficiaries in the Family Planning Access, Care, and Treatment (Family PACT) program and Breast and Cervical Cancer Treatment Program (BCCTP).

Medi-Cal Drug Rebates, 2019-20 Governor's January Budget		
Rebate Program	**2018-19**	**2019-20***
Managed Care (Fed only)	$(549,832,000)	$(639,218,000)
Federal Rebate Program	$(953,904,000)	$(727,582,000)
State Supplemental	$(65,385,000)	$(67,262,000)
Family PACT	$(3,067,000)	$(3,213,000)
BCCTP	$(3,166,000)	$(3,251,000)
TOTAL	**$(1,575,354,000)**	**$(1,440,526,000)**

* 2019-20 rebates deposited in the Medi-Cal Rebate Fund, which will offset General Fund expenditures

Federal 340B Drug Pricing Program Supports Safety Net Providers. The federal Veterans Health Care Act of 1992 established the 340B Drug Pricing Program (340B Program), which requires drug manufacturers that participate in Medicaid to offer significantly reduced prices to certain safety net health care providers, known as covered entities. According to the federal Health Resources and Services Agency (HRSA), which oversees the 340B Program, these discounts enable covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Health care organizations eligible to be covered entities are defined in federal statute and include HRSA-supported health centers and look-alikes (e.g. federally qualified health centers), Ryan White clinics and state AIDS Drug Assistance programs (ADAP), Medicare/Medicaid Disproportionate Share Hospitals, children's hospitals, and other safety net providers.

In general, federal law prohibits states from receiving federal drug rebates for Medicaid beneficiaries if the drugs dispensed were already discounted as part of the 340B Program. 340B- covered entities are also required to provide drugs purchased under the 340B program to Medi-Cal beneficiaries in the fee-for-service delivery system at the 340B price. It is unclear the extent to which Medi-Cal managed care plans, in an effort to maintain an adequate network of pharmacy providers, reimburse 340B entities at a higher rate than the 340B price. However, it is likely 340B entities receive a significant amount of revenue from the incremental difference between costs and managed care reimbursement, as this feature is the primary method utilized by the 340B program to assist safety net clinics and providers to stretch scarce funding resources to care for underserved populations.

Stakeholder Proposals Related to Pharmacy Services. Stakeholders have proposed the following proposals related to Medi-Cal pharmacy benefits.

Trailer Bill Language to Add Hemlibra to Carved-Out Products Similar to Blood Factors – Genentech requests trailer bill language to expand the definition of "blood factor" to ensure parity in access for all hemophilia products. Hemlibra was approved in November 2017 for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and children with Hemophilia A. Hemlibra is the only prophylactic treatment for Hemophilia A patients without factor VIII inhibitors that can be administered subcutaneously and at multiple dosing options. Hemlibra is a high-cost specialty drug and, despite the long-term savings that can ensue from the use of Hemlibra, the short-term costs are a significant deterrent to managed care organizations approving utilization. The proposed trailer bill language would treat Hemlibra similar to blood factors by carving it out of managed care.

Carve-Out of High Cost Drugs From Hospital Reimbursement – The California Children's Hospital Association requests trailer bill language to require DHCS to reimburse hospitals for newly-approved, high-cost, inpatient-administered drugs based on the acquisition cost of the drug, rather than as part of a diagnosis-related group (DRG) payment. When a Medi-Cal patient is administered a prescription drug on an inpatient basis, the hospital is reimbursed with a bundled payment called a DRG, which is meant to cover all the costs associated with treating someone with that condition, including the cost of any necessary medications. When a high-cost prescription drug is administered to a patient on an inpatient basis, and particularly when a high-cost drug first hits the market, the DRG payment does not adequately incorporate the cost of the medication. As such, hospitals experience significant financial losses if they administer these drugs, and have a disincentive to provide these treatments to patients.

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 department's proposal to transition pharmacy benefits to fee-for-service.

2. How does the department intend to address concerns from Medi-Cal managed care plans that inability to access or manage the pharmacy benefit would be detrimental to effective clinical management?

3. Has the department conducted or does it intend to conduct an analysis of safety net clinics that are also 340B entities to determine if loss of rebate revenue from the department's transition of the pharmacy benefit would result in a reduction in access to care for Medi-Cal beneficiaries?

4. When will the department be able to provide a fiscal estimate of the savings to the Medi-Cal program from the pharmacy benefit transition?

Issue 3: California 1115 Waiver - Medi-Cal 2020

Background. Section 1115 of the Social Security Act authorizes the federal Department of Health and Human Services to allow experimental, pilot, or demonstration projects likely to assist in promoting the objectives of Medicaid. The broad authority under Section 1115 allows states to request a waiver of Medicaid coverage requirements, such as the requirement that Medicaid benefits be offered uniformly statewide, which allows operation of demonstration components in specified counties or provision of benefits to specific populations. States may also request waiver of restrictions on expenditure authority, which allows states to receive federal financial participation for certain benefits not ordinarily eligible for federal Medicaid funds.

California's first 1115 Waiver, the Medi-Cal Hospital/Uninsured Care Demonstration, was approved in 2005 for five years and restructured the state's hospital financing system. California renewed the 1115 Waiver for an additional five years in 2010, renaming it "Bridge to Reform" and focusing on readying state health programs for implementation of the federal Affordable Care Act. Specifically, the Bridge to Reform Waiver: 1) allowed for health care coverage of up to 500,000 uninsured individuals in county Low Income Health Programs who would later become eligible for the state's optional expansion of Medi-Cal, 2) increased funding for uncompensated care, 3) improved care coordination for vulnerable populations such as dual-eligibles, and 4) promoted transformation of public hospital care delivery systems.

The most recent Waiver renewal, titled "Medi-Cal 2020", was approved on December 30, 2015, and contains four primary components: Public Hospital Redesign and Incentives in Medi-Cal, the Global Payment Program, Whole Person Care Regional Pilots, and the Dental Transformation Initiative.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME). PRIME is a five-year initiative under the Medi-Cal 2020 Waiver that builds upon the public hospital delivery system reforms implemented under the previous Bridge to Reform Waiver. PRIME is designed to continue improving the way care is delivered in California's safety net hospitals to maximize health care value and move toward alternative payment models, such as capitation and other risk-sharing arrangements. Participating PRIME entities, Designated Public Hospital (DPH) systems or District/Municipal Public Hospitals (DMPH), must submit plans to achieve goals within one of the following domains:

- **Domain 1: Outpatient Delivery System Transformation and Prevention**. These projects are meant to ensure patients experience timely access to high-quality, efficient, and patient-centered care. In addition, these projects identify and increase rates of cost-effective standard approaches to prevention services for a select group of high-impact clinical conditions and populations such as cardiovascular disease, breast, cervical and colorectal cancer, and obesity. The projects also aim to reduce disparities and variation in performance of targeted prevention services within their systems. Required and optional projects under this domain and the number of approved projects are as follows:

    i. Integration of Physical and Behavioral Health (required) – 23 Projects
    ii. Ambulatory Care Redesign: Primary Care (required) – 24 Projects
    iii. Ambulatory Care Redesign: Specialty Care (required) – 19 Projects
    iv. Patient Safety in the Ambulatory Setting (optional) – 13 Projects

v. Million Hearts Initiative (optional) – 18 Projects
vi. Cancer Screening and Follow-up (optional) – 12 Projects
vii. Obesity Prevention and Healthier Foods Initiative (optional) – 9 Projects

- **Domain 2: Targeted High-Risk or High-Cost Populations.** These projects are focused on specific populations that would benefit most significantly from care integration and alignment. Particular attention will be focused on managing and coordinating care during transitions from inpatient to outpatient and post-acute settings. Required and optional projects under this domain and the number of approved projects are as follows:

  i. Improved Perinatal Care (required) – 20 Projects
  ii. Care Transitions: Integration of Post-Acute Care (required) – 30 Projects
  iii. Complex Care Management for High-Risk Medical Populations (required) – 26 Projects
  iv. Integrated Health Home for Foster Children (optional) – 4 Projects
  v. Transition to Integrated Care: Post-Incarceration (optional) – 3 Projects
  vi. Chronic Non-Malignant Pain Management (optional) – 14 Projects
  vii. Comprehensive Advanced Illness Planning and Care (optional) – 13 projects

- **Domain 3: Resource Utilization Efficiency.** These projects are meant to reduce unwarranted variation in use of evidence-based, diagnostics, and treatments targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects will also eliminate the use of ineffective or harmful targeted clinical services. Optional projects under this domain and the number of approved projects are as follows:

  i. Antibiotic Stewardship – 12 Projects
  ii. Resource Stewardship: High-Cost Imaging – 8 Projects
  iii. Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals – 8 Projects
  iv. Resource Stewardship: Blood Products – 5 Projects

DHCS has approved a total of 17 plans submitted by DPHs and 37 submitted by DMPHs to become PRIME entities. These entities may receive up to $3.7 billion combined in federal Medicaid funding over five years for achieving metrics in implementing clinical projects designed to change the way care is delivered. 1115 Waiver financing regulations require these funds to be matched with a non-federal share of funding, which is provided by other governmental health entity funds that are transferred to DHCS as intergovernmental transfers (IGTs). The budget includes $1.7 billion ($843.9 million intergovernmental transfers and $843.9 million federal funds) in 2018-19 and $1.3 billion ($666 million intergovernmental transfers and $666 million federal funds) in 2019-20 for the PRIME program.

Global Payment Program. The Global Payment Program establishes a statewide pool of funding for the remaining uninsured by combining federal Disproportionate Share Hospital and uncompensated care funding. The program establishes individual public hospital system "global budgets" for each hospital from overall annual threshold amounts determined through analysis of services provided to the uninsured. Public hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher-value and preventative services. The program divides services into four categories for evaluating funding:

- Traditional provider-based, face-to-face outpatient encounters
- Other non-traditional provider, groups, prevention/wellness, face-to-face
- Technology-based outpatient
- Inpatient facility

The budget includes $2.4 billion ($1.2 billion intergovernmental transfers and $1.2 billion federal funds) in 2018-19 and $2.4 billion ($1.2 billion intergovernmental transfers and $1.2 billion federal funds) in 2019-20 for the Global Payment Program.

Whole Person Care (WPC) Pilots. The WPC Pilots are intended 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. WPC Pilots allow individual public entities or a consortium of public entities to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. WPC Pilot entities will identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population progress. Target populations may include but are not limited to individuals:

i. with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement.
ii. with two or more chronic conditions.
iii. with mental health and/or substance use disorders.
iv. who are currently experiencing homelessness.
v. individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutional settings.

WPC Pilots targeting individuals at risk of or experiencing homelessness can implement housing interventions, such as tenancy-based care management services or county housing pools.

DHCS approved eighteen applications for WPC Pilots from the following entities:

Lead Entity	Estimated Five-year Beneficiary Count	Total Five-Year Budget
Alameda County Health Care Services Agency	20,000	$283,453,400
City of Sacramento	4,386	$64,078,680
Contra Costa Health Services	15,600	$203,958,160
County of Marin, Dept. of Health and Human Services	3,516	$20,000,000
County of Orange Health Care Agency	9,303	$31,066,860
County of San Diego, Health & Human Services Agency	1,049	$43,619,950
County of Santa Cruz, Health Services Agency	625	$20,892,336
County of Sonoma, Dept. of Health Services	3,040	$16,704,136
Kern Medical Center	2,000	$157,346,500
Kings County Human Services Agency	600	$12,848,360
L.A. County Department of Health Services	154,044	$1,260,352,362

Mendocino County Health and Human Services Agency	600	$10,804,720
Monterey County Health Department	500	$34,035,672
Napa County	800	$22,921,433
Placer County Health and Human Services Department	450	$20,126,290
Riverside University Health System - Behavioral Health	38,000	$35,386,995
San Bernardino Co. - Arrowhead Regional Med. Center	2,000	$24,537,000
San Francisco Department of Public Health	16,954	$161,750,000
San Joaquin County Health Care Services Agency	2,255	$18,365,004
San Mateo County Health System	5,000	$165,367,710
Santa Clara Valley Health and Hospital System	10,000	$250,191,859
Small County Whole Person Care Collaborative	287	$10,362,176
Shasta County Health and Human Services Agency	600	$19,403,550
Solano County Health & Social Services	250	$4,667,010
Ventura County Health Care Agency	2,280	$107,759,837

The budget includes $839.7 million ($419.9 million intergovernmental transfers and $419.9 million federal funds) in 2018-19 and $646.7 million ($323.4 million intergovernmental transfers and $323.4 million federal funds) in 2019-20 for funding WPC Pilots. The budget also includes a one-time General Fund augmentation of $100 million to provide funding for supportive housing services for individuals who are homeless or are at risk of becoming homeless, with a focus on individuals with mental illness.

1115 Waiver – Medi-Cal 2020 Dental Transformation Initiative. Effective January 2016, the federal Centers for Medicare and Medicaid Services approved California's new 1115 Demonstration Waiver, known as Medi-Cal 2020. Through the Medi-Cal 2020 Waiver, DHCS is implementing four dental "domains", collectively referred to as the Dental Transformation Initiative (DTI) in order to improve the quality of care and increase utilization of dental services. The four domains of the DTI program are:

1. Increase Preventive Services Utilization for Children - This domain aims to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The domain's goal is to increase the utilization amongst children by at least 10 percent over a five year period. DHCS offers financial incentives for dental service office locations that increase delivery of preventive oral care to Medi-Cal eligible children.

   According to DHCS, Domain 1 costs for incentive payments to providers for increasing preventive services over the baseline will be $60.2 million ($30.1 million General Fund and $30.1 million federal funds) in 2018-19 and $76.9 million ($38.5 million General Fund and $38.5 million federal funds) in 2019-20.

2. Caries Risk Assessment and Disease Management – Under this domain, dental providers receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under.

   According to DHCS, Domain 2 costs for caries risk assessment and disease management will be $3.7 million ($1.8 million General Fund and $1.8 million federal funds) in 2018-19 and $4.1 million ($2 million General Fund and $2 million federal funds) in 2019-20.

3. Increase the Continuity of Care - This domain aims to encourage continuity of care among Medi-Cal beneficiaries age 20 and under. Dental provider service office locations receive an incentive payment for maintaining continuity of care for enrolled child beneficiaries for two, three, four, five, and six year continuous periods. Incentive payments are made annually.

   According to DHCS, Domain 3 costs for incentive payments for continuity of care will be $11.9 million ($5.9 million General Fund and $5.9 million federal funds) in 2018-19 and $18.1 million ($9 million General Fund and $9 million federal funds) in 2019-20.

4. Local Dental Pilot Programs (LDPPs) –15 LDPPs were approved, although two have been withdrawn, to address one or more of the previous three domains through alternative programs, using strategies focused on rural areas, including local case management initiatives and education partnerships. DHCS requires LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three domains. No more than 25 percent of the annual DTI funding is allocated to this domain.

   According to DHCS, Domain 4 costs for LDPPs will be $39.5 million ($19.7 million General Fund and $19.7 million federal funds) in 2018-19 and $50.1 million ($25 million General Fund and $25 million federal funds) in 2019-20.

The budget includes total funding of $115.2 million ($7.6 million General Fund and $57.6 million federal funds) in 2018-19 and $149.1 million ($74.5 million General Fund and $74.5 million federal funds) in 2019-20 for all four domains of the DTI.

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 an update on implementation, participation, and expenditures in each of the four domains of the 1115 Waiver.

Issue 4: Whole Person Care Housing Services

Budget Issue. DHCS requests General Fund expenditure authority of $100 million in 2019-20 to provide funding for supportive housing services for individuals who are homeless or are at risk of becoming homeless, with a focus on individuals with mental illness. The expenditure authority would be available until June 30, 2025.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$100,000,000	$-
Total Funding Request:	**$100,000,000**	**$-**

Background. The Medi-Cal 2020 Waiver includes Whole Person Care (WPC) pilot projects intended 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 WPC pilots allow individual public entities or a consortium of public entities to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. WPC pilot entities will identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population progress. Target populations may include but are not limited to individuals: 1) with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement; 2) with two or more chronic conditions; 3) with mental health and/or substance use disorders; 4) who are currently experiencing homelessness; or 5) individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutional settings. WPC pilots targeting individuals at risk of or experiencing homelessness can implement housing interventions, such as tenancy-based care management services or county housing pools. However, federal funding is not available to cover the cost of room and board, monthly rental or mortgage expense, food, regular utility charges, or household appliances. Direct funding for housing or housing-related goods and services must be provided by the state or county.

DHCS requests General Fund expenditure authority of $100 million in 2019-20 to provide multi-year funding for supportive housing services for individuals who are homeless or are at risk of becoming homeless, with a focus on individuals with mental illness. The funds would be provided to active WPC pilot programs that provide housing services and would be available for the costs of long-term and short-term housing, such as hotel vouchers, rental subsidies, and capital investment for housing projects for Medi-Cal beneficiaries who are mentally ill and are experiencing homelessness, or are at risk of homelessness. The funds may not supplant existing funds for this purpose.

The proposed allocation methodology for these funds would take into account the prevalence of homelessness and individuals who are mentally ill, the cost of living, and the performance of the pilot to which the funding would be allocated.

- Prevalence of Homelessness: 50 percent of the funds would be allocated in proportion to the total number of people experiencing homelessness in the county compared to the total for all WPC counties. Each county would receive a minimum allocation of $500,000.

- Cost of Living: 25 percent of the funding would be allocated in proportion to the cost of living in the pilot county, based on the federal Housing and Urban Development (HUD) Fair Market Rent Efficiency amounts for each pilot area.
- Prevalence of Individuals Who Are Mentall Ill and Are Experiencing Homelessness: 25 percent of the funding would be allocated in proportion to the total number of individuals who are mentally ill and are experiencing homelessness in the county compared to the total for all WPC counties, based on the HUD count of the Severely Mentally Ill subpopulation for each county.
- Performance: WPC pilots that have demonstrated unacceptable performance regarding their pilot housing supportive services for the homeless target population would not be eligible for funding.

According to DHCS, the funding is proposed to be allocated as follows:

Pilot	Allocation	Pilot	Allocation
Alameda	$4,647,160	Sacramento (City)	$3,059,351
Contra Costa	$2,058,505	San Benito	$1,600,251
Kern	$1,213,868	San Bernardino	$1,646,280
Kings	$1,166,795	San Diego	$5,327,990
Los Angeles	$36,139,682	San Francisco	$8,130,059
Marin	$2,522,163	San Joaquin	$1,366,775
Mariposa	$1,033,636	San Mateo	$2,340,849
Mendocino	$1,137,159	Santa Clara	$5,680,408
Monterey	$2,407,787	Santa Cruz	$2,642,337
Napa	$1,491,767	Shasta	$1,198,356
Orange	$3,413,987	Solano	$1,603,827
Placer	$1,318,476	Sonoma	$3,284,476
Riverside	$1,999,856	Ventura	$1,568,200
		TOTAL	$100,000,000

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 5: Private Hospital Directed Payment and Quality Incentive Pool

Budget Issue. DHCS requests four positions and expenditure authority of $1.7 million ($595,000 General Fund, $864,000 federal funds, and $270,000 Hospital Quality Assurance Revenue Fund) in 2019-20 and $1.6 million ($568,000 General Fund, $819,000 federal funds, and $252,000 Hospital Quality Assurance Revenue Fund) annually thereafter. If approved, these positions and resources would allow DHCS to implement the Private Hospital Directed Payment program, and support the Quality Incentive Pool program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$595,000	$568,000
0890 – Federal Trust Fund	$864,000	$819,000
3158 – Hospital Quality Assurance Revenue Fund	$270,000	$252,000
Total Funding Request:	**$1,729,000**	**$1,639,000**
Total Positions Requested:	**4.0**	**4.0**

***** Positions and resources ongoing after 2020-21.

Private Hospital Directed Payment Program. The Hospital Quality Assurance Fee (HQAF) program collects fees from private hospitals to draw down additional federal funds, which provide supplemental payments for hospital services and funding for health care coverage for children in the Medi-Cal program. The program supports hospital services for Medi-Cal beneficiaries by providing Medi-Cal managed care supplemental payments of approximately $4 billion annually for Medi-Cal hospitals. In 2016, the federal Centers for Medicare and Medicaid Services (CMS) issued a final rule that defined existing HQAF program payments in managed care as an unallowable direction of payment which must be discontinued, phased down over a 10-year period, or converted into an allowable directed payment model. To continue providing critical funding for hospital services and minimize risks related to CMS approval of future capitation rates, including HQAF program payments, and in consultation with CMS and the private hospital stakeholder community, DHCS is converting the majority of HQAF program payments into an allowable directed payment model, the private hospital directed payment (PHDP) program.

The PHDP program implements a uniform dollar increase in reimbursement to private hospitals that provide designated services under their contracts with plans. To comply with CMS regulations, DHCS must seek annual approval to continue the PHDP program and develop interim adjustments to the Medi-Cal managed care capitation rates to reflect the anticipated amount of PHDP program payments for each combination of plan, county or rating region, aid category, and rating period. Final PHDP program payment amounts are calculated by reweighting the interim adjustments based on the actual utilization of inpatient and outpatient hospital services. Payments are structured utilizing a pool approach that caps statewide payments to a maximum amount each year.

Quality Incentive Pool. DHCS has also developed several managed care directed payment programs to align, augment, and support the quality improvement initiatives promulgated through the managed care delivery systems and the Medi-Cal 2020 Demonstration. CMS approved California's Quality Incentive Pool (QIP) proposal for Designated Public Hospital (DPH) systems for delivery system and provider

payment initiatives under Medi-Cal managed care plan contracts. Implementation of this directed payment program will allow the state to continue the progress made through the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program and other programs of the 1115 waiver, Medi-Cal 2020. DHCS will direct plans to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization.

DHCS requests four positions and expenditure authority of $1.7 million ($595,000 General Fund, $864,000 federal funds, and $270,000 Hospital Quality Assurance Revenue Fund) in 2019-20 and $1.6 million ($568,000 General Fund, $819,000 federal funds, and $252,000 Hospital Quality Assurance Revenue Fund) annually thereafter to implement the PHDP and QIP programs. Specifically, this funding would support the following positions and limited-term resources for each of these programs:

PHDP Resources
Capitated Rates Development Division – Four positions (permanent)

- **Four Associate Governmental Program Analysts** would collect private hospital utilization data from each plan, analyze the data, produce reports to inform actuarial expectations for hospital services utilization, develop interim adjustment amounts within the capitation rates that account for anticipated directed payment model payments, compile managed care encounter data for each private hospital, segment and analyze each hospital's encounter data by plan, produce reports of actual utilization of contracted hospital services at every private hospital that is a network provider with each plan, and develop final adjustment amounts within the capitation rates that reflect the final distribution of payments to private hospitals based on actual patterns of inpatient utilization and outpatient hospital services.

QIP Resources
Office of the Medical Director – Limited-term resources equivalent to seven positions

- **One Nurse Consultant III** position would support the Medical Director and DHCS clinical team to perform clinical and quality improvement oversight on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization.
- **One Staff Services Manger I** position would oversee incentive claims and payment for the QIP program, complete more complex policy and projects, and convene and engage with other DHCS divisions on payment and programmatic activities.
- **One Health Program Specialist II** position would act as a subject matter expert on 26 measures under QIP, work with DHCS partners to create and maintain the metric specification manual and establish and maintain metric benchmarks, provide technical assistance to the 17 designated public hospital (DPH) systems, and develop program monitoring protocols.
- **One Health Program Specialist I** position would be in charge of the QIP online reporting platform, work collaboratively with the Enterprise Innovation & Technology Services Division to conduct any necessary technical updates to meet reporting deadlines, and provide technical assistance to the 17 DPH systems.
- **Two Associate Governmental Program Analysts** would perform day-to-day programmatic support for the 17 DPH systems, conduct completeness and comprehensive reviews on semi-annual and

annual reports, monitor and assess the implementation of program policy and protocols, and propose recommendations and programmatic solutions based on the analysis.

- **One Associate Governmental Program Analyst** would perform day-to-day administrative and analytical duties for the QIP team, conduct research related to emerging health care policy issues, and engage and maintain effective flow of communication among DHCS divisions and external partners.

Capitated Rates Development Division – Limited-term resources equivalent to one position

- **One Research Program Specialist I** would assist in developing and submitting annual proposals to CMS for approval to implement and continue the QIP in future years' rate setting, formulate and propose responses to CMS questions, perform calculations and analyses of rate adjustments by county and population for each affected plan, coordinate with DPH systems and plans related to calculations of payment amounts and rate adjustments, and develop exhibits required by CMS to obtain approval of rate adjustments related to QIP.

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: Home- and Community-Based Services Waiver Programs

Background. The Medicaid Home- and Community-Based Services (HCBS) waiver program is authorized in Section 1915(c) of the Social Security Act. The program permits states to furnish an array of home- and community-based services that assist beneficiaries to live in the community and avoid institutionalization. States have broad discretion to design waiver programs to address the needs of the waiver's target population. Waiver services complement or supplement the services that are available to participants through the state plan and other federal, state and local public programs as well as the supports that families and communities provide.

California operates several home- and community-based services waivers for Medi-Cal beneficiaries.

Acquired Immune Deficiency Syndrome (AIDS) Waiver. Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home and community-based services as an alternative to nursing facility care or hospitalization. Services provided include: administrative expenses, attendant care, case management, financial supplements for foster care, home-delivered meals, homemaker services, in-home skilled nursing care, minor physical adaptations to the home, non-emergency medical transportation, nutritional counseling, nutritional supplements, and psychotherapy.

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an aid code with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE). Participants must also have a written diagnosis of HIV disease or AIDS, certified by the nurse case manager to be at the nursing facility level of care, and score 60 or less using the Cognitive and Functional Ability Scale assessment tool. Children under 13 years of age are eligible if they have been certified by the nurse case manager as HIV/AIDS symptomatic. All waiver participants must have a home setting that is safe for both the client and service providers. According to DHCS, federal approval for renewal of the AIDS Waiver was received on March 27, 2017.

Assisted Living Waiver. The Assisted Living Waiver pays for assisted services and supports, care coordination, and community transition in 14 counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, San Diego, Kern, San Mateo, Santa Clara and Orange). Waiver participants can elect to receive services in a Residential Care Facility for the Elderly (RCFE), an Adult Residential Facility (ARF), or through a home health agency while residing in publicly subsidized housing. Eligibility into the ALW is based on a qualifying skilled nursing level of care which is captured through the assessment tool used by care coordination agencies to assess potential participants. Approved capacity of unduplicated recipients for the ALW is currently 3,744. The federal government approved a renewal of the ALW on August 28, 2014 effective from March 1, 2014 through February 28, 2019.

DHCS received federal approval of a waiver amendment to expand the ALW by 2,000 slots from 3,744 to 5,744 between July 2017 and June 2020 to accommodate current and anticipated need. According to DHCS, the waiver will require that 60 percent of all new enrollments be reserved for individuals transitioning from institutional settings after residing in them for a minimum of 90 consecutive days. The budget includes savings of $16.4 million ($7.4 million General Fund and $7.4 million federal funds) in 2018-19 and $42.7 million ($21.3 million General Fund and $21.3 million federal funds) in 2019-20

for ALW expansion. The costs of ALW services are offset by a higher level of savings from transitions of individuals from skilled nursing facilities into community settings under the ALW.

In-Home Operations Waiver. The In-Home Operations (IHO) Waiver serves either: 1) participants previously enrolled in the Nursing Facility A/B Level of Care (LOC) Waiver who have continuously been enrolled in a DHCS administered HCBS waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse, or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Home and Community Based Alternatives Waiver, for the participant's assessed LOC. CMS approved the IHO waiver renewal from January 1, 2015 through December 31, 2019. DHCS indicates it will not renew the IHO Waiver at the expiration of the current waiver term. At the point of annual reassessment for each participant, DHCS will offer the option of transitioning to the Home- and Community-Based Alternatives Waiver. All IHO Waiver participants will be given sufficient notice of the waiver expiration and provided options to transition prior to the expiration of the IHO Waiver.

Home- and Community-Based Alternatives Waiver. The Home- and Community-Based Alternatives (HCBA) Waiver provides Medi-Cal members with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute or nursing facility Level of Care (LOC), with the option of returning to or remaining in his or her home or home-like setting in the community in lieu of institutionalization. DHCS will contract with waiver agencies for the purpose of performing waiver administration functions and directing the comprehensive care management waiver service. The waiver agencies are responsible for functions including: participant enrollment, LOC evaluations, plan of treatment and person-centered care and service plan review and approval, waiver service authorization, utilization management, provider enrollment and network development, quality assurance activities and reporting to DHCS, billing the fiscal intermediary, and provider claims adjudication.

DHCS indicates it will continue its role in administering the program by determining all waiver participant eligibility, setting enrollment goals, and providing continuous, ongoing monitoring and oversight. DHCS received approval of the HCBA Waiver in May 2017 with a January 2017 effective date. DHCS expects the waiver renewal will serve up to 8,964 participants by the end of the five year waiver term.

Multipurpose Senior Services Program (MSSP) Waiver. Under the MSSP Waiver, the California Department of Aging contracts with local agencies to provide social and health care management for frail elderly clients who are at risk of placement in a nursing facility, but who wish to remain in the community. The MSSP arranges for and monitors the use of community services to prevent or delay premature institutional placement of these individuals. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and can be certified for placement in a nursing facility. Services provided by MSSP include adult day care and support center, housing assistance, household and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, and communication services. Under the approved waiver, beginning July 1, 2014 through June 30, 2019, capacity of unduplicated recipients is as follows:

- Waiver Year 1: 12,000
- Waiver Year 2: 11,684
- Waiver Year 3: 11,684
- Waiver Year 4: 11,684
- Waiver Year 5: 11,684

HCBS Waiver for Persons With Developmental Disabilities (DD Waiver). The DD Waiver provides home and community-based services to persons with developmental disabilities who are Regional Center consumers as an alternative to care provided in a facility that meets the federal requirement of an intermediate care facility; in California, intermediate care facility-developmental disabilities-type facilities, or a state developmental center. CMS recently approved renewal of the DD Waiver until December 31, 2022, with an approved capacity of unduplicated recipients of 130,000 in 2018, 135,000 in 2019, 140,000 in 2020, 145,000 in 2021, and 150,000 in 2022. As of March 29, 2017, behavioral health treatment services for waiver participants under the age of 21 is covered as a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enroll into managed care.

Pediatric Palliative Care (PPC) Waiver. The PPC Waiver provides children hospice-like services, in addition to state plan services during the course of an illness, even if the child does not have a life expectancy of six months or less. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and family unit, including siblings, parents and legal guardians, and others living in the residence. The pilot waiver was approved for April 1, 2009, through March 31, 2012. CMS has approved renewal of the Pediatric Palliative Care Waiver for a period of five additional years effective April 1, 2012, through December 26, 2017. Approved capacity of unduplicated recipients for this waiver is 1,800. According to DHCS, after discussion with CMS regarding service delivery issues, the department decided to end the waiver and transition current waiver participants to other systems of care beginning January 1, 2019.

Stakeholder Proposals for Investment. Stakeholders have proposed the following investments and other changes related to home- and community-based services and long-term care.

Continuation of California Community Transitions Services. Disability Rights California (DRC) and East Bay Innovations request General Fund authority of $19.1 million to continue the California Community Transitions (CCT) program. According to DRC, CCT has successfully helped more than 3,600 people move out of nursing homes and into their own homes or other community settings. Federal funding was scheduled to end last year, but a recent extension, passed on a bipartisan vote in Congress and signed by the President, has provided temporary support. The House of Representatives recently approved funding anticipated to last through the end of the federal fiscal year and a five-year extension bill is pending.

Caregiver Resource Center Funding. The Association of California Caregiver Resource Centers requests one-time General Fund expenditure authority of $30 million over three years to expand services and capabilities to meet the challenges of a changing family caregiver population. California is set to see a rapid increase in older adults over the next decade when 20 percent of the population will be over age 65. This population and their family caregivers will be more diverse than in any other time in CA history. The estimated 4.5 million unpaid family caregivers are the largest long-term workforce caring

for older and disabled adults. The state needs to expand support to family caregivers so adults needing assistance can remain in the community and family caregivers can get the services they need to work, care and thrive.

Feasibility Study and Actuarial Analysis for Long-Term Services and Supports Benefit. The California Aging and Disability Alliance, requests General Fund expenditure authority of $1 million to fund a feasibility study and actuarial analysis of long-term services and supports (LTSS) financing and benefit options to meet the growing need for these services in California. This study and analysis are an essential first step toward the ultimate goal of creating a new, independent, and sustainably funded LTSS benefit for all Californians regardless of income or zip code.

This study and analysis would provide critical guidance on the following: the scope of services for such a benefit; eligibility criteria; projected cost estimates and financing options; and projected savings to state funded programs and services associated with each option, including, but not limited to, Medi-Cal and the In-Home Supportive Services (IHSS) program.

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 update on the status of renewal and expansion of the Assisted Living Waiver.

Issue 7: Statewide Transition Plan Extension

Budget Issue. DHCS requests expenditure authority of $575,000 ($288,000 General Fund and $287,000 federal funds) annually until 2021-22. If approved, these resources would support implementation, ongoing monitoring, and oversight of the Statewide Transition Plan for Home- and Community-Based Services.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$288,000	$288,000
0890 – Federal Trust Fund	$287,000	$287,000
Total Funding Request:	**$575,000**	**$575,000**

***** Additional fiscal year resources requested – 2021-22: $575,000.

Background. Federal Centers for Medicare and Medicaid Services (CMS) regulations require DHCS to develop, implement, and monitor characteristics of home- and community-based services (HCBS) settings. In May 2017, the requirements under these regulations was extended to March 16, 2022, and require revisions to statutes and regulations, administering and evaluating provider self-surveys for thousands of providers, performing extensive validation of provider self-surveys through on-site assessments, beneficiary-self surveys, and a robust heightened examination process.

Currently, there are eight HCBS 1915(c) waivers, one 1915(i), one 1915(k) State Plan program, one 1115 Demonstration waiver benefit, and one Community-Based Adult Services (CBAS) in California. HCBS programs differ significantly from each other in the following areas: the population they serve, provider types and network, size and complexities, structure of delivery system and operations, as well as statutory and regulatory authorities. Due to the complexity of each program, being in compliance with the federal regulations while serving over 500,000 beneficiaries, will pose a challenge without additional resources.

The 2016 Budget Act included limited-term resources equivalent to five positions, expiring June 30, 2019. These resources were approved as part of a budget change proposal, "Statewide Transitions Plan – Long Term Care Waivers". DHCS requests expenditure authority of $575,000 ($288,000 General Fund and $287,000 federal funds) annually until 2021-22 to support implementation, ongoing monitoring, and oversight of the Statewide Transition Plan for Home- and Community-Based Services. These resources are an extension of the previously requested resources and would support the following:

Integrated Systems of Care Division – Limited-term resources equivalent to five positions

- **Four Associate Governmental Program Analysts** would manage consultant contracts for the compliance determination process, as well as statutory and regulatory revisions, update HCBS provider enrollment processes, analyze assessment results and issue corrective action plans, and provide technical assistance to agencies and stakeholders.
- **One Office Technician** would coordinate and document meetings, and respond to inquiries from stakeholders and other agencies.

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 8: Proposition 56: Medi-Cal Provider Reimbursement Rates

Background. Section 1396a(a)(30)(A) of Title 42 of the United States Code requires state Medicaid programs to pay reimbursement rates "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area". However, this requirement has been the subject of decades of litigation to determine what constitutes compliance and what level of reimbursement rate should be considered sufficient. In California, provider organizations and independent surveys of individual providers suggest low reimbursement rates for services provided in the Medi-Cal program have led to a decrease in providers willing to participate in the program.

Ten Percent Reduction of Provider Reimbursement Rates. AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, implemented a ten percent reimbursement rate reduction for most providers of services to Medi-Cal beneficiaries and an actuarially equivalent reduction in capitation rates paid to Medi-Cal managed care plans. The reduction applies to dates of service on or after June 1, 2011. Due to court injunctions, which were subsequently lifted in December 2012, the department was unable to reduce reimbursements during this period. This delay, coupled with system implementation issues, required the department to retroactively recoup the overpayments to providers that occurred while the reductions were enjoined or delayed. Over time, the department eliminated many of the reductions and forgave much of the retroactive recoupment amounts due to concerns that the reductions might adversely impact beneficiaries' access to necessary medical care. In addition, the federal government's approval of the State Plan Amendment to implement these reductions was contingent on the state agreeing to implement an access monitoring plan. The plan identifies 23 separate metrics in the three key areas of beneficiary measures, provider availability, and service use and outcomes. The budget includes savings of $531.9 million ($181.3 million General Fund and $350.6 million federal funds) in 2018-19 and $531.9 million ($185.5 million General Fund and $346.4 million federal funds) in 2019-20 for the provider rate reductions imposed pursuant to AB 97.

Proposition 56 Provides Supplemental Reimbursements to Medi-Cal Providers. Proposition 56, approved by voters in 2016, increased the excise tax rate on cigarettes by $2 per pack, with an equivalent increase on other tobacco products, including electronic cigarettes, to provide funding for various public health and tobacco-related law enforcement programs.

Figure HHS-03

Proposition 56 Expenditures

(Dollars in Millions)

Investment Category	Department	Program	2019-20 Governor's Budget
Enforcement	Department of Justice	Local Law Enforcement Grants	$26.0
	Department of Justice	Distribution and Retail Sale Enforcement	$6.9
	Department of Tax & Fee Administration	Distribution and Retail Sales Tax Enforcement	$4.5
	Department of Public Health	Law Enforcement	$5.3
Education, Prevention, and Research	University of California	Cigarette and Tobacco Products Surtax Medical Research Program	$58.6
	University of California	Graduate Medical Education	$36.5
	Department of Public Health	State Dental Program	$28.8
	Department of Public Health	Tobacco Prevention and Control	$137.0
	State Department of Education	School Programs	$24.2
Health Care	Department of Health Care Services	Health Care Treatment	$1,053.5
Administration and Oversight	State Auditor	Financial Audits	$0.4
	Department of Tax & Fee Administration	Sales and Use Tax	$1.0
Revenue Backfills	Proposition 99, Breast Cancer Research Fund, Proposition 10, and General Fund		$69.7
Total			**$1,452.5**

Figure 1: Proposition 56 Expenditures, 2019-20 Governor's Budget
Source: *2019-20 Governor's Budget Summary – Health and Human Services, January 2019*

After allocations for administration, auditing, and backfills of other revenue streams, Proposition 56 requires 82 percent of remaining funds be transferred to the Healthcare Treatment Fund to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services in the Medi-Cal program. Proposition 56 also provides that "funds shall not be used to supplant existing state general funds for these same purposes", "the funding shall be used only for care provided by health care professionals, clinics, health facilities" and "health plans contracting with the State Department of Health Care Services to provide health benefits".

The 2017 Budget Act allocated Medi-Cal funding for supplemental payments for certain physician services, dental services, women's health, intermediate care facilities for individuals with developmental disabilities (ICF-DDs), and provider serving beneficiaries of the AIDS Waiver. The 2018 Budget Act increased the allocation for physician and dental services by expanding eligible preventive service codes

and the level of reimbursement for each code, as well as funding for home health services, pediatric day health centers, free-standing pediatric subacute facilities, and certain qualified community-based adult services programs,

The budget includes $2.1 billion ($711.9 million Proposition 56 and $1.4 billion federal funds) in 2018-19 and $2.2 billion ($769.5 million Proposition 56 and $1.4 billion federal funds) in 2019-20 for supplemental provider payments in Medi-Cal. The supplemental payments by category are as follows:

Category	2018-19	2019-20	Category	2018-19	2019-20
Physician Services			***PDHCs***		
Total Fund	$1,299,439	$1,387,169	Total Fund	$11,753	$14,246
Proposition 56	$409,156	$455,549	Proposition 56	$5,620	$6,880
Federal Funds	$890,283	$931,620	Federal Funds	$6,133	$7,366
Dental Services			***Ped Subacute***		
Total Fund	$510,070	$546,633	Total Fund	$6,189	$1,811
Proposition 56	$194,391	$216,624	Proposition 56	$2,993	$876
Federal Funds	$315,679	$330,009	Federal Funds	$3,196	$935
Women's Health			***CBAS***		
Total Fund	$203,057	$159,614	Total Fund	$1,913	$-
Proposition 56	$54,198	$41,943	Proposition 56	$1,327	$-
Federal Funds	$148,859	$117,671	Federal Funds	$586	$-
ICF-DDs			***Home Health***		
Total Fund	$29,377	$27,819	Total Fund	$56,600	$64,834
Proposition 56	$13,744	$13,041	Proposition 56	$27,042	$31,205
Federal Funds	$15,633	$14,778	Federal Funds	$29,558	$33,629
AIDS Waiver			***TOTAL***		
Total Fund	$6,800	$6,800	Total Fund	$2,125,198	$2,208,926
Proposition 56	$3,400	$3,400	Proposition 56	$711,872	$769,518
Federal Funds	$3,400	$3,400	Federal Funds	$1,413,326	$1,439,408

Additional Augmentations Funded by Proposition 56. The budget includes $965 million ($282.5 million Proposition 56 funds and $682.5 million federal funds) in 2019-20 for three augmentations:

- Value-Based Payments Program – The budget includes $360 million ($180 million Proposition 56 funds and $180 million federal funds) to fund a value-based payments program to encourage Medi-Cal managed care providers to meet goals in critical areas such as chronic disease management and behavioral health integration.
- Developmental and Trauma Screening – The budget includes $105 million ($52.5 million Proposition 56 funds and $52.5 million federal funds) to provide early developmental screenings for children and adverse childhood experiences (ACEs) screenings for children and adults in Medi-Cal.
- Family Planning Services – The budget includes $500 million ($50 million Proposition 56 funds and $450 million federal funds) for family planning services in the Medi-Cal program.

Proposals for Investment to Improve Provider Reimbursement and Access to Care in Medi-Cal. Various stakeholders have proposed the following investments to improve provider reimbursement and access to care in Medi-Cal.

Proposition 56 Supplemental Payments Timing. The California Medical Association (CMA) requests language to direct DHCS to submit a three-year federal State Plan Amendment (versus the current single year approval) to smooth and make more certain the Proposition 56 revenue stream supporting increased access to health care for Medi-Cal beneficiaries. According to CMA, approving this budget committee action will return clinical time back to physicians (versus spending administrative time reconciling supplemental payments), allowing them to spend more time with acute patients, coordinating care and improving health outcomes. The net boost to a physician's practice of the Proposition 56 supplemental payments is lessened by unexpected administrative tasks - tracking down payments and patient level data from the plans or matching up multiple supplemental payments based on various funding timelines. Providers will be able to reclaim clinical time to spend with beneficiaries if the administrative burden of the payments are lessened. The supplemental payments provided through Proposition 56 are effectively increasing access to care, and physicians are more likely to see more Medi-Cal beneficiaries if they can count on the funding without delays or lags in payments. In addition, the administrative burden for DHCS of obtaining approval by CMS each year will be lessened, giving them more capacity to monitor the Medi-Cal managed care plans and enforce accurate and timely distribution of the supplemental payments to providers. Once federal approval is received for the three-year State Plan Amendment, CMA believes continued oversight and transparency of the program is necessary to ensure that the benefit of Proposition 56 dollars continue to flow from Medi-Cal managed care plans to providers and beneficiaries as intended.

Breast Pump Rate Increase. The California WIC Association requests $7 million ($3.5 million General Fund and $3.5 million federal funds) to increase reimbursements for breast pumps for Medi-Cal beneficiaries. According to the California WIC Association, science proves that when infants are breastfed, their risk for obesity is reduced. Breastfeeding is also responsible for the reduction in many childhood illnesses including ear infections, digestive and lower respiratory infections and other serious illnesses. Studies also show that breastfeeding leads to reduced risk of both breast and ovarian cancer in mothers. Rates for breast pumps have not been raised since 1998. Low quality breast pumps may yield little or no milk, preventing mothers from establishing or maintaining breastfeeding, which impacts their baby's feeding and ultimately overall health. Lack of quality breast pumps through Medi-Cal has forced new mothers to search for alternative providers, such as WIC, to cover gaps in breast pumps and related supplies.

Air Ambulance Provider Rate Increase. The California Association of Air Medical Services (Cal-AAMS) requests General Fund resources of $25 to $35 million to increase air ambulance provider reimbursements commensurate with rural Medicare rates. According to Cal-AAMS, emergency air ambulance services are an essential part of the statewide EMS system and provide a critical link between rural areas and urban tertiary care hospitals (trauma centers, heart/stroke centers, burn units, children's hospitals and neonatal centers, etc.). They also play a key role in homeland security and disaster response, including the evacuating hospitals in the path of wildfires. The vast majority of the emergency air ambulance services throughout CA are provided by private entities that do not receive local tax support. These critical service providers transport all emergency patients without knowing if the patient has any form of medical insurance or ability to pay for the service. A significant number of emergency

patients transported by air ambulances have no insurance, and have no ability to pay for the service, yet these patients are given the same high level of care as those with medical insurance. Medi-Cal payment rates for air ambulance services have not increased in more than twenty five years. Without this proposed rebasing, Medi-Cal payments will revert back to 1993 levels of payment, less the 10 percent reduction applied in 2011.

Rate Increase for Stand-Alone Pediatric Sub-Acute Facilities. Sun Valley Specialty Healthcare requests General Fund expenditure authority of $10 million to increase reimbursement rates for stand-alone pediatric sub-acute facilities and trailer bill language to remove the statutory rate freeze applicable to these facilities. According to Sun Valley, the daily rate for these facilities has not increased in 10 years. As a result, providers are facing ongoing and growing shortfalls that threaten their ability to continue providing services. Because these free-standing sub-acute services are much more cost-effective than acute facilities, increasing their daily rate will help preserve this important step-down level of care for medically-fragile children.

Eliminate 10 Percent Reduction for Community-Based Adult Services Programs. The California Association for Adult Day Services (CAADS) requests restoration of the 10 percent reduction for Community-Based Adult Services (CBAS) programs pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, as well as a 15 percent cost-of-living increase. According to CAADS, local CBAS centers have been straining to cover the costs of doing business. There has been no increase to the CBAS Medi-Cal fee-for-service published rate for the past 10 years, threatening center closures and access to this valuable community based care for eligible program participants. CBAS providers deliver essential nursing, clinical, occupational and other supports to adults with complex medical, cognitive and psychological conditions. As evidence mounts that use of CBAS results in decreased use of more costly interventions including emergency room visits, hospital admissions and re-admissions and skilled nursing care, it makes fiscal sense to invest in the viability of this program so it can continue to meet the growing needs of California's aging population and other adults with complex medical, cognitive and psychological conditions.

Clinical Laboratory Reimbursement Methodology. The California Clinical Laboratory Association (CCLA) requests revision of the statutory clinical laboratory services rate methodology in Medi-Cal. According to CCLA, the historical statutory rate methodology in California has also included a provision capping Medi-Cal laboratory rates at no more than 80 percent of the Medicare rate. In 2018, the federal government implemented the Protecting Access to Medicare Act (PAMA). As a part of PAMA, Congress directed the Centers for Medicare and Medicaid Services (CMS) to establish new Medicare rates for clinical lab services based on commercial market rates calculated by CMS. This has resulted in a reduction for most Medicare clinical lab rates. As a result, now (for the first time) when DHCS applies California's existing 80 percent of Medicare cap, the resulting Medi-Cal rates are often lower than the California market-based rates that DHCS has painstakingly developed to serve the California market. This entirely undermines the purpose behind developing Medi-Cal's market-based rates, and often results in Medi-Cal rates that are well below market. This unintended and inequitable result can be remedied simply by eliminating the current statutory "80 percent of Medicare" cap for Medi-Cal clinical lab rates. CCLA requests elimination of the cap on Medi-Cal's clinical laboratory rates of 80 percent of the new Medicare rates, and the AB 97 10 percent reduction as applied to clinical laboratories.

Eliminate Rate Freeze and Increase Reimbursement for Intermediate Care Facilities. Developmental Services Network (DSN) requests resources to eliminate the 2008 Medi-Cal rate freeze and adjust rates by 15 percent for intermediate care facilities for individuals with developmental disabilities (ICF-DDs). According to DSN, the Great Recession was hard on California and in 2008 ICF-DD Medi-Cal rates were frozen. Other than small adjustments for complying with certain state and federal mandates, and a Quality Assurance Fee adjustment, rates remain frozen at the 2008 level. The recent supplemental payment funded through Proposition 56 revenues has served as a lifeline and kept homes afloat, but a core baseline rate increase is absolutely necessary to continue their existence.

Proposition 55 Allocations. The California Hospital Association requests recalculation of the Proposition 55 formula allocating revenue to Medi-Cal to fund the following investments:

- Address the workforce shortage - Allocate $250 million to bolster the state's physician workforce by expanding the number of primary care and psychiatrists trained and supporting efforts to retain them.
- Improve the state's behavioral health infrastructure - Direct $100 million in grants to improve infrastructure and care systems for individuals in crisis with behavioral health needs.
- Expand access to care in rural communities - **.** Allocate $100 million to hospitals in rural, remote, or low-population density areas to support greater access to medical services, particularly telepsychiatry and regional crisis stabilization services.
- Disproportionate share hospitals - Allocate $250 million to enhance payments for providers that serve a disproportionate number of Medi-Cal and uninsured patients, given recent payment cuts at the federal level.

Restoration of 10 Percent Reduction for Certified Nurse Midwives and Alternative Birth Centers. The California Birth Center Association requests restoration of the 10 percent reduction in Medi-Cal payments for certified nurse-midwives and alternative birth centers imposed pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. While the reduction has been restored for physicians and hospitals, it has not been restored for these providers.

Durable Medical Equipment Rates. The California Association of Medical Products Suppliers (CAMPS) requests expenditure authority of approximately $7 million for the following changes to reimbursement for durable medical equipment in Medi-Cal: 1) establish that all categories of DME be reimbursed at 100 percent of the lowest maximum allowance for California for Medicare, and 2) require Medi-Cal, when reimbursing for custom rehabilitation equipment when reimbursing using 100 percent of the Medicare rate to recognize the KU modifier and increase reimbursement according to the applicable Medicare rate.

Complex Rehabilitation Technology Reimbursement. The National Coalition for Assistive and Rehab Technology (NCART) requests the following changes to Medi-Cal reimbursement for complex rehabilitation technology (CRT): 1) repeal AB 97 ten percent reduction to CRT providers, and 2) revise the upper billing limit to include labor costs. According to NCART, the CRT industry provides critical and essential products to some of California's most vulnerable patients with the most severe conditions. Medi-Cal reimbursement reductions and pending additional cuts through the SPA, the payment levels will be well below the actual cost of providing the service.

Restoration of 10 Percent Reduction for Non-Emergency Medical Transportation. The California Medical Transportation Association (CMTA) requests General Fund expenditure authority of $4.8

million annually to restore the ten percent Medi-Cal reimbursement cut for non-emergency medical transportation (NEMT) provider, and an additional fifteen percent increase in reimbursement to address an access to care problem that is preventing Medi-Cal beneficiaries from receiving life sustaining care on an outpatient basis. Without reliable and timely access to NEMT (wheelchair and litter vans), sick and frail Medi-Cal beneficiaries' conditions worsen until they need emergency care at a far higher cost to the state, and the healthcare delivery system. Since a vast majority of NEMT transports involve dialysis patients, it cannot be overemphasized that timely delivery and return of these frail dialysis patients is essential for their having full four-hour treatments to diminish the need for hospital emergency room care and inpatient stays due to missing or shortened dialysis treatments.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items 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 an update on supplemental provider payments funded by Proposition 56 revenue.

2. Is DHCS gathering data to evaluate the impact of the supplemental provider payments program on access to care for Medi-Cal beneficiaries?

Issue 9: Proposition 56: Physician and Dentist Loan Repayment Program

Background. The 2018 Budget Act included a one-time allocation of $220 million of Proposition 56 tobacco tax revenue for a loan repayment program to increase access to care for Medi-Cal beneficiaries. $190 million was allocated for recent graduate physicians and $30 million was allocated to recent graduate dentists. The funding was made available until June 30, 2025.

DHCS contracted with Physicians for a Healthy California (PHC) to administer the loan repayment program, known as CalHealthCares. Eligible physicians may apply for a loan repayment up to $300,000 in exchange for a five-year service obligation. Eligible dentists may apply for either a loan repayment up to $300,000 in exchange for a five-year services obligation or a practice support grant up to $300,000 in exchange for a ten-year service obligation. All medical and dental specialties are eligible. In this cycle, CalHealthCares expects to award approximately 125 physicians and 20 dentists. All awardees are required to maintain a patient caseload of 30 percent or more Medi-Cal beneficiaries.

Eligibility Requirements. According to CalHealthCares, eligibility requirements for the loan repayment program are as follows:

To be considered for an award, the applicant must be a current licensed healthcare provider (physician or dentist) or current dental student, as well as, a physician or dental resident, intern, or fellow.

For physicians, the applicant must:

- Have an unrestricted license and currently be in good standing with the Medical Board of California or the Osteopathic Medical Board of California
- Be an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
- Have graduated from an ACGME-approved residency program and/or completed a fellowship within the last five years (on or after January 1, 2014)
- Have existing educational loan debt incurred while pursuing a medical degree
- Not currently participating in another loan repayment program
- Practice in California
- If awarded, maintain a patient caseload of 30 percent or more Medi-Cal beneficiaries

For current dental students, medical or dental residents, or fellows, the following must be true as of July 1, 2019:

- Have an unrestricted license and currently be in good standing with the Medical Board of California, the Osteopathic Medical Board of California, or the Dental Board of California
- Be an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
- Have graduated from a dental school, as well as, a physician or dental residency program, and/or completed a fellowship
- Have existing educational loan debt incurred while pursuing a medical or dental degree
- Not currently participating in another loan repayment program

- Practice in California
- If awarded, maintain a patient caseload of 30 percent or more Medi-Cal beneficiaries
- One letter of recommendation

The application process for the loan repayment program opened on April 1, 2019 and the deadline to submit applications is April 26, 2019.

Subcommittee Staff Comment – This is an informational item.

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

1. Please provide a brief update on the Physician and Dentist Loan Repayment Program.

2. How many physicians and dentists does the department expect to receive loan repayment under this program? How many have applied?

Issue 10: Proposition 56: Value-Based Payment Program

Budget Issue and Trailer Bill Language. DHCS requests $360 million ($180 million Healthcare Treatment Fund and $180 million federal funds) to establish a Value-Based Payment program to provide incentive payments to providers for meeting specific metrics aimed at improving care for high-cost or high-need populations. DHCS also requests trailer bill language to implement the program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0890 – Federal Trust Fund	$180,000,000	$180,000,000
3305 – Healthcare Treatment Fund	$180,000,000	$180,000,000
Total Funding Request:	**$360,000,000**	**$360,000,000**

Background. The Governor's January budget proposes to implement a Value-Based Payment (VBP) program in the Medi-Cal managed care delivery system. The VBP would provide risk-based incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. The payments would be targeted at physicians that meet specific achievement on metrics targeting areas such as behavioral health integration, chronic disease management, prenatal and post-partum care, and early childhood prevention. DHCS released its preliminary measures for payments under the VBP program for public comment until March 22, 2019. The preliminary measures in each category are as follows:

Pre-Natal/Post-Partum Care

Proposed Measure	Measure Payment Method	Measure Purpose
Prenatal Pertussis Vaccine	Incentive payment to the provider for every pertussis vaccination for women between 27 and 36 weeks of pregnancy.	Improve the content and quality of prenatal care. Pertussis vaccination prevents pertussis or whooping cough, a potentially severe illness in young infants, but must be given during pregnancy to be effective.
Prenatal Care Visit	Incentive payment to the provider for ensuring that the woman comes in for her initial, first trimester prenatal visit.	Improve prenatal care by incentivizing it to start early in pregnancy.

Postpartum Care Visits	Incentive payment for completion of recommended postpartum care visits after a woman gives birth. Partial incentive payment if complete only one of the visits, full incentive payment for completing both visits.	Given the importance of the postpartum period to the health of mothers and infants, improve postpartum care by incentivizing providers to provide two postpartum visits
Postpartum Depression Screening	Incentive payment for each screening for clinical depression using a standardized screening tool of postpartum women within 12 weeks after delivery.	Improve the content and quality of postpartum care. Depression screening is one of the recommended key components of postpartum care per the American College of Obstetricians and Gynecologists (ACOG).
Postpartum Birth Control	Incentive payment to provider when the provide either a moderately or more effective form of birth control (birth control pills, shot, patch, ring, diaphragm, intrauterine device, implant or sterilization) for postpartum women between 3 and 60 days after delivery	Improve the content and quality of postpartum care. Birth control and birth spacing are one of the recommended key components of postpartum care per ACOG.

Early Childhood

Proposed Measure	Measure Payment Method	Measure Purpose
Well Child Visits in first 15 months	Incentive payment to a provider for successfully completing the last three well child visits out of eight total - 6th, 7th, and 8th visits.	Increase the number of well child visits that infants and toddlers receive, as well as the preventive services ssociated with those visits, by incentivizing the latter visits in the series of well child visits recommended by the American Academy of Pediatrics (AAP) between birth and 15 months of life.
Well Child Visits 3-6 years old	Incentive payment to provider for successfully completing all four well child visits during the 3rd to 6th years of life. Full incentive payment for all four visits, partial incentive payments if complete some but	Increase the number of well child visits that young children receive, as well as the preventive services associated with those visits, by incentivizing the AAP recommended well child visits

	not all.	in the young childhood years.
All childhood vaccines for 2 year olds	For two year old children, pay an incentive payment to a provider when the last dose in any of the multiple dose vaccine series is given (e.g., the last dose of the diphtheria, tetanus and pertussis four vaccine series; the last dose of the three vaccine polio series; the 2nd flu vaccine, etc.).	Improve vaccination rates in young children by incentivizing the last doses in the multi-dose vaccine series required by AAP to ensure that children two years of age are fully immunized.
Blood Lead Screening	Incentive payment to a provider for completing a blood lead screening in children up to two years of age.	Improve the rate of identification and treatment of elevated blood lead levels among young children.
Dental Fluoride Varnish	Incentive payment to provider if provides oral fluoride varnish application for children 6 months to 5 years.	Promote and improve on preventive dental care, specifically the prevention of dental caries (tooth decay) in young children by incentivizing a preventive dental service that managed care primary care providers perform.

Chronic Disease Management

Proposed Measure	Measure Payment Method	Measure Purpose
Controlling High Blood Pressure	Incentive payment to provider for each event of adequately controlled blood pressure for members 18 to 85 years being seen by the provider for their diagnosis of high blood pressure.	Improve the management and outcome of members with high blood pressure, a chronic disease that affects numerous adult managed care members.
Diabetes Care	Incentive payment to provider for each event of diabetes (HbA1c) testing that shows better than poor control (a result of less than 9%) for members 18 to 75 years with a diagnosis of diabetes.	Improve the management and outcome of members with diabetes, a chronic disease that affects numerous adult managed care members.

Control of Persistent Asthma	Incentive payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of persistent asthma who has more controller medications prescribed than those for the treatment of acute asthma.	Improve the management of persistent asthma for both children and adults by incentivizing better asthma control and the prevention of acute asthma attacks.
Tobacco Use Screening	Incentive payment to provider for tobacco use screening provided to members 18 years and older.	Improve tobacco screening, and ultimately tobacco cessation efforts, by incentivizing providers to identify their members who are current smokers.
Adult Influenza Vaccine	Incentive payment to a provider for ensuring influenza vaccine administered to members 19 years and older for individuals with a chronic disease diagnosis (e.g., high blood pressure, atherosclerotic coronary artery disease, stroke, chronic obstructive pulmonary disease, asthma, chronic kidney disease, chronic liver disease, diabetes, and dementia)	Increase the provision of the flu vaccine to adults with a chronic disease diagnosis in order to prevent flu-related complications from these chronic conditions.

Behavioral Health Integration

Proposed Measure	Measure Payment Method	Measure Purpose
Screening for Clinical Depression	Incentive payment for provider for conducting screening for clinical depression (with a standardized screening tool) for beneficiaries 12 years and older	Increase screening for clinical depression which will lead to better identification and treatment of members suffering from depression, as well as promote the integration of behavioral health and primary care.

Management of Depression Medication	Incentive payment for provider if beneficiary 18 years and old with a diagnosis of major depression and treated with an antidepressant medication has remained on the anti-depressant medication for at least 12 weeks.	Improve on the management and outcome of members who have been diagnosed with clinical depression.
Screening for Unhealthy Alcohol Use	Incentive payment for provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older	Increase screening for unhealthy alcohol use which will lead to better identification and treatment of members with alcohol use disorders, as well as promote the integration of behavioral health and primary care.
Colocation of primary care and behavioral health services	Health plan to attest to co-location of the provider and the direct payments to those providers. Payment per visit at the provider level.	Incentivize an arrangement that promotes the most seamless integration of behavioral health and primary care.

Stakeholder Proposal – Include Metrics in VBP to Reduce Health Disparities. The California Pan-Ethnic Health Network requests to include a requirement that the Value-Based Payment program prioritizes metrics that reduce health disparities and that DHCS consult with stakeholders on the mechanics of the proposal.

Stakeholder Proposal – Allow Clinics to Receive VBP Incentive Payments. The California Primary Care Association requests the Value-Based Payment program include federally qualified health centers and rural health clinics as eligible providers for incentive payments.

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. When will DHCS complete its review of submitted comments for this proposal? Is the proposal likely to change significantly based on submitted comments?

Issue 11: Proposition 56: Developmental and Trauma Screening

Budget Issue. DHCS requests $105 million ($52.5 million Healthcare Treatment Fund and $52.5 million federal funds) annually to provide developmental and trauma screening for Medi-Cal beneficiaries.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0890 – Federal Trust Fund	$52,500,000	$52,500,000
3305 – Healthcare Treatment Fund	$52,500,000	$52,500,000
Total Funding Request:	**$105,000,000**	**$105,000,000**

Developmental Screening – Background. According to DHCS, developmental screening is the use of a standardized set of questions to see if a child's motor, language, cognitive, social, and emotional development are on track for their age. The American Academy of Pediatrics' Bright Futures periodicity schedule recommends developmental screening for all children at 9 months, 18 months, and 30 months of age, and as medically necessary when risk is identified on developmental surveillance. All children enrolled in Medi-Cal are entitled to receive developmental screening under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which follows the Bright Futures schedule.

DHCS requests $60 million ($30 million Healthcare Treatment Fund and $30 million federal funds) annually to provide early developmental screening for children. According to DHCS, the screening would be provided through both the managed care and fee-for-service delivery systems and the supplemental payments to providers would be in addition to the amounts paid for the office visit during which the screening occurs. DHCS expects 25,000 children age 9 months, 29,000 children age 18 months, and 29,000 children age 30 months would receive developmental screenings every month. The screenings would use a tool that meets criteria set forth by both the American Academy of Pediatrics and the federal Centers for Medicare and Medicaid Services. The additional reimbursement to providers for developmental screenings would be $59.90 per screen.

Trauma Screening – Background. According to DHCS, trauma-informed care is a model of care intended to promote healing and reduce risk for re-traumatization. Early identification of trauma and providing the appropriate treatment are critical tools for reducing long-term health care costs for both children and adults. Individuals who experienced trauma in childhood are at significantly increased risk of heart disease and diabetes compared to those who did not experience traumatic events. Research has shown that individuals who experienced several traumatic childhood events are likely to die 20 years sooner than those without these experiences. These physical health costs are in addition to the mental health and substance use disorders that often follow childhood trauma.

DHCS requests $45 million ($22.5 million Healthcare Treatment Fund and $22.5 million federal funds) annually to support trauma screenings for all children and adults in Medi-Cal. According to DHCS, the trauma screening would also be provided through both the managed care and fee-for-service delivery systems and the supplemental payments to providers would also be in addition to the amounts paid for the office visit during which the screening occurs. The screenings for children would use a tool recommended by the AB 340 Trauma Screening Advisory Workgroup, known as PEARLS and

developed by the Bay Area Research Consortium on Toxic Stress and Health (BARC). According to DHCS, there are two versions of the tool. One version is for ages one through 12 and the other for teens ages 13 through 19. For adults, DHCS intends to use the Adverse Childhood Experiences (ACEs) assessment or a similar tool. The additional reimbursement to providers for developmental screenings would be $29 per screen.

Stakeholder Proposal – Provider Training and Data Collection on Trauma Screenings. Californians for Safety and Justice and the County Welfare Directors Association request one-time expenditure authority of $15 million in 2019-20 for provider training and data collection. $10 million would fund training for primary care providers and others who will administer the PEARLS trauma screening. $5 million would fund data collection and the creation of new screening codes to allow the Administration and the Legislature to monitor the progress of trauma screening implementation and track the improvement in children's health and well-being.

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 these proposals.

Issue 12: Proposition 56: Family Planning Supplemental Payment

Budget Issue. DHCS requests $500 million ($50 million Healthcare Treatment Fund and $450 million federal funds) to provide supplemental payments for family planning services in Medi-Cal fee-for-service and Medi-Cal managed care.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0890 – Federal Trust Fund	$450,000,000	$450,000,000
3305 – Healthcare Treatment Fund	$50,000,000	$50,000,000
Total Funding Request:	**$500,000,000**	**$500,000,000**

Background. The 2017 Budget Act allocated up to $40 million of Proposition 56 revenue to fund supplemental payments for women's health services provided under the Family Planning, Access, Care, Treatment (Family PACT) program for the evaluation and management (E&M) portion of office visits and up to $10 million to fund supplemental payments for medical pregnancy termination. The payments for E&M services were set at a rate equal to 150 percent of the existing Family PACT reimbursement rates. These payments were continued in the 2018 Budget Act and DHCS proposes to extend these payments indefinitely. The budget includes $203.1 million ($54.2 million Healthcare Treatment Fund and $148.9 million federal funds) in 2018-19 and $159.6 million ($41.9 million Healthcare Treatment Fund and $117.7 million federal funds) in 2019-20 for supplemental payments for women's health services.

DHCS requests $500 million ($50 million Healthcare Treatment Fund and $450 million federal funds) to provide supplemental payments for family planning services in Medi-Cal fee-for-service and Medi-Cal managed care. According to DHCS, these payments are intended to help support the larger Medi-Cal population accessing and using family planning services, as well as the providers delivering such services in Medi-Cal. DHCS intends to provide a fixed $20 supplemental payment in fee-for-service and managed care for family planning office visits under new patient claim codes (99201, 99202, 99203, and 99204) and established patient claim codes (99211, 99212, 99213, and 99214).

Stakeholder Proposal – Alternative Investments to Support Reproductive Health. Planned Parenthood Affiliates of California has proposed several alternative priority investments for the Administration's allocation of Proposition 56 funding for family planning. These alternative investments are as follows:

- Supplemental payments for an expanded list of Family PACT codes that would receive a 150 percent supplement, including education and preventive counseling, as well as various reproductive health services.
- Supplemental payments for Medi-Cal E&M codes to achieve 150 percent rate parity
- Supplemental payments for Medi-Cal family planning services to achieve 150 percent rate parity
- Allow family planning providers to offer and be reimbursed for a broader range of services by adding claim codes
- Create encounter rates or global fees for family planning providers that offer select public health promoting interventions on a single date of service

- Permit family planning providers to be reimbursed for care management, care connection, patient navigation, or patient follow-up and referral
- Make capital investments to support infrastructure and workforce to increase access to sexual and reproductive health care in areas of need and to pilot new health care delivery technologies or models.

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 13: Proposition 56 Staffing

Budget Issue. DHCS requests 18 positions and expenditure authority of $3 million ($1.5 million Healthcare Treatment Fund and $1.5 million federal funds) annually. If approved, these positions and resources would allow DHCS to support implementation of the new Value-Based Payments program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0890 – Federal Trust Fund	$1,500,000	$1,500,000
3305 – Healthcare Treatment Fund	$1,500,000	$1,500,000
Total Funding Request:	**$3,000,000**	**$3,000,000**

***** Positions and resources ongoing after 2020-21.

Background. The Governor's January budget proposes to implement a Value-Based Payment (VBP) program in the Medi-Cal managed care delivery system. The VBP program would provide risk-based incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. The payments would be targeted at physicians that meet specific achievement on metrics targeting areas such as behavioral health integration, chronic disease management, prenatal and post-partum care, and early childhood prevention.

DHCS requests 18 positions and expenditure authority of $3 million ($1.5 million Healthcare Treatment Fund and $1.5 million federal funds) annually to support implementation of the new Value-Based Payments program including designing program elements, developing and calculating performance metrics, coordinating with stakeholders, developing capitation rates and supplemental payment amounts, and preparing payment systems. Specifically, the funding would support the following positions:

Managed Care Quality Management Division – Eight positions

- **One Staff Services Manager III** position would provide critical oversight and direction for the development of the Medi-Cal managed care performance metric, take the lead role in all managerial aspects of performance measure development and maintenance, and act as the primary point of contact for the division when coordinating efforts with other state and federal agencies, internal and external stakeholders, and other divisions within DHCS.
- **Two Health Program Specialist II** positions would provide analytic support for the VBP program, receive, manage, and calculate encounter data to be used for performance metrics, and take the lead in programmatic aspects of performance management.
- **Two Health Program Specialist II** positions would provide policy support for the VBP program, develop and implement policies for the program, assist with compliance measurements and quality improvement activities, and prepare warning letters, corrective action plans, and sanctions for noncompliance.
- **Two Health Program Specialist I** positions would support the development of performance metrics and measurement, coordinate on program design, analyze feedback from stakeholders on metrics and reporting, calculate metric results, and produce reports and dashboards.
- **One Office Services Supervisor I** position would provide clerical support, develop correspondence, schedule meetings, track projects, and organize relevant documents.

Information Management Division – Two positions

- **One Staff Services Manager II** position would plan, organize, and direct analysis and research required to calculate the performance measures, work with other parts of DHCS that are supporting the VBP program to assess data quality, evaluate results, and communicate findings to internal and external partners.
- **One Health Program Specialist I** position would plan, organize, and carry out data preparation, assessment, and reporting for the VBP program measures, serve as a team member and act as a technical consultant to inform program and policy implications of the results of the performance measures.

Capitated Rates Development Division – Six positions

- **One Staff Services Manager I** position would plan, organize, and direct the activities of staff responsible for implementing the VBP program, assume a lead role on the financial policy related to each VBP program, work closely with actuaries to assist in rate-setting activities for the VBP program, perform management review of all applicable rate exhibits, financial calculations, and written correspondence, and coordinate with other divisions regarding the financial aspects of the VBP program.
- **One Health Program Specialist I** position would perform more complex programmatic and financial analysis related to the VBP program, contribute to the development and implementation of related financial policy, complete all documents required to obtain federal approval of the directed payments, and respond to complex or non-routine inquiries affecting the VBP program.
- **Four Associate Governmental Program Analysts** would perform less complex programmatic and financial analysis related to the VBP program, collect historical cost and utilization data, prepare and populate rate exhibits for CMS and managed care plans as well as payment exhibits for the Managed Care Oversight Division, write All Plan Letters, memoranda, and other guidance documents, and respond to routine inquiries affecting the VBP program.

Managed Care Operations Division – Two positions

- **One Health Program Specialist I** position would serve as subject matter expert on the VBP program, conduct research and analysis, develop project plans, policies, guidance materials, issue papers and reports, and communicate with stakeholders.
- **One Associate Governmental Program Analyst** would assist with analysis, documentation, and implementation of changes to the Capitation Payment Management System, evaluate system-related impacts, provide guidance and procedural documentation for improvement to the system, conduct ongoing quality control activities to proactively address system changes, and create trend analyses, pivot charts, and dashboard reports for reporting of system modifications, improvements, or changes.

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 14: Program for All-Inclusive Care for the Elderly Expansion

Budget Issue. DHCS requests two positions and expenditure authority of $279,000 ($140,000 General Fund and $139,000 federal funds) in 2019-20 and $261,000 ($131,000 General Fund and $131,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to manage the expansion of Programs of All-Inclusive Care for the Elderly operating in California.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$140,000	$131,000
0890 – Federal Trust Fund	$139,000	$130,000
Total Funding Request:	**$279,000**	**$261,000**
Total Positions Requested:	**2.0**	**2.0**

***** Positions and resources ongoing after 2020-21.

Background. Programs for All-Inclusive Care for the Elderly (PACE) provide care to California's frail population as an alternative to institutionalization by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care services. These services are provided to beneficiaries while still residing in a home- or community-based setting, rather than a skilled nursing facility or other institutional setting. Eligible PACE participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. PACE programs are the sole provider of Medicare and Medi-Cal services for participants.

The 2016 Budget Act included trailer bill language, the PACE Modernization Act, that implemented new flexibilities and growth of the PACE program. The provisions included removal of the cap on the total number of PACE organizations in the state (previously limited to 15), implementation of an experience-based rate methodology, and allowing for-profit entities to participate. The PACE Modernization Act has resulted in significant growth in the number of PACE programs providing services to Medi-Cal beneficiaries.

DHCS requests two positions and expenditure authority of $279,000 ($140,000 General Fund and $139,000 federal funds) in 2019-20 and $261,000 ($131,000 General Fund and $131,000 federal funds) annually thereafter to manage contracting and compliance workload related to the expansion of PACE programs under the PACE Modernization Act. Specifically, DHCS is requesting the following positions in the Integrated Systems of Care Division:

- **One Associate Governmental Program Analyst** would be added to the Contract Management Unit to prepare, review, track, monitor, and process all contracts and contract amendments for assigned PACE organizations. This position would serve as the point of contact for all applicants, would collaborate with the PACE Policy Unit to verify policies and procedures are aligned with contract deliverables and requirements, and would serve as subject matter expert for contract needs and deliverables.
- **One Associate Governmental Program Analyst** would be added to the Compliance and Oversight Unit to provide technical assistance and guidance to PACE organizations regarding corrective action

plans, deficiencies, and audit findings. This position would also conduct monitoring and oversight through review of policies and procedures, contract requirements, development of audit tools and guidance documents, review of sub-contractor compliance, collaboration with CMS on current PACE program policies and procedures, ongoing tracking and monitoring of federal and state laws and regulations, and training for PACE programs for proper submission of documents for DHCS review and approval.

Stakeholder Proposal – Amendments to the PACE Modernization Act. The California Association of Programs of All-Inclusive Care for the Elderly (CalPACE) requests adoption of trailer bill language to make changes to the Medi-Cal rate methodology for PACE. According to CalPACE, the current PACE rate methodology, which was adopted as part of the budget in 2016, moved the payment methodology from a fee-for-service based methodology to an experience-based rate methodology, under which payments are more closely tied to each organization's costs, similar to the methodology used for Medi-Cal managed care plans.

DHCS has pointed to the capital intensive nature of PACE as a factor that is limiting more rapid PACE expansion. The proposed changes would better align the rate methodology with this inherent feature of PACE. The relatively small average enrollment in PACE (approximately 700 enrollees versus several thousand in traditional managed care plans) severely limits the ability of PACE organizations to manage the risks and volatility in costs associated with their highest cost enrollees by spreading them across their overall enrollment. The proposed changes would enable PACE organizations to create reasonable reserves to manage this increased risk and volatility.

The proposed trailer bill language would ensure that PACE continues to be a viable program for older adults and seniors with higher care needs while continuing to be cost-effective for the state by establishing a floor for rates that is linked to the amount that would otherwise be paid for comparable beneficiaries.

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 15: Provider Enrollment Workload Increase

Spring Finance Letter. DHCS requests expenditure authority of $3.1 million ($795,000 General Fund and $2.4 million federal funds) in 2019-20 and $3 million ($744,000 General Fund and $2.2 million federal funds) in 2020-21. If approved, these resources would allow DHCS to process an increase in provider enrollment applications from Drug Medi-Cal and Medi-Cal managed care plans resulting from new federal requirements.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$795,000	$744,000
0890 – Federal Trust Fund	$2,386,000	$2,230,000
Total Funding Request:	**$3,181,000**	**$2,974,000**

Background. DHCS' Provider Enrollment Division (PED) is responsible for enrollment and renewal of medical providers and applicants pursuant to state and federal laws and regulations. PED is required to complete application review for new physicians or physician groups, which comprise the majority of PED applications, within 90 days. Applications for other providers, including psychologists, licensed clinical social workers, licensed midwives, nurse practitioners, physician assistants, and podiatrists must be completed within 180 days.

Federal Provider Enrollment Requirements. The federal Patient Protection and Affordable Care Act requires providers to be revalidated every five years and monitored monthly to ensure they continue to meet state and federal requirements. In addition, the federal 21st Century Cures Act and CMS Final Rule CMS-2390-F requires the state to screen, enroll, and periodically revalidate health plan network providers by implementing a plan-specific enrollment process, or by directing providers to enroll as Medi-Cal fee-for-service providers. According to DHCS, nearly all Medi-Cal managed care plans opted to direct their network providers to enroll in Medi-Cal fee-for-service rather than implementing their own enrollment process.

DHCS reports these new provider enrollment requirements have led to a significant increase in provider applications and a backlog of approximately 19,000 applications. PED expects to receive approximately 33,600 applications in 2018-19 and 2019-20, and 53,600 applications annually beginning in 2020-21. In September 2018, PED deployed the Provider Application and Validation for Enrollment (PAVE) enrollment portal and associated business process applications with electronic provider management activities. PED staff currently are able to process 800 paper applications per person annually. Once PED is able to reduce its paper-based application backlog, it expects to be able to process 1,500 PAVE applications per person annually. According to DHCS, PED became fully automated with PAVE functionality on March 5, 2019.

DHCS requests expenditure authority of $3.1 million ($795,000 General Fund and $2.4 million federal funds) in 2019-20 and $3 million ($744,000 General Fund and $2.2 million federal funds) in 2020-21, equivalent to 21 positions, to clear the application backlog and process the additional provider enrollment applications. Specifically, DHCS requests the following two-year, limited-term resources in the following divisions:

Provider Enrollment Division – Two-year funding equivalent to 21 positions

- **One Staff Services Manager II** would supervise and direct activities in the section, provide leadership to staff and managers, develop and monitor goals and objectives, establish and maintain workload priorities and reporting processes, respond to calls from legislative and executive staff and providers regarding provider issues or problems, recruit and train staff, evaluate performance, and prepare probationary and performance reports.
- **Three Staff Services Manager I** positions would supervise the unit, assign work and manage workflows, direct staff in conducting enrollment activities, oversee review of all provider enrollments, recruit and train staff, evaluate performance and prepare probationary and performance reports, consult with DHCS management, contractors and other state and federal agencies to improve fraud prevention, and meet with providers and provider organizations about enrollment issues.
- **16 Associate Governmental Program Analysts** would review enrollment provider applications and supporting materials, communicate with providers regarding deficiencies, verify licensure and permit status, evaluate applications for fraud risk factors and compliance with state and federal requirements, generate and analyze workload reports, and track workflow.
- **One Associate Governmental Program Analyst** would also perform secondary review of provider applications and supporting materials, and perform quality control reviews.

Office of Administrative Hearings and Appeals – Two-year funding equivalent to two positions

- **One Health Program Audit Manager I** would manage increased workload related to appeals of denied provider enrollment applications. DHCS expects approximately 3,520 applications will be denied annually and 5 percent, or 176, will be appealed to the Office of Administrative Hearings and Appeals.
- **One Legal Secretary** would perform necessary clerical functions associated with processing appeals and transmitting the increased number of appeal decisions within required timeframes.

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 16: Office of Civil Rights Increased Workload

Spring Finance Letter. DHCS requests two positions and expenditure authority of $296,000 ($148,000 General Fund and $148,000 federal funds) in 2019-20 and $278,000 ($139,000 General Fund and $139,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to address workload increases in its equal employment opportunity, reasonable accommodations, and civil rights compliance programs.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$148,000	$139,000
0890 – Federal Trust Fund	$148,000	$139,000
Total Funding Request:	**$296,000**	**$278,000**
Total Positions Requested:	**2.0**	**2.0**

* Positions and resources ongoing after 2020-21.

Background. DHCS' Office of Civil Rights is responsible for three main program areas: Equal Employment Opportunity (EEO), Reasonable Accommodations (RA), and Civil Rights Compliance (CRC). The Office protects the employment rights of its employees through the EEO and RA programs, while the Office, through the CRC program, is responsible for preventing and correcting civil rights violations in the delivery of services administered by the department.

Equal Employment Opportunity Responsibilities. According to the California Department of Human Resources (CalHR), all state agencies have an affirmative duty to take reasonable steps to prevent and promptly address discrimination and harassment in the workplace. Agencies are responsible for integrating equal employment opportunity into every aspect of human resource management policies and practices in the recruitment, examination, selection, training and advancement of employees. Under the California Fair Employment and Housing Act, equal employment opportunity is afforded to all applicants and employees without regard to age, ancestry, color, disability (mental or physical), engaging in a protected activity, gender, gender identity or expression, genetic information, marital status, medical condition, military veteran status, national origin, political affiliation, pregnancy, race, religion, sex, and sexual orientation. State agencies' EEO programs are responsible for preventing employment harassment and discrimination by monitoring recruitment, examination, hiring, and retention policies, investigating complaints in a timely manner, and overseeing curriculum and learning objectives for employee training regarding their rights and responsibilities to maintain a harassment-free work environment.

Reasonable Accommodations Responsibilities. California state agencies are also required by state and federal laws to provide Reasonable Accommodation (RA) to applicants and employees with disabilities. An RA may be a modification or adjustment to a job, or to the work environment, that enables an individual with a disability to have the same employment opportunities and benefits as those without a disability. When a request for a disability accommodation is made employers are required to enter an interactive process with the employee to make an individualized assessment of the essential job functions and the specific limitations of the person with a disability. The Fair Employment and Housing Act also prohibits employment discrimination based on religion. This discrimination includes refusing to accommodate an applicant's or employee's sincerely held religious beliefs or practices. Applicants and

employees may obtain exceptions to rules or policies in order to fulfill their essential job functions within the constraints of their religious beliefs or practices.

Civil Rights Compliance Responsibilities. Section 1557 of the federal Patient Protection and Affordable Care Act prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities, extending federal nondiscrimination protections to individuals participating in any health program or activity receiving funding from the federal Department of Health and Human Services (HHS), any health program or activity administered by HHS, health insurance marketplaces, and all plans offered by issuers that participate in those marketplaces. These requirements extend to all programs administered by DHCS that receive federal funding including Medi-Cal, community behavioral health programs, family planning programs, and many others. The Office of Civil Rights is responsible for preventing and correcting civil rights violations in the delivery of services administered by DHCS.

DHCS Reports Increased Office of Civil Rights Workload. According to DHCS, the Office's workload related to EEO, RA, and civil rights compliance has experienced a steady increase in recent years. The Office has received a steady increase in complaints that established a bona fide allegation of discrimination or harassment requiring an investigation. DHCS indicates this increased workload may be due to the increase in awareness of rights and remedies for incidents of discrimination or harassment, as well as the department's efforts to make employees aware of the availability of the Office of Civil Rights.

DHCS also has experienced an increase in RA requests, as the department has begun taking a more active role in facilitating accommodation discussions with employees. In addition, many of the requests are more complex, involving developmental disabilities or mental health issues. The complexity of these requests require additional work to make the necessary accommodation.

DHCS also reports a steady increase in volume and complexity of its civil rights compliance workload, particularly over the past three years. During that period, the number of complaints requiring investigation has increased from one to ten cases. DHCS is also increasing enforcement of managed care plan contract requirements related to civil rights compliance and directing counties to report civil rights complaints by Medi-Cal beneficiaries in a timely manner. DHCS is attempting to address the increase in workload by standardizing and streamlining the process for civil rights complaints.

DHCS requests two positions and expenditure authority of $296,000 ($148,000 General Fund and $148,000 federal funds) in 2019-20 and $278,000 ($139,000 General Fund and $139,000 federal funds) annually thereafter to address the workload increases in its EEO, RA, and civil rights compliance programs. These resources would fund the following positions in the Office of Civil Rights:

- **One Staff Services Manager I** position would act as a subject matter expert in civil rights compliance, provide additional resources for more complex and sensitive workload, and develop policies and procedures to improve responsiveness and reduce liability risks.
- **One Associate Governmental Program Analyst** would provide additional responsiveness to workload increases in EEO, RA, and civil rights compliance, and would provide training to DHCS management and staff at all work locations throughout the state.

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 17: Federally Qualified Health Centers Drug Medi-Cal Providers

Spring Finance Letter. DHCS requests one position and expenditure authority of $139,000 ($70,000 General Fund and $69,000 federal funds) in 2019-20 and $130,000 ($65,000 General Fund and $65,000 federal funds) annually thereafter. If approved, this position and resources would allow DHCS to support workload to allow federally qualified health centers and rural health clinics to participate in the Drug Medi-Cal program, pursuant to the requirements of SB 323 (Mitchell), Chapter 540, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$70,000	$65,000
0890 – Federal Trust Fund	$69,000	$65,000
Total Funding Request:	**$139,000**	**$130,000**
Total Positions Requested:	**1.0**	**1.0**

* Position and resources ongoing after 2020-21.

Background. The Medi-Cal program reimburses federally qualified health centers (FQHCs) and rural health clinics (RHCs) using an all-inclusive per-visit rate, known as the Prospective Payment System (PPS), for the provision of health care services, including primary care, dental services, pharmacy, psychology/psychiatry, drug counseling, and occupational/physical therapy. A clinic's per-visit rate is calculated by determining its annual total allowable costs for services provided and dividing those costs by the number of eligible visits. Clinics submit cost reports and an accounting of annual visits to the department, which audits the reports and calculates the per-visit rate. Once this rate is set, it grows annually by the Medicare Economic Index, a measure of medical practice cost inflation used by the federal government, unless the rate is recalculated due to a change in the scope of services offered by the clinic.

A clinic may only receive a single per-visit reimbursement on any one day, as the rate is meant to be inclusive of all of the services provided by the clinic. A beneficiary may receive one or more services offered by a clinic on a single day, such as primary care and mental health services, but will only be reimbursed for one visit. If a clinic schedules additional services on a different day, it may receive reimbursement for a second visit at the per-visit rate. However, clinics report that the beneficiary return rate for subsequent referrals is a challenge, particularly for mental health referrals and in rural areas. Under certain circumstances, such as the provision of dental services, clinics may elect to receive reimbursement in Medi-Cal's fee-for-service delivery system, even if the clinic has already received a per-visit rate reimbursement for other services that day.

SB 323 allows FQHCs and RHCs to be reimbursed directly from DHCS or a county for providing Drug Medi-Cal services or specialty mental health services (SMHS). Drug Medi-Cal services may be provided under contract with a county pursuant to the terms of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, if the county is participating, or under direct contract with the county or DHCS if the county is not participating. Specialty mental health services may be provided under contract with a county mental health plan that provides services to Medi-Cal beneficiaries pursuant to a contract with DHCS. Reimbursement for Drug Medi-Cal or specialty mental health services must be provided separately from the clinic's PPS rate and any clinic seeking to be reimbursed separately must

apply to DHCS for a change in scope of service request. According to DHCS, some clinics' PPS rates include provision of these realigned services because their rates were calculated prior to the 2011 realignment of Drug Medi-Cal and certain specialty mental health services to the counties and have not been updated to reflect current allowable costs.

According to DHCS, an uncertain number of FQHCs and RHCs currently offer substance use disorders treatment services that could be claimed under a separate billing structure for Drug Medi-Cal. Because these services are offered within the clinics' PPS reimbursement rate structure, they are not enrolled as Drug Medi-Cal providers and are not regulated by DHCS for the provision of these services. Clinics that elect to begin providing Drug Medi-Cal services separately would be required to enroll and become certified as Drug Medi-Cal providers through the department's Provider Enrollment Division.

2018 Budget Act Resources for Provider Enrollment and Rate Audits. The 2018 Budget Act included five positions and expenditure authority of $891,000 ($446,000 General Fund and $445,000 federal funds) in 2018-19, and $3 million ($1.5 million General Fund and $1.5 million federal funds) in 2019-20, $3.2 million ($1.6 million General Fund and $1.6 million federal funds) in 2020-21, $1.2 million ($581,000 General Fund and $580,000 federal funds) in 2021-22, and $595,000 ($298,000 General Fund and $297,000 federal funds) in 2022-23 and annually thereafter. The positions included two permanent program staff to provide technical assistance to clinics for enrollment and claims payment for Drug Medi-Cal services and limited-term resources equivalent to 15 auditors to process reimbursement rate audits to remove the Drug Medi-Cal and SMHS components from clinics' per-visit rates.

DHCS reports that ten clinics have enrolled as Drug Medi-Cal providers since passage of SB 323, but this number is expected to increase as waiver counties attempt to meet federal network adequacy requirements. DHCS estimates approximately 180 new clinics will ultimately be enrolled as Drug Medi-Cal providers. While the two positions approved in the 2018 Budget Act are responsible for managing the provider enrollment and claims payment workload, DHCS indicates it needs an additional position to maintain program integrity and avoid duplicate billing.

DHCS requests one position and expenditure authority of $139,000 ($70,000 General Fund and $69,000 federal funds) in 2019-20 and $130,000 ($65,000 General Fund and $65,000 federal funds) annually thereafter to support workload to allow federally qualified health centers and rural health clinics to participate in the Drug Medi-Cal program.

One Associate Governmental Program Analyst in the Performance Integrity Branch of the Substance Use Disorder Program, Policy, and Fiscal Division would conduct on-site technical assistance and compliance reviews of Drug Medi-Cal certified clinics, oversee clinic compliance with applicable state and federal laws and regulations, evaluate beneficiary and program records, compare paid claims to beneficiary service documentation, perform peer reviews of utilization review and technical assistance draft reports, and participate in meetings and workgroups regarding Drug Medi-Cal policy and regulations.

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. How will the workload of this new position differ from the two positions approved in the same division in the 2018 Budget Act?

Issue 18: Reappropriation: Behavioral Health Modernization Resources

Spring Finance Letter. DHCS requests reappropriation of expenditure authority of $2.1 million ($808,000 General Fund and $1.2 million federal funds) in 2019-20. If approved, these reappropriated resources would cover planning costs of the department's Comprehensive Behavioral Health Data Systems Modernization Project.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$808,000	$-
0890 – Federal Trust Fund	$1,245,000	$-
Total Funding Request:	**$2,053,000**	**$-**

Background. DHCS administers several behavioral health programs in California that receive federal support, including Medi-Cal Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Community Mental Health Block Grant, the Mental Health Services Act (MHSA), and the Bronzon-McCorquodale Act (1991 Realignment). Most mental health and substance use disorder services are provided by county behavioral health departments. DHCS is responsible for oversight of claims for federal matching funds, distribution of MHSA funds, distribution of block grant funds, and behavioral health programs funded by 1991 Realignment. State and federal requirements related to these funding sources require DHCS to monitor delivery of behavioral health services and collect data for reporting, evaluation, and monitoring for compliance with the conditions of each of the funding sources. According to DHCS, the data for this purpose is currently collected through multiple data systems in an extremely labor-intensive process.

The 2018 Budget Act included expenditure authority to fund planning costs to develop a Comprehensive Behavioral Health Data Systems Modernization (CBHDSM) project. DHCS completed the Stage 1 Business Analysis, as part of the Project Approval Lifecycle (PAL) process at the California Department of Technology (CDT), in October 2016. In December 2017, DHCS submitted a Planning Advanced Planning Document (PAPD) to the federal Centers for Medicare and Medicaid Services (CMS) to request an enhanced federal match of 90 percent for the project. In February 2018, CMS approved the PAPD funding request for federal fiscal years 2018 and 2019. Total funding in the 2018 Budget Act was $2.1 million ($808,000 General Fund and $1.2 million federal funds). DHCS indicates the second phase of planning work will occur in 2020-21 upon CMS approval of additional documentation and CDT approval of the department's Stage 2 Alternatives Analysis under the PAL process.

According to DHCS, the funding included in the 2018 Budget Act was not spent, and the project delayed for the following reasons:

- Because the request for offer (RFO) contract amount was over DHCS' purchasing authority, the department was directed to work with Statewide Technology Procurement.
- The development and approval of the RFO was delayed. DHCS indicates the contractor is estimated to start October 2019.

DHCS requests reappropriation of expenditure authority of $2.1 million ($808,000 General Fund and $1.2 million federal funds) in 2019-20 to cover planning costs of the CBHDSM project funded, but unexpended, in the 2018 Budget Act. The requested reappropriation language is as follows:

4260-491 – Reappropriation. Department of Health Care Services. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for those appropriations and shall be available for encumbrance or expenditure until June 30, 2020:

0001 – General Fund
(1) Item 4260-001-0001, Budget Act of 2018 (Chs 29 and 30, Statutes of 2018)

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 19: Strengthening Preventive Services for Children in Medi-Cal

Spring Finance Letter. DHCS requests 12 positions and expenditure authority of $22.7 million ($11.1 million General Fund and $11.6 million federal funds) in 2019-20, $7.5 million ($3.5 million General Fund and $4 million federal funds) in 2020-21 through 2022-23, and $6 million ($2.8 million General Fund and $3.1 million federal funds) annually thereafter. If approved, these resources would allow DHCS to improve delivery of preventive services for children in Medi-Cal in response to findings of a state audit.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$11,079,000	$3,495,000
0890 – Federal Trust Fund	$11,603,000	$3,998,000
Total Funding Request:	**$22,682,000**	**$7,493,000**
Total Positions Requested:	**12.0**	**12.0**

* Additional fiscal year resources requested – 2021-22 through 2022-23: $7,493,000; 2023-24 and ongoing: $5,996,000.

Background. Medi-Cal offers an array of preventive diagnostic and treatment services for individuals under age 21 as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The EPSDT benefit covers all medically necessary services, including those to correct or ameliorate defects and physical and mental illnesses or conditions. EPSDT ensures that children receive age appropriate preventive services, including screening for medical, dental, vision, hearing, mental health, and substance use disorders. Services provided under EPSDT include, but are not limited to, physician services, nurse practitioner services, hospital services, physical therapy, speech and language therapy, occupational therapy, home health services, medical equipment, supplies and appliances, treatment for mental health and substance use disorders, and treatment for vision, hearing, and dental diseases and disorders.

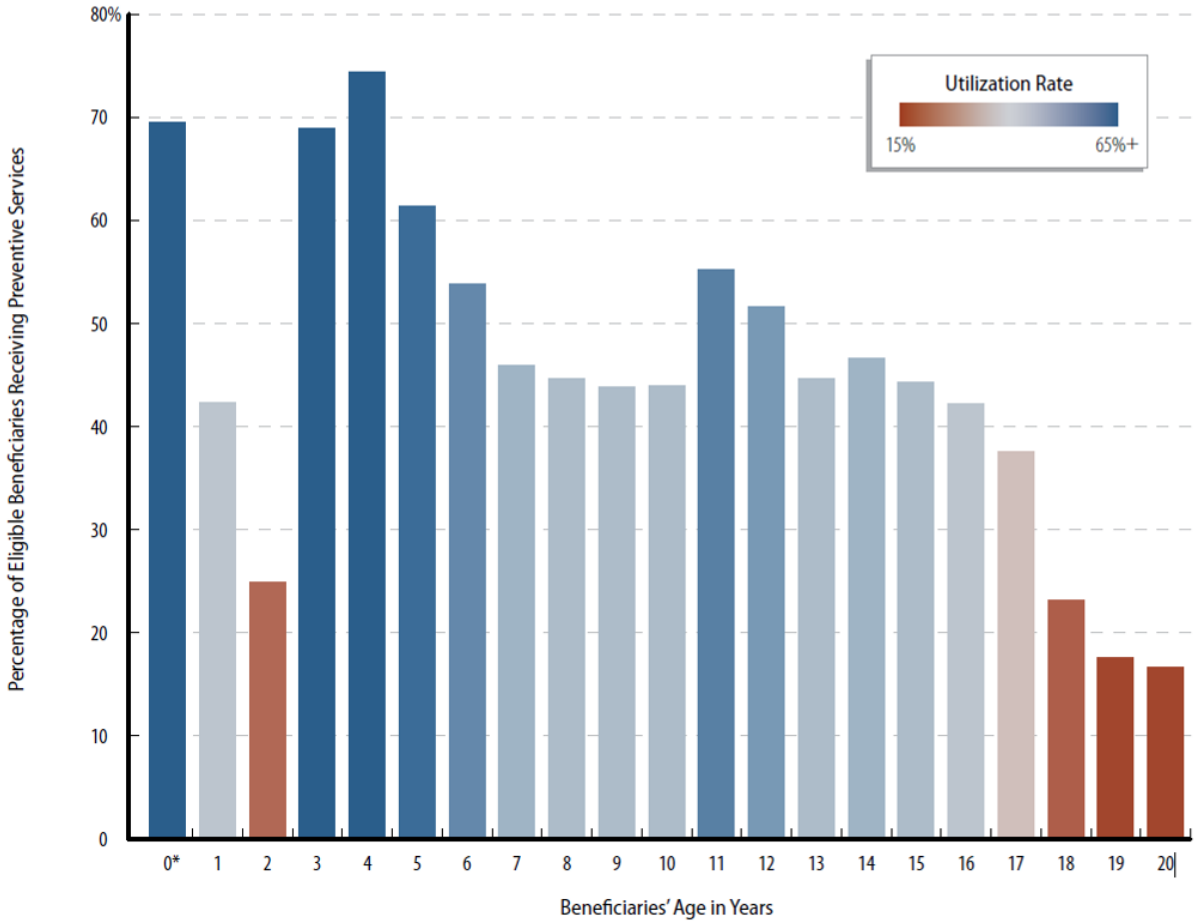
Medi-Cal uses the American Academy of Pediatrics' Bright Futures periodicity schedule to achieve the goal of age-appropriate periodic screenings. The Bright Futures periodicity schedule outlines the appropriate timing for various screenings performed by health care providers including medical history, body measurements (e.g. length, height, weight, head circumference, body-mass index, etc.), sensory screening (e.g. vision and hearing), developmental and behavioral health screening (e.g. for autism spectrum disorder, tobacco or substance use, depression, etc.), physical examination, regular testing and monitoring (e.g. testing for blood lead, tuberculosis, dyslipidemia, sexually transmitted diseases, cervical dysplasia, etc.), immunizations, and oral health (e.g. fluoride varnish or supplementation).

Medi-Cal managed care plans, which cover more than 80 percent of Medi-Cal beneficiaries are required under terms of their contracts with the state to adhere to the Bright Futures periodicity schedule for children's preventive services. According to DHCS, All Plan Letter 18-007 outlines plans requirements for delivering the EPSDT benefit and references federal requirements that children receive services according to Bright Futures.

State Audit Finds Children Not Receiving All Preventive Services in Medi-Cal. In March 2019, the California State Auditor released the results of its audit of DHCS, "Department of Health Care Services, Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services" (Report 2018-111),

which found that an annual average of 2.4 million children in Medi-Cal, or more than 50 percent, do not receive all required preventive services. The audit found most of the lowest rates of preventive utilization for children were in 15 rural counties in the eastern part of California, with the lowest usage in Alpine, Plumas, Mariposa, and Sierra counties. The audit also found significantly lower utilization rates for children ages two and under, when many important developmental and other screenings are expected under the Bright Futures periodicity schedule.

Utilization Rates Were Low for Some of the Youngest Children in Medi-Cal
Fiscal Years 2013–14 Through 2017–18



Source: California State Auditor. "Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services" (March 2019)

DHCS requests 12 positions and expenditure authority of $22.7 million ($11.1 million General Fund and $11.6 million federal funds) in 2019-20, $7.5 million ($3.5 million General Fund and $4 million federal funds) in 2020-21 through 2022-23, and $6 million ($2.8 million General Fund and $3.1 million federal funds) annually thereafter to make the following changes to improve children's preventive utilization in response to the audit findings:

- **Managed Care Performance Measures** – DHCS is expanding the scope of performance measures for Medi-Cal managed care plans to include measures from the Centers for Medicare and Medicaid

Services (CMS) Child Core Set and Adult Core Set. Plans are currently required to report yearly on certain measures from the Healthcare Effectiveness Data and Information Set (HEDIS), a set of performance measured developed by the National Committee for Quality Assurance. DHCS is also planning to issue a follow-up All Plan Letter specifically highlighting the requirements for plans to deliver services according to the Bright Futures periodicity schedule.

- **Minimum Performance Level** – DHCS is updating its requirements for managed care plan performance on the new core sets from the 25th percentile to the 50th percentile of Medicaid plans in the United States. If data is not available to determine nationwide percentile rankings, DHCS may establish alternative benchmarks. When plans do not meet the minimum performance level, sanctions and corrective action plans will be imposed and quality improvement work required.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey** – DHCS contracts with an external quality review organization (EQRO) to administer the CAHPS survey triennially, which assesses beneficiary experience and satisfaction with health care services for managed care beneficiaries by county and plan. The EQRO conducts the survey annually for children on a statewide level. DHCS is planning to conduct the CAHPS survey every two years instead of every three years to better monitor plan performance.
- **Beneficiary Outreach Activities** – DHCS intends to conduct a beneficiary outreach campaign, including a mail and phone survey, to inform parents and caregivers about the need to schedule preventive services for their children and the availability of these services under Medi-Cal. According to DHCS, this outreach campaign would be similar to a campaign it conducted recently which successfully improved dental utilization among children in Medi-Cal.

Specifically, DHCS is requesting the following positions and contract resources in the following divisions:

Managed Care Quality Monitoring Division (MCQMD)

MCQMD requests 12 positions, four-year limited-term funding equivalent to six positions, and $18.5 million contract funding, as follows:

- **One Staff Services Manager III** position would oversee a new branch within the division for development of the outreach campaign and methodologies for reporting. This position would manage quality monitoring including directing programmatic staff on quality strategy, monitoring, oversight, and act as the primary point of contact when coordinating efforts with state and federal agencies, internal and external stakeholders, and other DHCS divisions.
- **One Staff Services Manager II** position would oversee and direct program staff relating to utilization reporting for preventive services for children, quality improvement efforts, and health equity. This position would also manage programmatic aspects of the beneficiary outreach campaign including second-level review and quality assurance of program staff work, and serve as primary point of contact for the campaign.
- **Four Nurse Consultant III** positions (two permanent, two limited-term) would work with the EQRO and managed care plans on quality improvement plans and other monitoring such as performance on quality indicators, comparison of plan performance to the minimum performance level, establishing and monitoring corrective action plans, providing technical assistance to plans, identifying and reviewing quality improvement goals for plans, analyzing EQRO findings, and collaborate with other staff to support efforts to reduce health disparities.

- **One Nurse Consultant III** position would analyze quality improvement and health disparity interventions, determine if interventions were successful, identify promising practices, and support addition of Child and Adult Core Set measures to plan performance metrics.
- **Four Health Program Specialist II** positions would work with the EQRO and plans on corrective action plans and other improvement activities, develop and implement policies and strategies for improving preventive services for children, support procedures for tracking corrective action plans and calculate potential sanctions for non-compliance.
- **One Health Program Specialist II** position (limited-term) would serve as the lead on facility site review policy, data collection, monitoring reporting, and compliance. This position would provide plans with technical assistance, maintain documentation of promising improvement practices, and develop strategy for dissemination and implementation of promising improvement practices.
- **One Health Program Specialist I** position would develop an annual compliance report issued publicly to outline health plan quality interventions and results.
- **One Associate Governmental Program Analyst** (limited-term) would collaborate with DHCS consultants and the Department of Public Health to assist in development of the beneficiary outreach campaign including development and design of an outreach website, engaging in focus groups for messaging purposes, development of beneficiary notices, and creating outreach campaign policies and procedures for plans.
- **One Associate Governmental Program Analyst** would be the lead on corrective action plans and sanctions including monitoring and tracking plan performance, drafting corrective action plan and sanction correspondence with plans, documenting actions taken by plans and plan progress, providing guidance to plans during the corrective action plan process, publicly posting results, and answering stakeholder inquiries.
- **One Research Scientist III** position would lead the development of methodologies for evaluations and studies on utilization and disparities for preventive services for children in Medi-Cal including workgroup facilitation for methodology development, validation of methodology, presentation of research methodologies to DHCS leadership, peer review of EQRO deliverables, and serve as the lead on reviewing and making recommendations with results from EQRO findings.
- **One Research Data Specialist II** (limited-term) would provide technical analytic support to MCQMD staff, carry out research projects and develop monitoring reports using managed care encounter and provider network data.
- **One Research Data Specialist II** (limited-term) would lead maintenance and development of DHCS' Enterprise Performance Measurement system to expand its oversight specifically to children's preventive services.
- **Contract Resources – EQRO Activities -** $4 million ($2 million General Fund and $2 million federal funds) annually to fund additions to the EQRO contract to expand health disparities report, create a utilization report and analysis, continue and expand encounter data validation reports, expand performance metrics, expand timely access surveys, expand HEDIS auditing, and conduct CAHPS survey every two years.
- **Contract Resources – FSR Process** - $500,000 ($250,000 General Fund and $250,000 federal funds) annually for a contract to automate the facility site review (FSR) process, in which DHCS and plans send nurses to provider offices to gather data by surveying medical records. This contract would allow plans to submit data electronically rather than requiring an on-site visit.
- **Contract Resources – Initial Beneficiary Outreach Campaign -** $4 million ($2 million General Fund and $2 million federal funds) in 2019-20 to conduct an initial mailing and phone campaign by

January 1, 2020. The campaign would include consultation with stakeholders on development of letters and call scrips. Managed care plans would be responsible for calling beneficiaries.

- **Contract Resources – Beneficiary Outreach Campaign** - $10 million ($5 million General Fund and $5 million federal funds) in 2019-20 for a contract with an independent consultant to conduct surveys of beneficiaries, design outreach materials, engage with stakeholders, and create an outreach campaign recommendations report.

Office of Legal Services (OLS)

- OLS requests four-year limited term funding equivalent to **one Attorney IV** position to provide comprehensive legal support and services for improving preventive services to children including reviewing sanction letters, corrective action plans, and sanction appeals. This position would also provide litigation legal support in the event that sanctions are appealed.

Managed Care Operations Division (MCOD)

MCOD requests four-year limited-term funding equivalent to two positions and $500,000 contract funding, as follows:

- **Two Associate Governmental Program Analysts** would assist in reviewing health plan provider directories to ensure accuracy is at least at an 81 percent confidence level. These positions would also work with plans to initiate, develop, and deliver corrective action plans and provide resolution to deficiencies, review and analyze reports and performance data, and make recommendations regarding plan performance.
- **Contract Resources – Provider Directory Tool and Document Storage** - $500,000 ($250,000 General Fund and $250,000 federal funds) in 2019-20 for a contract to automate the oversight process for provider directory accuracy. The contract would also help build a document storage system for plan deliverables.

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 impact does DHCS expect the beneficiary outreach campaign to have on increasing utilization of preventive services by children in Medi-Cal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Alzheimer's Grant Awards & Governor's Task Force on Alz. Prevention & Preparedness

Spring Finance Letter. DPH requests a shift of General Fund expenditure authority of $300,000 from local assistance to state operations in 2019-20. If approved, this shift of resources would support contracts needed to administer the Governor's Task Force on Alzheimer's Prevention and Preparedness and would reduce research grant funding in 2019-20 related to the incidence of Alzheimer's disease among women and communities of color.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund		
State Operations	$300,000	$-
Local Assistance	($300,000)	$-
Total Funding Request:	**$-**	**$-**

Background. In the Governor's January budget, DPH requests two positions and General Fund expenditure authority of $3 million annually to expand research grants in the Alzheimer's Disease Program focused on the prevalence of the disease among women and communities of color. These resources would also support creation and implementation of the Governor's Task Force on Alzheimer's Prevention and Preparedness (previously known as the Governor's Task Force on Brain Health). The task force, chaired by Maria Shriver, will be co-chaired by the Governor, will hold listening sessions in different parts of the state and develop guidelines on brain health that can be shared with partners in the public, private, and non-profit sectors. The task force will also look at the effects of Alzheimer's disease and policies that can point the way for brain-healthy families, workplaces, and communities.

According to the Administration, the task force will need to rely on contract resources to manage and coordinate its activities. The shift in General Fund resources from research purposes on a one-time basis would fund a contractor to provide project management, meeting facilitation, act as an author for task force documents, and provide event management services for listening sessions and other meetings. The Administration indicates the California Health and Human Services Agency's Let's Get Healthy California project relied on similar contract resources for its activities.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 2: Center for Healthcare Quality, Licensing and Certification Program

Budget Issue. The budget includes expenditure authority for the Center for Healthcare Quality of $291.4 million ($3.7 million General Fund, $104.5 million federal funds, and $183.1 million special funds and reimbursements) in 2018-19, an increase of $10.2 million or 3.6 percent compared to the 2018 Budget Act, and $309.6 million ($3.7 million General Fund, $99.3 million federal funds, and $206.5 million special funds and reimbursements) in 2019-20, an increase of $20.1 million or 6.9 percent compared to the revised 2018-19 budget. According to DPH, the increase in 2018-19 is attributable to adjustments for employee compensation, retirement, and federal approval of a Certified Nurse Assistant (CNA) Kickstarter program. For 2019-20, the increase in expenditures is attributed to increased costs for the department's contract with Los Angeles County, implementation of a centralized program flexibility unit, and legislatively mandated hospital licensing timelines and implementation of online and distance learning opportunities for CNA training.

CHCQ Funding Summary, November 2018 Estimate		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$3,700,000	$3,700,000
0890 – Federal Trust Fund	$104,534,000	$99,349,000
0942 – Special Deposit Fund		
Internal Departmental Quality Improvement Account	$2,600,000	$2,600,000
State Health Facilities Citation Penalty Account	$2,144,000	$2,144,000
Federal Health Facilities Citation Penalty Account	$2,166,000	$2,201,000
0995 – Reimbursements	$12,265,000	$12,187,000
3098 – Licensing and Certification Program Fund	$163,942,000	$189,248,000
Total CHCQ Funding	**$291,351,000**	**$311,429,000**
Total CHCQ Positions	**1304.3**	**1346.3**

Background. DPH's Center for Health Care Quality, Licensing and Certification Program (L&C) is responsible for administering the licensure, regulation, inspection, and certification of health care facilities and certain health care professionals in California. The program is organized into 14 district offices and Los Angeles County, which operates under a contract with the L&C program. L&C staff conduct periodic inspections and investigation of complaints and entity-reported incidents to ensure health care facilities comply with state and federal laws and regulations, conducting more than 30,000 complaint and entity-reported incident investigations of long-term care facilities annually. L&C also contracts with the federal Centers for Medicare and Medicaid Services (CMS), which provides federal funding to ensure that facilities accepting Medicare and Medi-Cal payments comply with federal laws and regulatory requirements. In addition to facility oversight, L&C oversees the certification of certified nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

History of Problems with Health Facility Oversight. L&C's regulatory oversight of health care facilities has raised concerns from the federal government, the Legislature, the California State Auditor, stakeholders, and the media for more than ten years. In particular, L&C has demonstrated a consistently poor record of completing investigations of health care facility complaints of abuse and neglect of residents in a timely manner.

California State Auditor (2007) - The L&C program was the subject of a 2007 state audit that found investigations were promptly initiated for only 51 percent of its 15,275 complaints and promptly completed only 39 percent of the time. The audit noted that, despite efforts to increase staffing, the reliance on nurses to conduct complaint investigations resulted in struggles to fill vacant facility evaluation staff positions due to low salaries and a shortage of available nurses.

Federal Office of Inspector General (2011, 2012, 2014) – The L&C program was the subject of three separate reports from the federal Office of Inspector General for the U.S. Department of Health and Human Services. These reports found that L&C was not meeting its federal oversight requirements for health care facilities pursuant to Medicare and Medicaid laws and regulations. In particular, L&C investigators were not properly identifying unmet federal requirements in its surveys and inspections of health care facilities.

California State Auditor (2014) – The L&C program was the subject of a second audit in 2014 that found systemic problems completing health care facility complaint investigations timely that were substantially similar to the problems identified by the Auditor in 2007. The new audit found that, as of April 2014, the L&C program had more than 10,000 open complaints and entity-reported incidents against long-term care facilities and nearly 1,000 open complaints against individuals. Many of these complaints, including those indicating a safety risk to one or more facility residents, had remained open for nearly a year.

Los Angeles County Investigation, Audit (2014) – In 2014, an investigative report published in the *Los Angeles Daily News* discovered the Los Angeles County Department of Public Health was administratively closing health care facility complaints of abuse and neglect that were submitted anonymously without completing an investigation. In response, the county's Board of Supervisors ordered an audit of the county department's Health Facilities Inspection Division (HFID). This review found more than 30 percent of complaint investigations had been open for more than two years, there was no central state or county monitoring of complaint investigation completion or timeliness, and HFID could neither identify the number of staff devoted to investigations nor the number of staff it would need to complete investigations timely.

Hubbert Systems Consulting Assessment and Gap Analysis (2014) – In response to concerns expressed by the Legislature, L&C contracted with Hubbert Systems Consulting to perform an organizational assessment and evaluate areas where L&C was experiencing challenges and barriers contributing to less than optimal performance. Hubbert released its report in 2014 identifying issues with completing state and federal survey and licensing workload, facility and professional complaint investigations, oversight of the Los Angeles County contract, staff vacancy and retention, and other organizational management challenges. The report also provided 21 separate recommendations for remediating these issues including improvements in leadership, performance data monitoring, workforce development and retention, and operational management.

Budget Augmentations, Oversight and Legislative Reporting Mandates. The Legislature has sought to address the ongoing issues with L&C through a variety of budget actions and reporting requirements.

2014 Budget Act – The 2014 Budget Act included trailer bill language requiring L&C to:

- Report metrics quarterly on: (1) investigations of paraprofessional complaints; (2) long-term care health facility complaints, investigations, state relicensing, and federal recertification surveys; and (3) vacancy rates and hiring within L&C.
- Report by October 2016 the above information for all facility types.
- Assess the possibilities of using professional position classifications other than health facility evaluator nurses to perform licensing and certification survey or complaint workload.
- Hold semiannual meetings for all interested stakeholders to provide feedback on improving the L&C program.

2015 Budget Act – The 2015 Budget Act included*:*

- Approval of 237 positions over two years to address the licensing and certification workload.
- $2 million from the Internal Departmental Quality Improvement Account to implement quality improvement projects.
- $14.8 million from the L&C Program Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County.
- $378,000 from the L&C Program Fund and 3 positions to provide on-site oversight and perform workload management, training, and quality improvement activities to improve the efficiency and effectiveness of the Los Angeles County contract licensing and certification activities.
- Trailer bill language to establish timeframes to complete complaint investigations at long-term care facilities, as follows:
  - For immediate jeopardy complaints the department must complete the investigation within 90 days of receipt, with an additional extension of 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
  - For all other categories of complaints received on or after July 1, 2017, the department must complete the investigation within 90 days of receipt, with an additional extension of 90 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
  - For all complaints received on or after July 1, 2018, the department must complete the investigation within 60 days of receipt, with an additional extension of 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
  - Report on an annual basis (in the Licensing and Certification Fee report) data on the department's compliance with these new timelines.
  - Beginning with the 2018-19 Licensing and Certification November Program budget estimate, the department must evaluate the feasibility of reducing investigation timelines based on experience implementing the timeframes described above.

- States the intent of the Legislature that the department continues to seek to reduce long-term care complaint investigation timelines to less than 60 days with a goal of meeting a 45-day timeline.

2016 Budget Act – The 2016 Budget Act included*:*

- $2 million from the Internal Departmental Quality Improvement Account to execute two contracts to redesign the Centralized Applications Unit (CAU) information technology systems, and the Health Facilities Consumer Information System (HFCIS).
- $2.5 million in expenditure authority from the L&C Program Fund to convert 18 existing two-year limited-term positions to permanent positions, and fund two additional positions for the Office of Legal Services, for a total of 20 positions to improve the timeliness of investigations of complaints against caregivers.
- One-time $1 million augmentation to the Long-Term Care Ombudsman Program using funds from the State Health Facilities Citation Account.
- $2.1 million from the L&C Program Fund to augment the Los Angeles County contract to account for two, three percent salary increases effective October 2015 and October 2016, an increase to the employee benefit rate from 55.1 to 57.8 percent, and a decrease in the indirect cost rate from 33.2 to 31.4 percent.

2017 Budget Act – The 2017 Budget Act included*:*

- $2 million from the Internal Departmental Quality Improvement Account for IT assessment, performance dashboards, implementation of tablet use, automation of caregiver applications, outcomes and effectiveness evaluation, quality improvement facilitation, onboarding and retention contract for Health Facilities Evaluator Nurses (HFEN), and contracts to continue the redesign of the CAU and HFCIS.
- $1.1 million to augment the Los Angeles County contract to account for salary increases approved by the Los Angeles County Board of Supervisors.
- Implementation of requirements that free-standing skilled nursing facilities have a minimum number of direct care services hours of 3.5 per patient day, including a minimum of 2.4 hours per patient day for certified nurse assistants, beginning July 1, 2018.

2018 Budget Act – The 2018 Budget Act included*:*

- $2.6 million from the Licensing and Certification Program Fund to fund a one-year extension of the Los Angeles County contract for licensing and certification activities and to account for adjustments to the indirect cost rate, employee benefits rate, personnel costs, and lease costs.
- Budget bill language to authorize DPH to increase funding for the Los Angeles County contract as needed based on actual cost information that becomes available during 2018-19.
- Trailer bill language to authorize a supplemental license fee on facilities located in Los Angeles County to offset additional costs necessary to regulate facilities in the county.
- 22 positions and expenditure authority of $2.7 million ($2.4 million Licensing and Certification Program Fund and $294,000 Internal Departmental Quality Improvement Account) annually to allow DPH to improve core operations and effectiveness, foster quality improvement projects, and address workforce needs, particularly in the licensing of certified nurse assistants.

Vacancy Rates: Center for Health Care Quality and HFEN Classification. According to DPH's Vacancy Reports Metrics Dashboard, the Center for Health Care Quality, which oversees the L&C

Division, had an 8.2 percent vacancy rate for all positions reported as of the fourth quarter of 2017-18, compared to 14.64 percent in the fourth quarter of 2016-17. The vacancy rate for the HFEN classification, the primary classification conducting health facility oversight and investigation, was 4.8 percent in the fourth quarter of 2017-18, compared to 15.2 percent in the fourth quarter of 2016-17. L&C vacancies, particularly in the HFEN classification, have been a persistent concern for the program, the Legislature, and stakeholders, about the program's ability to manage its licensing and certification and complaint and entity-reported incident investigation workload. While publicly available vacancy data is only available through the fourth quarter of 2017-18, DPH reports its current HFEN vacancy rate is 4.2 percent.

DPH indicates its successful reduction in its vacancy rate is due to recent implementation of recruitment and retention strategies. The program hired two contractors to help remedy the high vacancy rates for HFENs in the L&C program: 1) an onboarding and retention contractor assists hiring candidates to navigate the state civil service process and helps improve retention of hired staff, and 2) a recruitment contractor seeks candidates for HFEN positions at job fairs, conducts outreach to registered nurses in California, develops marketing materials and attempts to meet recruitment targets. Funding for these contracts was approved in the 2015 Budget Act from the Internal Departmental Quality Improvement Account. These activities also represent two of the recommendations from the Hubbert assessment.

Persistent Complaint Investigation Backlog. While the program has significantly reduced its position vacancy rate, data released to date on timeliness of complaint and entity-reported incident investigations has not shown a significant impact. Beginning in 2014, L&C has produced quarterly reports on the number, investigation, completion and other details about health care facility complaints and entity-reported incidents. According to the program's Complaints and Entity-Reported Incidents Dashboard, since the first quarter of 2014-15, the number of open complaints has grown from 4,312 to 5,184 in the fourth quarter of 2017-18, while the number of entity-reported incidents has grown from 7,568 to 10,705 during the same period. The backlog of open complaints and entity-reported incidents continues to grow despite the approval of significant staff resources for the division and contract resources for the Los Angeles County contract, although it has remained level or decreased slightly during the four quarters of 2017-18. DPH reports that it is attempting to utilize enhanced data tools, such as dashboards and metrics in its district offices, to better manage its complaint and entity-reported incident investigation workload. DPH also reports it will release metrics for the first and second quarter of 2018-19 shortly, which will provide additional data to determine if the program's attempts to improve its investigation timeliness, including its recent reduction in position vacancy rates, are having a measurable effect.

Stakeholder Proposal to Improve Integrity of Inspections. The California Nurses Association (CNA) requests trailer bill language to allow employees of entities inspected by DPH to have the right to discuss possible regulatory violations or patient safety concerns with an inspector privately during the course of an investigation or inspection by DPH. These provisions are similar to Labor Code sections regarding inspections by the California Division of Occupational Safety and Health (Cal-OSHA).

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 DPH to respond to the following:

1. Please provide a brief overview of the L&C Program, including regulatory responsibilities, organizational structure, funding, and performance.

2. Please provide an update on the L&C Program's vacancy rate, particularly for the HFEN classification.

3. Please provide an update on the most current timeliness metrics for investigation of complaints and entity-reported incidents. In what activities is the program currently engaged to help reduce the persistent backlog of investigations and high average age of open cases?

Issue 3: L&C – Los Angeles County Contract

Budget Issue. DPH requests expenditure authority from the Licensing and Certification Program Fund of $17.2 million in 2019-20, $38.2 million in 2020-21, and $57.3 million annually thereafter. If approved, these resources would allow DPH to implement a new three-year contract with the Los Angeles County Department of Public Health to transition workload related to federal certification, state licensing, and investigation of complaints and reported incidents in facilities located in Los Angeles County effective July 1, 2019.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$17,158,000	$38,219,000
Total Funding Request:	**$17,158,000**	**$38,219,000**

* Additional fiscal year resources requested: 2021-22 and ongoing: $57,326,000

Background. For over 30 years, DPH has contracted with Los Angeles (LA) County to perform federal certification and state licensing surveys and investigate complaints and entity-reported incidents for approximately 2,900 health care facilities in the LA County area. Roughly one third of licensed and certified health care facilities in California are located in LA County, and 20 percent of the long-term care complaints and entity-reported incidents received statewide each year are generated in LA County.

In July 2015, DPH and LA County renewed the contract for a three-year term, ending June 30, 2018, for an annual budget of $41.8 million to fund 224 positions. The 2016 Budget Act authorized an additional $2.1 million in expenditure authority to fully fund LA County to conduct tier 1 and tier 2 federal workload, long-term care complaints and entity-reported incidents, and pending complaints and entity-reported incidents. The 2017 Budget Act approved an additional $1.1 million for general salary increases approved by the LA County Board of Supervisors for employees covered by the LA County contract after the negotiation of the contract renewal.

The department's contract with LA County has long been the subject of increased scrutiny due to its performance on regulatory oversight of health care facilities, including timeliness and management of complaint investigations. As a result, the terms of the contract renewal included several metrics and deliverables the county would be required to meet. DPH and LA County both report that the county is meeting the deliverables contained in the contract. However, DPH is continuing its monitoring activities to ensure effectiveness and efficiencies of the licensing and certification activities in LA County.

The 2018 Budget Act included resources to allow DPH to extend the LA County contract for an additional year until June 30, 2019. The Legislature also approved trailer bill language to assess a supplemental license fee on facilities located in LA County to offset additional costs necessary to regulate entities in the county. The supplemental fee is intended to prevent the need to increase license fees on health care facilities statewide to absorb increasing contract costs and to allow health care facilities in LA County to receive services comparable to other health care facilities statewide.

The department and LA County are completing negotiations on the terms of a new three-year contract beginning July 1, 2019, that emphasizes pay for performance with defined quality, quantity, and service metrics. According to DPH, the new contract reflects a gradual increase for LA County workload and

resources to hire necessary staff over three years to complete 100 percent of the mandated workload, including its existing tier 1 and tier 2 federal workload, complaint and incident investigations, as well as new tier 3 and tier 4 federal workload, state licensure activities, and responsibility for all complaints and entity-reported incidents in the county. DPH has expenditure authority for the existing contract of $48.4 million. According to DPH, the new contract would require an additional $17.2 million in 2019-20, $38.2 million in 2020-21, and $57.3 million annually thereafter. Once fully phased in, the LA County contract would result in annual expenditures of $105.6 million beginning in 2021-22 and would be sufficient for LA County to hire an additional 172 health facility evaluator nurse (HFEN) positions and associated support and supervisory staff, for a total of 491 staff including 317 HFENs.

New Contract Includes Performance Metrics, Penalties and Additional Oversight Tools. According to DPH, while final details are still being negotiated, the department and LA County have agreed the contract would include financial penalties in the event the county does not achieve defined quantity metrics. These quantity metrics would likely include the percent of complaints and licensing and certification surveys completed within required timeframes.

The contract would also require LA County to provide and implement a corrective action plan if the county does not meet quality or customer service metrics. These metrics would likely include regular State Observation Survey Analysis (SOSA) surveys for skilled nursing facilities and intermediate care facilities, yearly review of closed complaints and entity-recorded files, average rating of 75 percent or higher on Provider Evaluation Surveys, timely scheduling and completion of initial and final letter to complainants, and timely scheduling and completion of informal conferences and dispute resolutions.

The contract would also include provisional language to allow for a reduction of the budget in 2021-22 if the actual workload of the county does not align with the workload projections upon which the third-year budget is based. DPH also intends to increase the supplemental license fee in LA County to account for the expanded costs of the new contract.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. How would the department manage budgetary changes related to using the proposed contract provisional language to reduce the LA County budget in 2021-22 if actual workload is below projections? Would budgetary provisional language be necessary?

3. If LA County were assessed a financial penalty under the new contract for failure to meet quantity metrics, where would the financial penalty revenue be deposited and for what purpose would it be used?

Issue 4: L&C – Creation of a Centralized Program Flex Unit

Budget Issue. DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $973,000 annually. If approved, these positions and resources would allow DPH to shift health facility program flexibility application workload from district offices to a new centralized headquarters unit.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$973,000	$973,000
Total Funding Request:	**$973,000**	**$973,000**
Total Positions Requested:	**6.0**	**6.0**

* Positions and resources ongoing after 2020-21.

Background. Health and Safety Code section 1276 requires DPH to grant facilities certain flexibility from regulatory requirements by using alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting pilot projects as long as the facility meets statutory requirements and the program flexibility is approved by DPH with specified terms and conditions. Applications for program flexibility must include justification for the request and adequate supporting documentation that the alternative does not compromise patient care. DPH is required to approve, approve with conditions or modifications, or deny the application within 60 days.

According to DPH, each of the thirteen district offices of the Licensing and Certification Division reviews program flexibility requests submitted by facilities in their areas of oversight. Between 2013-14 and 2017-18 facilities submitted more than 1,600 program flexibility requests. DPH indicates the 60 day review timeline is not being met consistently, with only 50 percent completed on time in 2017-18. Because each district office handles program flexibility requests differently, there is no consistency in review and approval.

DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $973,000 annually to shift health facility program flexibility application workload from district offices to a new centralized headquarters unit. According to DPH, the new unit would provide program-wide efficiency and consistency, promote development of subject matter expertise and promote consistency in evaluation of the requests. Centralizing these functions would also allow for analysis of data, identification of trends, and more informed decisions on the need for future policy or regulatory changes. The requested resources would support the following positions within the new unit:

- **One Health Program Manager II** would oversee the centralized program flexibility unit, supervise the unit's multidisciplinary team, consult with subject matter experts and state and federal staff to assess and evaluate alternative methods of compliance with licensing and certification requirements, monitor trends in requests to assess and make recommendations on the need for policy or regulatory changes, and perform personnel and administrative responsibilities.
- **Three Nurse Consultant II** positions would evaluate program flexibility requests and supporting documentation, assess alternatives proposed by facilities, research clinical standards of practice applicable to various care settings for consideration of program flexibility applications, and evaluate whether proposed alternative meet relevant regulatory requirements and program standards.

- **One Associate Governmental Program Analyst** would review program flexibility applications, prepare monthly summary reports, maintain electronic logs of all aspects of work for tracking purposes, and prepare outcome letters for facilities.
- **One Office Technician** would process program flexibility applications, update electronic databases with request information, and process mail.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 5: L&C – Increased IT Customer Support

Budget Issue. DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $911,000 annually. If approved, these positions and resources would allow DPH to increase information technology services associated with a new federally required health facility survey automation system.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$911,000	$911,000
Total Funding Request:	**$911,000**	**$911,000**
Total Positions Requested:	**6.0**	**6.0**

* Positions and resources ongoing after 2020-21.

Background. The federal Centers for Medicare and Medicaid Services (CMS) approved a new Long Term Care Survey Process (LTCSP), a resident-centered, outcome-oriented inspection that supports identification of quality of care and quality of life problems in health facilities. The LTCSP was intended to combine two existing survey processes into one efficient and comprehensive survey that includes various existing requirements and new requirements contained in long-term care reform regulations. According to DPH, CMS requires use of a single, software-based nationwide survey process and requires surveyors to complete in-depth on-site surveys and share information in the field. CMS implemented LTCSP for skilled nursing facilities in November 2017 and expects to add one to two facility types annually over the next several years to the new process.

DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $911,000 annually to increase information technology services associated with implementation and transitioning staff to the new LTCSP. DPH reports its Information Technology Services Division has experienced an increase in information technology (IT) support tickets and slower response times for resolving those support tickets. The division is responsible for addressing software and hardware issues for 800 surveyors and 2,000 total users. The requested resources will support two teams, as follows:

- **Three Information Technology Specialist I** positions would focus on resolving IT support tickets within three days, serve as subject matter experts and provide problem resolution, respond to phone calls and other communications, and monitor helpdesk ticket requests.
- **Three Information Technology Specialist I** positions would support surveyors with updating technologies, setting up workstations, and completing configuration and desktop support.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: L&C – Timelines for Hospital Licensing Applications (AB 2798)

Budget Issue and Trailer Bill Language. DPH requests 21 positions and expenditure authority from the Licensing and Certification Program Fund of $3.4 million annually. If approved, these positions and resources would allow DPH to comply with new health facility licensing application processing timelines, pursuant to the requirements of AB 2798 (Maienschein), Chapter 922, Statutes of 2018. DPH also requests trailer bill language to amend a provision of AB 2798 to allow the Licensing and Certification Program Fund to support the required workload.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$3,386,000	$3,386,000
Total Funding Request:	**$3,386,000**	**$3,386,000**
Total Positions Requested:	**21.0**	**21.0**

* Positions and resources ongoing after 2020-21.

Background. The Centralized Applications Branch (CAB) in the Licensing and Certification (L&C) Division processes health care facility applications including initial facility licensure, changes to existing licensure, and licensure renewals. This workload was previously distributed to the L&C Division's district offices, but was centralized at the state level in 2015-16 to provide a standardized application process and create consistent application processing timelines. CAB is responsible for licensing of the following facility types:

Acute Psychiatric Hospitals	District Hospitals (<100 beds)	ICF-DD Nursing
Adult Day Health Centers	General Acute Care Hospitals	Pediatric Day Health and Respite Care Facility
Alternative Birthing Centers	Home Health Agencies	Psychology Clinics
Chemical Dependency Recovery Hospitals	Hospices	Referral Agencies
Chronic Dialysis Clinics	Hospice Facilities	Rehabilitation Clinics
Primary Care Clinics – Community Clinics/Free Clinics	Intermediate Care Facilities (ICF)	Skilled Nursing Facilities
Congregate Living Health Facilities	ICF/Developmentally Disabled (ICF-DD)	Special Hospitals
Correctional Treatment Centers	ICF-DD Habilitative	Surgical Clinics

According to DPH, CAB processes licensing applications in the order in which they are received. The most recent data released by DPH on processing timeliness indicates a median age of open applications of 211 days as of the last quarter of 2017-18. The median age is down somewhat from the 221 days in the third quarter of 2017-18, but higher than the 130 day median age of open applications for the entire

2016-17 fiscal year. DPH indicates CAB has increased staffing from 25 to 95 staff members and implemented new training and procedures to reduce application backlogs.

AB 2798 Mandates Expedited Review of Certain Hospital Licensure Applications. AB 2798 requires DPH to evaluate and approve or deny an application from a general acute care hospital or an acute psychiatric hospital within 100 days of receipt. Upon approval, DPH is also required to complete any additional review of the application within 30 days. In addition, DPH is required to review and approve applications for expansions of existing services in general acute care hospitals or acute psychiatric hospitals within 30 days of receipt. If DPH does not complete its review within 30 days, the application is automatically approved. In addition to the accelerated processing timelines for these facility applications, AB 2798 requires the department to develop an automated application system on or before December 31, 2019, and establish an advice program to assist applicants to complete their applications.

DPH requests 21 positions and expenditure authority from the Licensing and Certification Program Fund of $3.4 million annually to comply with the new general acute care hospital and acute psychiatric hospital licensing application processing timelines required by AB 2798. These resources would fund the following staff:

- **Three Associate Governmental Program Analysts** would review incoming applications for completeness and accuracy, notify applicants of missing documentation, monitor survey reports, assist in the development of the automated application system, and assist in the establishment of an advice program to assist applicants to complete their applications.
- **14 Health Facilities Evaluation Nurses**, as well as $199,000 to support the equivalent of two nurses in the Los Angeles County contract, would survey hospitals to assess compliance with regulations, prepare written analyses of findings, and provide technical assistance to facility administrators.
- **Four Associate Governmental Program Analysts** would perform licensing functions, monitor compliance with processing timelines, and perform survey workload.

DPH also requests trailer bill language to authorize expenditures from the Licensing and Certification Program Fund to support the new licensing application processing timelines. A provision of AB 2798 required resources to support implementation to be appropriated from the Internal Departmental Quality Improvement Account. Because this account typically funds time-limited quality improvement projects, DPH believes implementation of the provisions of AB 2798 would be more appropriately funded from the Licensing and Certification Program Fund on an annual basis. The proposed trailer bill language deletes the specific funding requirements included in AB 2798.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 7: L&C – Online and Distance-Learning Nurse Assistant Training Programs (AB 2850)

Budget Issue. DPH requests nine positions and expenditure authority from the Licensing and Certification Program Fund of $1.2 million annually. If approved, these positions and resources would allow DPH to review, approve, and monitor applications from new online and distance learning nurse assistant training programs and instructors, pursuant to the provisions of AB 2850 (Rubio), Chapter 769, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$1,243,000	$1,243,000
Total Funding Request:	**$1,243,000**	**$1,243,000**
Total Positions Requested:	**9.0**	**9.0**

* Positions and resources ongoing after 2020-21.

Background. Certified nurse assistants (CNAs) provide basic patient care services directed at the safety, comfort, personal hygiene, and protection of patients under the supervision of a registered nurse or licensed vocational nurse. The Professional Certification Branch (PCB) within the Licensing and Certification Division at DPH is responsible for the certification of CNAs. To become a CNA, an individual must be 16 years of age or older, complete a background check, complete an approved nurse assistant training program (NATP) consisting of 60 hours of classroom training, and pass the required examination.

In addition to issuing CNA certification, PCB is also responsible for review and approval of proposed NATP curriculum prior to operation to verify inclusion of all required components and consistency with relevant laws and regulations. PCB enforcement includes monitoring classes, assessing enrollment, and evaluating examination pass rates. Facilities must maintain a 60 percent pass rate to maintain approval.

2017 Budget Act Increased Minimum Staffing Ratios for CNAs in Skilled Nursing Facilities. The 2017 Budget Act included trailer bill language to require free-standing skilled nursing facilities (SNFs) to have a minimum number of direct care services hours of 3.5 per patient day, including a minimum of 2.4 hours per patient day for CNAs, beginning July 1, 2018. In addition to the new direct care service hour requirements, the trailer bill language required DPH to develop a waiver process for SNFs seeking a waiver of the 3.5 overall direct care service hour requirement and/or the 2.4 CNA requirement due to a workforce shortage. The workforce shortage waivers were developed to provide flexibility to SNFs if insufficient staff are available to fulfill the direct care service hour requirements. Waivers require SNFs to provide evidence of efforts to address the workforce shortage and a detailed plan for maintaining high quality resident care despite the shortage. Waivers may be renewed annually, but no facility may receive more than two consecutive renewals. According to DPH, 117 facilities were granted workforce waivers for the required minimum 2.4 direct care service hours for CNAs. As a result of the need for a more robust CNA workforce, DPH has engaged in several initiatives to increase opportunities to train and be certified as a CNA.

AB 2850 Allows Online or Distance-Learning for Classroom Component of CNA Training. AB 2850 allows SNFs or other health facilities, educational institutions, or local agencies to conduct the 60 hours of classroom training required to be certified as a CNA in an online or distance learning course

format. The program may be provided by a registered nurse or licensed vocational nurse with at least two years of nursing experience, one year of which must be providing care and services to chronically ill or elderly patients in an acute care hospital, SNF, or other health facility. The online or distance learning programs must comply with specific requirements including: 1) online instruction in real-time with instructors and trainees, 2) use of personal identification methods to confirm identities of instructors and trainees, 3) protection of personal information, 4) policies and procedures to insure instructor accessibility outside of normal instruction times, 5) policies and procedures for equipment failures, student absences, and completing assignments past original deadlines, 6) provide clear explanation of all technology requirements to complete the program, and 7) provide DPH statistics about performance of trainees in the program.

DPH requests nine positions and expenditure authority from the Licensing and Certification Program Fund of $1.2 million annually to review, approve, and monitor applications from new online and distance learning nurse assistant training programs and instructors, pursuant to the provisions of AB 2850. Eight positions would comprise a new Nurse Assistance Training Program Unit within the Aide and Technician Certification Section in PCB. The unit would include the following positions:

- **One Health Facilities Evaluator Manager I** position would oversee the program including supervising and coordinating staff activities to provide oversight and monitoring of program and instructor applications.
- **Three Health Facilities Evaluator Nurses** would review clinical training components of online training programs, conduct complaint investigations for programs, develop and maintain standards for course and quality control reviews, and consult with and provide technical assistance to entities offering programs.
- **Three Associate Governmental Program Analysts** would review initial program and entity applications for accuracy and completeness, correspond with applicants to correct application deficiencies, assist with training and outreach to applicants and entities, and develop reporting and other communications related to the program.
- **One Program Technician II** position would provide clerical support and perform general office tasks.

One Information Technology Specialist I position in the Information Technology Services Division would serve as the subject matter expert for online CNA training program compliance, provide oversight and enforcement of training course requirements, provide technical assistance and other guidance to DPH staff to support compliance monitoring, and participate in joint application development sessions.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 8: L&C – Soliciting and Implementation of Projects to Benefit Nursing Home Residents

Spring Finance Letter and Budget Bill Language. DPH requests one position and expenditure authority from the Federal Health Facilities Citation Penalties Account of $680,000 in 2019-20, $431,000 in 2020-21, and $149,000 annually thereafter. If approved, this position and resources would allow DPH to implement a federally approved Nurse Leadership project and solicit future projects to benefit skilled nursing facility residents. In addition, DPH requests budget bill language to augment expenditure authority from the Federal Health Facilities Citation Penalties Account upon federal approval of project planning funded by the account and after legislative notification.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0942 – Special Deposit Fund**	$680,000	$431,000
Total Funding Request:	**$680,000**	**$431,000**
Total Positions Requested:	**1.0**	**1.0**

* Additional fiscal year resources requested: 2021-22 and ongoing: $149,000.
** Special Deposit Fund - Federal Health Facilities Citation Penalties Account

Background. DPH's Licensing and Certification (L&C) Division regulates more than 10,000 health care facilities in California for compliance with state and federal laws and regulations. For violations of federal laws and regulations, the federal Centers for Medicare and Medicaid Services (CMS) may impose monetary penalties against skilled nursing facilities and other facilities based on the number of days or for each instance of non-compliance. These penalties are returned by CMS to the state and may be reinvested to support CMS-approved activities that benefit nursing home residents that protect or improve their quality of life.

In California, federal penalties are deposited in the state's Federal Health Facilities Citation Penalties Account, a Special Deposit Fund. According to DPH, states must submit an annual plan for use of penalty funds including fund balances, current obligations, and plans for solicitation and review of future projects. Previous projects funded by federal penalty revenue include the following:

1. 2013-14 – Three-year project to reduce antipsychotic medication in skilled nursing facilities, in collaboration with the California Culture Change Coalition.
2. 2015-16 – Three-year project for a Music and Memory program to improve dementia care, in collaboration with the California Association of Health Facilities (CAHF).
3. 2017-18 – Four-year project to improve dietary services in skilled nursing facilities, in collaboration with CAHF.
4. 2018-19 – Three-year project for a Volunteer Engagement Project, in collaboration with CAHF.
5. 2018-19 – Two-year project for the Certified Nursing Assistant Training Kickstarter Project, in collaboration with the Quality Care Health Foundation.

DPH requests one position and expenditure authority from the Federal Health Facilities Citation Penalties Account of $680,000 in 2019-20, $431,000 in 2020-21, and $149,000 annually thereafter. DPH reports CMS has approved a grant funded by federal citation penalties for a Nurse Leadership Project, which would concentrate on development of nurse leaders, focusing on leadership abilities, effective communication, managing expectations, accountability, delegation, and mentorship. The goal

of the project would be to reduce turnover rates of direct care staff to improve resident care and satisfaction. The project is approved for $1.7 million of funding for three years ($567,000 in 2019-20, $579,000 in 2020-21, and $592,000 in 2021-22). DPH indicates a portion of the funding is available under its existing expenditure authority for the account, but will need additional expenditure authority of $531,000 in 2019-20 and $282,000 in 2020-21 to implement the project.

The request also includes establishment of **one Staff Services Manager I** position to solicit and monitor implementation of projects to benefit skilled nursing facility residents using federal citation penalty funds. This position would monitor expenditures under the federally approved plan for citation penalty expenditures, solicit new projects at quarterly conference meetings and in All Facilities Letters, and review and evaluate project applications.

Provisional Language to Augment Expenditure Authority Upon Federal Approval. DPH also requests budget bill language to augment expenditure authority from the Federal Health Facilities Citation Penalties Account upon federal approval of project planning funded by the account and after legislative notification. According to DPH, CMS recently released guidance requesting states to obtain sufficient expenditure authority to timely and efficiently expend federal penalty funds. Without sufficient expenditure authority, projects may be delayed by up to one year and such delays may discourage entities from submitting project applications. The requested budget bill language is as follows:

Item 4265-115-0942

1. The Department of Finance may augment this item, after review of a request submitted by the State Department of Public Health reflecting federal approval to use this account. Any augmentation shall be authorized not sooner than 30 days after notification in writing to the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may determine.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 9: Center for Infectious Diseases

Background. DPH's Center for Infectious Diseases (CID) protects the people in California from the threat of preventable infectious diseases and assists those living with an infectious disease in securing prompt and appropriate access to healthcare, medications and associated support services. CID is composed of four primary entities: the Division of Communicable Disease Control, the Office of AIDS, the Office of Binational Border Health, and the Office of Refugee Health.

Division of Communicable Disease Control. The Division of Communicable Disease Control (DCDC) within DPH works to promptly identify, prevent and control infectious diseases that pose a threat to public health, including emerging and re-emerging infectious diseases, vaccine-preventable agents, bacterial toxins, bioterrorism, and pandemics. DCDC coordinates with local health departments, health care providers, and local public laboratories to perform these functions. The division's Infectious Disease Branch provides consultation and assistance to local public health, environmental health, and vector control agencies in the control and prevention of communicable diseases and outbreaks; collection, coordination, and analyses of surveillance data of over 50 infectious diseases; investigations of local, regional, statewide, or multistate outbreaks; information on infectious diseases to the DPH, local health jurisdictions, the medical community, and the public through emails, press releases, postings of pamphlets and fact sheets on the department's website, and publications in medical journals; and recommendations, guidelines, policies, and regulations on communicable disease prevention and control. DPH also oversees and coordinates with local, state, and federal public health laboratories. State public health laboratories confirm the presence of disease, respond to emergencies, detect outbreaks, and provide situational awareness.

DPH also maintains the California Reportable Disease Information Exchange (CalREDIE), a secure system for electronic disease reporting and surveillance. Specified diseases and conditions are mandated by state law and regulation to be reported by healthcare providers and laboratories to the public health authorities. CalREDIE improves the efficiency of surveillance activities and the early detection of public health events through the collection of complete and timely surveillance information on a state wide basis. Local health departments and DPH have access to disease and laboratory reports in near real-time for disease surveillance, public health investigation, and case management activities. The CalREDIE system is widely utilized by local health departments and healthcare providers in California and over 350 laboratories electronically submit reportable lab results through the CalREDIE Electronic Laboratory Reporting (ELR).

Recent Outbreak of Hepatitis A. In November 2016, an outbreak of Hepatitis A began in San Diego County and subsequently spread to Santa Cruz, Los Angeles, and Monterey counties. According to DPH, the majority of people infected with hepatitis A virus in this outbreak were people experiencing homelessness and/or using illicit drugs in settings of limited sanitation. During the outbreak, DPH helped to support the local health department response in the following ways: 1) coordinating and supporting hepatitis A outbreak response efforts across California; 2) monitoring the outbreak and providing epidemiologic support to the response by enhancing monitoring of cases, testing specimens to identify the outbreak strain, and providing staff and technical expertise, including developing and disseminating disease control, clinical, and vaccine prioritization guidance; 3) buying, distributing, and monitoring about 123,000 hepatitis A vaccine doses to local health departments during this outbreak;

and 4) communicating accurate information about the outbreak, control measures, and level of risk of hepatitis A infection for different populations with partners, the media, and the public.

According to DPH, after review of the availability of Hepatitis A vaccine, the Governor issued a declaration of a state of emergency to secure and purchase additional vaccine. The Administration provided an augmentation from emergency appropriation authority provided in the state budget to account for the purchase of the additional vaccine. Following intensive efforts by local health departments and their clinical and community partners, including vaccination campaigns targeting the at-risk population, education, obtaining and managing vaccine, and many other interventions, the number of reported outbreak-associated cases has substantially decreased in California.

Office of AIDS. DPH's Office of AIDS (OA) has lead responsibility for coordinating state programs, services, and activities relating to HIV/AIDS. OA's mission is to: 1) assess, prevent, and interrupt the transmission of HIV and provide for the needs of infected Californians by identifying the scope and extent of HIV infection and the needs which it creates, and by disseminating timely and complete information; 2) assure high-quality preventive, early intervention, and care services that are appropriate, accessible, and cost effective; 3) promote the effective use of available resources through research, planning, coordination, and evaluation; and 4) provide leadership through a collaborative process of policy and program development, implementation and evaluation.

OA oversees four primary program branches:

1) The Surveillance, Research & Evaluation Branch conducts a variety of epidemiologic studies, evaluates the efficiency and effectiveness of publicly funded HIV/AIDS prevention and care programs, and maintains California's HIV/AIDS Case Registry.
2) The HIV Care Branch has responsibility for programs related to the delivery of care, treatment, and support services for people living with HIV/AIDS. Programs are designed to provide an effective and comprehensive continuum of care to underserved individuals.
3) The HIV Prevention Branch funds initiatives to assist local health departments and other HIV service providers to implement effective HIV detection and prevention programs.
4) The AIDS Drug Assistance Program (ADAP) helps ensure that people living with HIV and AIDS who are uninsured and under-insured have access to medication. OA works closely with the pharmacy benefits manager (PBM), to administer and manage ADAP for the clients served.

Office of Binational Border Health. The mission of the Office of Binational Border Health (OBBH) is to facilitate communication, coordination, and collaboration among California and Mexico health officials, health professionals, and communities in order to optimize binational and border health. The OBBH also publishes the Annual Border Health Status Report to the Legislature to provide a general overview of the health status of border communities in the California-Mexico border region.

Established in 1983, the La Paz Agreement defined a binationally agreed upon border region, the area within 62 miles (100 km) on either side of the border, an area that encompasses approximately 250,000 square miles. Of the 1,952-mile boundary between the United States and Mexico, California's border region spans 140 miles, including San Diego and Imperial Counties, the state's southernmost counties. This area is remarkable because of its assorted geography, highly mobile, culturally and linguistically diverse population.

Recognizing the distinctiveness of the border region, AB 63 (Ducheny) Chapter 765, Statutes of 1999, established a permanent Office of Binational Border Health within the California Department of Public Health "to facilitate cooperation between health officials and health professionals in California and Mexico, to reduce the risk of disease in the California border region and in those areas directly affected by border health conditions". The Office of Binational Border Health began operating in January 2000.

Office of Refugee Health. The Federal Refugee Act of 1980 created the Office of Refugee Resettlement (ORR) to fund and coordinate post-arrival health assessments, time-limited medical services and cash assistance, and other benefits to newly arrived refugees, asylees, and other eligible entrants to help them achieve economic self-sufficiency as quickly as possible after their arrival to the United States. In California, the Office of Refugee Health (ORH) coordinates the following programs supported with ORR funds:

Refugee Health Assessment Program (RHAP) - Impacted local health jurisdictions provide culturally and linguistically-appropriate comprehensive health assessments to newly arrived refugees, asylees, federally-certified victims of severe forms of trafficking, and other eligible entrants. The RHAP focuses on screening of and prevention of communicable diseases; early identification and diagnosis of chronic diseases and other important conditions; assessment of immunization status for children and adults; mental health screening; and referral to health providers for further medical evaluation, treatment, and follow-up.

Refugee Medical Assistance Program (RMA) – In coordination with the Department of Health Care Services, Medi-Cal Eligibility Division, the ORH provides time-limited RMA-based Medi-Cal benefits to refugees, asylees, federally-certified victims of human trafficking, and other entrants who are not eligible to receive Medi-Cal benefits. This benefit is available only for the first eight months from the date admitted to the U.S. or from the date of certification.

Stakeholder Proposals in the Center for Infectious Diseases. Stakeholders have proposed the following investments in programs overseen by CID.

Communicable Disease Infrastructure for Local Health Departments – The County Health Executives Association of California (CHEAC) and the Health Officers Association of California (HOAC) request annual General Fund expenditure authority of $50 million to improve infrastructure to prevent and control the spread of infectious disease in California using strategies that best meet the needs of local jurisdictions. Examples of these strategies include disease surveillance, contact tracing, staff development and training, education and outreach to the general public and health care providers, clinical services, and laboratory testing. According to CHEAC and HOAC, local health departments do not have adequate funding to fulfill their unique mandate to prevent and control infectious diseases within their jurisdictions. State and federal funding for communicable disease control activities have considerably declined over time and are primarily siloed based on disease. This has led to significant challenges in addressing the rising rates of ever-present diseases such as sexually transmitted diseases and tuberculosis, and addressing outbreaks experienced in California such as Hepatitis A, influenza, Zika and measles, posing a health and safety risk to residents throughout the state.

According to statistics from DPH:

1) Nearly 360,000 cases of communicable diseases were reported in 2016
2) In 2016, an estimated 5.8 million cases of foodborne illness occurred in California, leading to nearly 400 deaths
3) An estimated 1.1 million to 4.3 million cases of influenza occurred in 2016, leading to an estimated 1,400 to 6,800 deaths
4) California has experienced a 45 percent increase in chlamydia, gonorrhea and early syphilis since 2012
5) Early syphilis has increased by 600 percent since 2012, 283 children were born with syphilis, and 30 stillbirths occurred due to syphilis
6) The 2017 Hepatitis A outbreak resulted in 704 cases, 461 hospitalizations, and 21 deaths

Communicable disease risks are further exacerbated by key issues facing Californians, such as the alarming number of Californians living in unsanitary or congregate settings due to homelessness or natural disasters.

Funding for California Immunization Registry – The California Immunization Coalition requests expenditure authority of $2.4 million annually to provide full funding for the California Immunization Registry (CAIR). According to the Coalition, state funding for CAIR was eliminated during budget reductions in 2010. Since then, the program has been primarily federally funded and subject to the uncertain availability of those funds. Full funding of the program would require approximately $7.4 million per year, $1.1 million more than its current funding level of $6 million. In addition, the program would need $1.3 million annually for system enhancements and software upgrades to modernize and integrate the registry.

End the Epidemics: Funding to Prevent HIV, Hepatitis C, and STDs – A coalition of 20 organizations including the California HIV Alliance, Essential Access Health, and the California Hepatitis Alliance request a total General Fund expenditure authority of $62 million to fund efforts to end the epidemics of HIV, Hepatitis C and sexually transmitted diseases (STDs) in California. The specific requests are as follows:

- Comprehensive HIV Prevention Services - $20 million would provide grants to local health jurisdictions and community-based organizations for outreach and education, HIV testing, linkage to care, increased access to PrEP, and services for people who use drugs.
- Hepatitis C Prevention, Testing, and Linkage to Care - $20 million would fund two Hepatitis C microelimination projects. $15 million would fund the first project to focus on Hepatitis C in people who use drugs, supporting 25 to 30 programs to serve over 166,000 Californians with evidence-based Hepatitis C outreach, screening, and linkage to and retention in care services. $5 million would fund the second project to focus on Hepatitis C in people coinfected with HIV.
- STD Prevention, Testing, and Treatment Services - $20 million would support a comprehensive, evidence-informed approach to STD prevention. The funding would provide STD screening, testing, and treatment, conduct surveillance activities to trach and share data, support culturally appropriate and responsive outreach and health promotion efforts, and implement innovative community-based projects to effectively reduce local STD rates.

- End the Epidemics Task Force - $2 million would fund an End the Epidemics Task Force to develop a statewide strategy to address HIV, Hepatitis C, and STDs, set targets for ending the epidemics, and identify recommended programs, policies, strategies, and funding for achieving these targets.

Treatment Navigators in Harm Reduction Programs – The Drug Policy Alliance requests one-time General Fund expenditure authority of $15.2 million for grants to harm reduction programs, including syringe access programs, to add staff to reach people who use drugs who are not in treatment and assist them with linkage to health care services, increasing the number of people who are able to benefit from medication assisted treatment such as methadone and buprenorphine. These funds would be available over four years and the programs would be required to report on how many people were linked to and enrolled into treatment and how many acquired health insurance to provide them with improved on-going health care access.

HIV Prevention Clearinghouse and Syringe Access Program Amendments – The Drug Policy Alliance requests annual General Fund expenditure authority of $3 million to the OA Clearinghouse to provide materials, such as sterile syringes, sharps containers, and fentanyl test strips, to authorized syringe exchange programs statewide for distribution to high-risk drug users. According to the Drug Policy Alliance, due to the increased number of programs and the increased number of clients per program, the current annual allocation of $3 million is no longer adequate. Drug Policy Alliance also requests trailer bill language updating requirements for the syringe access program.

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 DPH and the invited panelists to respond to the following:

1. Please provide an overview of the programs and activities of the department's Center for Infectious Diseases.

Issue 10: AIDS Drug Assistance Program (ADAP)

Background. The Office of AIDS within DPH administers the AIDS Drug Assistance Program (ADAP), which provides access to life-saving medications for Californians living with HIV and assistance with costs related to HIV pre-exposure prophylaxis (PrEP) for Californians at risk for acquiring HIV. Clients are eligible for ADAP services if they meet the following criteria:

1. are HIV infected;
2. are a resident of California;
3. are 18 years of age or older;
4. have a Modified Adjusted Gross Income that does not exceed 500 percent of the Federal Poverty Level; and
5. are not fully covered by or eligible for Medi-Cal or any other third-party payer.

ADAP Programs. ADAP provides services to its clients through support for medications, health insurance premiums and out-of-pocket costs. Clients participate in three main programs:

1. Medication Program – This program pays prescription costs for medications on the ADAP formulary for the following coverage groups (either the full cost of medications or deductibles and co-pays):
   a. *ADAP-only clients* – These clients are people living with HIV who are uninsured. ADAP pays 100 percent of the cost of prescription medications on the ADAP formulary
   b. *Medi-Cal Share of Cost clients* – These clients are people living with HIV enrolled in Medi-Cal, but who have a share of cost. ADAP pays 100 percent of the cost of prescription medications on the ADAP formulary up to the client's Medi-Cal share of cost amount
   c. *Private insurance clients* – These clients are people living with HIV enrolled in private health insurance. ADAP pays prescription drug deductibles and co-pays for these clients
   d. *Medicare Part D clients* – These clients are people living with HIV enrolled in Medicare and who have purchased Medicare Part D. ADAP pays the Medicare Part D drug deductibles and copays for these clients
2. Office of AIDS-Health Insurance Premium Payment (OA-HIPP) Program – This program pays for private health insurance premiums or Medicare Part D premiums for clients co-enrolled in the ADAP medication program. ADAP pays health insurance premiums for eligible clients with one of three different types of health insurance:
   a. *Non-Covered California private insurance* (OA-HIPP/non-Covered California)
   b. *Private insurance through Covered California* (OA-HIPP/Covered California)
   c. *Medicare Part D* (OA/Medicare Part D)
3. Pre-Exposure Prophylaxis (PrEP) Assistance Program – This program, which is scheduled to begin in early 2018, covers medication costs and out-of-pocket costs for PrEP for individuals at risk for, but not infected with HIV. PrEP is a daily medication taken by HIV-negative individuals that significantly reduces the risk of HIV infection.

ADAP is funded by federal funds and the ADAP Rebate Fund (Fund 3080). The federal government began funding state programs to assist people living with HIV to purchase antiretroviral medications in 1987. Since 1990 with the passage of the Ryan White Comprehensive AIDS Resources Emergency Act,

now known as the Ryan White Program, the federal Health Resources and Services Administration (HRSA) provides funding to states for ADAP programs. In addition to federal funds, ADAP receives significant funding from mandatory and voluntary manufacturer rebates for ADAP drug expenditures.

ADAP Local Assistance Estimate. The November 2018 ADAP Local Assistance Estimate reflects revised 2018-19 expenditures of $407.9 million, which is a decrease of $26.2 million or six percent compared to the 2018 Budget Act. According to DPH, this decrease is primarily due to reduction in expenditures for medication-only clients due to transitions to private insurance or Medi-Cal. For 2019-20, DPH estimates ADAP expenditures of $449.8 million, an increase of $41.9 million or 10.3 percent compared to revised expenditures for 2018-19. According to DPH, this increase is primarily due to an increase in medication expenditures per client, an increase in insurance premium expenditures for private insurance clients, and overall caseload growth.

ADAP Local Assistance Funding Summary		
Fund Source	**2018-19**	**2019-20**
0890 – Federal Trust Fund	$129,143,000	$135,138,000
3080 – AIDS Drug Assistance Program Rebate Fund	$278,735,000	$314,650,000
Total ADAP Local Assistance Funding	**$407,878,000**	**$449,789,000**

ADAP tracks caseload and expenditures by client group. DPH estimates ADAP caseload and expenditures for 2018-19 and 2019-20 will be as follows:

Caseload by Client Group	**2018-19**	**2019-20**
Medication-Only	12,882	12,653
Medi-Cal Share of Cost	134	134
Private Insurance	9,807	10,752
Medicare Part D	7,712	7,712
PrEP Assistance Program	1,007	2,207

Expenditures by Client Group	**2018-19**	**2019-20**
Medication-Only	$308,019,032	$321,101,989
Medi-Cal Share of Cost	$1,093,904	$1,276,211
Private Insurance	$62,184,844	$83,228,041
Medicare Part D	$23,776,501	$27,114,211
PrEP Assistance Program	$4,101,355	$5,958,138

In addition, enrollment costs are estimated to be $6.9 million in 2018-19 and $7.5 million in 2019-20. Beginning in 2017-18, ADAP introduced a new reimbursement methodology for enrollment sites which includes a payment floor and variable payments dependent on new client medication enrollment, client bi-annual self-verification, client annual re-enrollment, client insurance assistance enrollment and re-enrollment, and PrEP client enrollment and re-enrollment.

ADAP Enrollment System. DPH requests expenditure authority from the ADAP Rebate Fund of $3.3 million in 2019-20. If approved, these resources would allow DPH to support implementation of the ADAP Enrollment System (AES). DPH previously terminated its enrollment vendor contract due to material breaches related to protection of confidential client information. To prevent disruption of client services and care, DPH implemented an interim AES solution in March 2017 to replace the functionality of the terminated vendor contract. Since that time, DPH has been engaging in the California Department of Technology's Project Lifecycle Approval (PAL) process to implement a permanent AES solution. According to DPH, the project received approval for the Stage 2 Alternatives Analysis portion of the PAL process, which determined that enhancements to the existing interim AES offered the highest benefit to the program. The increased funding request in 2019-20 of $3.3 million includes $233,000 for system enhancements, $2.8 million to support maintenance and operations, and $228,000 for costs related to the PAL process.

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 DPH to respond to the following:

1. Please provide a brief overview of the major changes to the ADAP Estimate.

2. Please provide a brief overview of the resource request for implementation of the ADAP Enrollment System.

Issue 11: Sexually Transmitted Disease Prevention

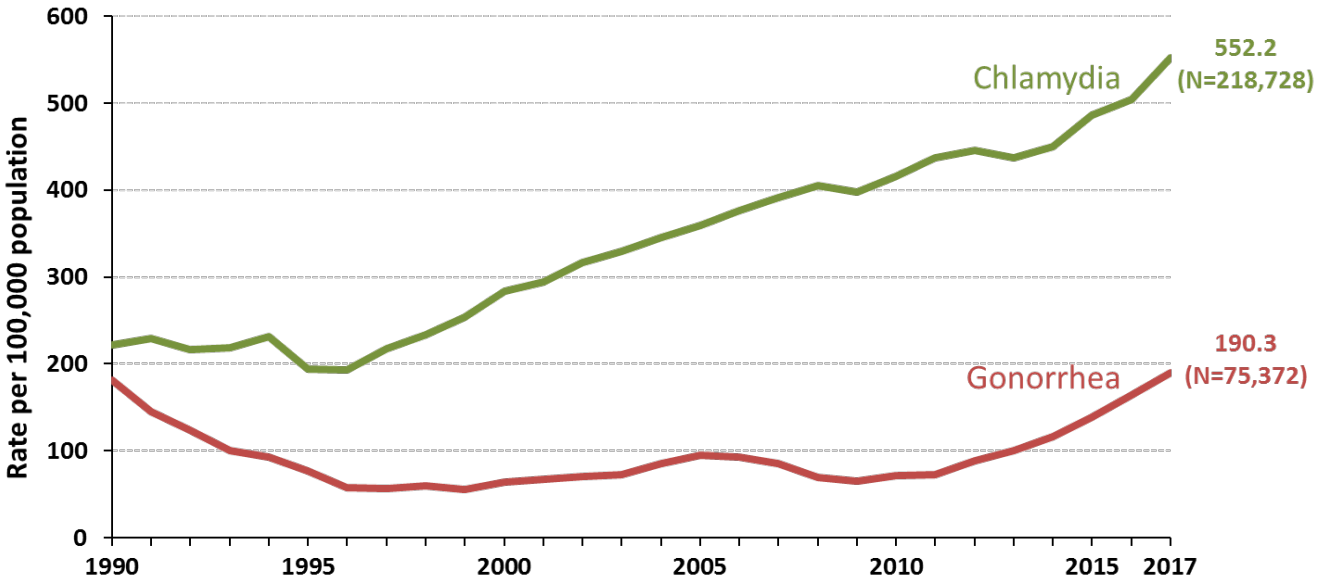
Budget Issue. DPH requests General Fund expenditure authority of $2 million annually. If approved, these resources would allow DPH to provide additional funding to local health jurisdictions for the prevention of sexually transmitted diseases.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$2,000,000	$2,000,000
Total Funding Request:	**$2,000,000**	**$2,000,000**

* Resources ongoing after 2020-21.

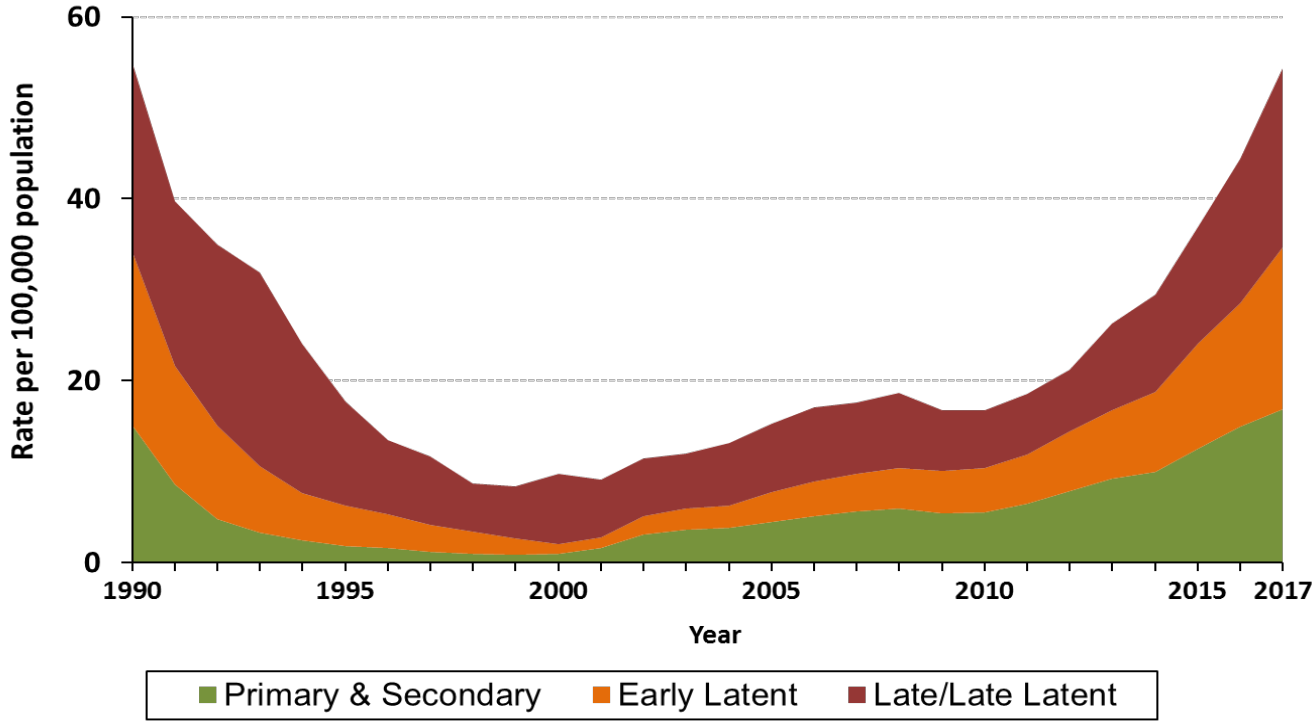
Background. California has experienced a significant multi-year increase in incidence of sexually transmitted diseases (STDs), such as chlamydia, gonorrhea, and syphilis. According to the 2017 California STD Annual Report prepared by DPH, chlamydia is the most common reportable disease in California and is at the highest level since mandated reporting began in 1990. In 2017 there were 552.2 chlamydia cases per 100,000 population, a 10 percent increase in cases compared to 2016 and a 30 percent increase since 2013. The report also indicates gonorrhea cases have increased sharply to 190.3 cases per 100,000 population, a 17 percent increase compared to 2016 and two times higher than in 2013. Early syphilis cases have also increased significantly to 34.6 cases per 100,000 population, a 22 percent increase compared to 2016 and two times higher than in 2013. Of particular concern is an increase in the number of infants born with congenital syphilis, which increased for the fifth consecutive year to 58.2 cases per 100,000 live births, a 32 percent increase since 2016 and five times higher than in 2013. Syphilitic stillbirths also increased from seven cases in 2013 to 30 cases in 2017.

Chlamydia and Gonorrhea – California Incidence Rates 1990-2017



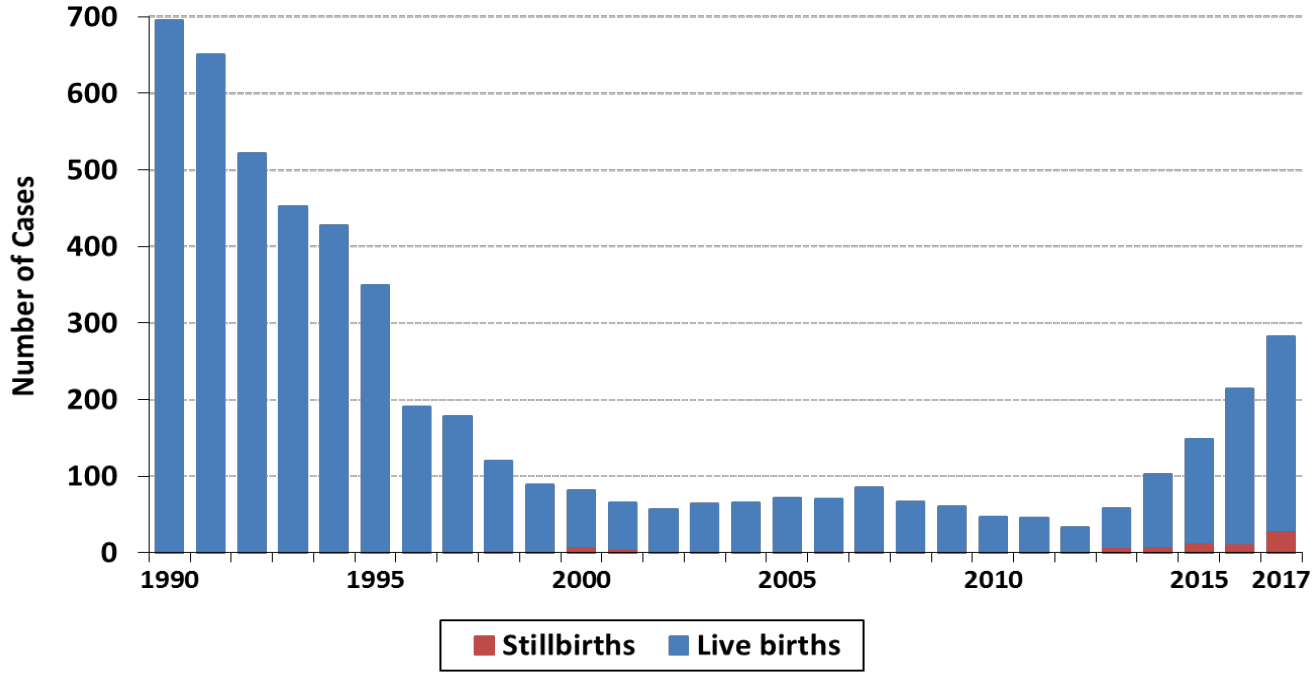
Source: California Department of Public Health. "California STD Surveillance – 2017 Data Graph Set" (2017)

Syphilis – California Incidence Rates by Stage 1990-2017



Source: California Department of Public Health. "California STD Surveillance – 2017 Data Graph Set" (2017)

Congenital Syphilis and Stillbirths – California Number of Cases 1990-2017



Source: California Department of Public Health. "California STD Surveillance – 2017 Data Graph Set" (2017)

According to DPH, STDs disproportionately affect populations that are vulnerable and living in poverty and are associated with significant health disparities, particularly African-Americans and men who have sex with men. African-American women have a disproportionately high rate of syphilis, which can lead to congenital syphilis, potentially resulting in deformities or still births. In addition, the largest proportion of congenital syphilis cases in California are born to Latina women. Importantly, these diseases are preventable and there are new opportunities to protect California residents from these diseases

One-Time Resources for STD Prevention. The 2016 Budget Act included one-time General Fund expenditure authority of $5 million for STD prevention grants to targeted local health jurisdictions with high incidence of STDs. The 2018 Budget Act included additional one-time General Fund expenditure authority of $2 million for STD prevention grants. The 2018 allocation also targeted counties based on population and STD incidence, as well as awards to authorize innovative and impactful outreach, screening, and other core services. The funds were required to enhance services already provided and not replace existing local services.

Budget Proposes Annual STD Prevention Funding. DPH requests General Fund expenditure authority of $2 million annually to provide additional funding to local health jurisdictions for the prevention of sexually transmitted diseases. According to DPH, this funding would enable local health jurisdictions to collaborate with health care providers serving vulnerable populations to provide an optimal level of STD prevention services and help reduce disparities. The funding would be prioritized for counties with the largest incidence of STDs, particularly syphilis, congenital syphilis and gonorrhea. The funding allocations would also place a particular focus on syphilis infections passed from mother to newborn.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe how local health jurisdictions have utilized previous budget allocations for STD prevention and how DPH expects annual funding would be utilized to decrease incidence of STDs in California.

Issue 12: Richmond Lab: Viral Rickettsial Disease Lab Enhanced Upgrade

Capital Outlay Spring Finance Letter. DPH requests additional General Fund expenditure authority of $1.1 million for its project to upgrade the Richmond Campus Viral Rickettsial Disease Laboratory to meet Bio-Safety Level-3 requirements established by the Centers for Disease Control and the National Institute of Health.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$1,080,000	$-
Total Funding Request:	**$1,080,000**	**$-**

Background. According to DPH, at the time of construction the Richmond Campus Viral Rickettsial Disease Laboratory (VRDL) was designed to meet the existing Centers for Disease Control (CDC) and National Institute of Health (NIH) requirements as a Bio-Safety Level 3 (BSL-3) facility. BSL-3 facilities are required to handle, identify, and respond to outbreaks of certain deadly viruses including hantavirus, poxviruses, novel influenza, Middle East Respiratory System (MERS)-CoV, Severe Acute Respiratory System (SARS), Chikungunya virus, Japanese encephalitis virus, and West Nile virus. In 2006, in response to world health concerns, the CDC and NIH implemented enhanced requirements for BSL-3 certified laboratories.

To upgrade the Richmond VRDL to meet the new BSL-3 requirements, approximately 2,000 square feet of existing space will need to be demolished and replaced with a new laboratory. The new space will include three laboratories, one work room, two entry and changing rooms with a shower, a staging area with freezer space and an autoclave, a decontamination room large enough to move large pieces of equipment, a clean autoclave room, a viewing area, and a valve room to house mechanical equipment. All rooms, with the exception of the clean autoclave room and the valve room, will be within a containment area.

Planning and design for this project began with an allocation of $241,000 General Fund approved for preliminary planning, and an allocation of $232,000 for designs and working drawings approved in the 2007 Budget Act. An additional $534,000 General Fund was allocated for working drawings and $3.8 million General Fund allocated for construction in the 2015 Budget Act. However, according to DPH, construction was delayed due to delayed approval of the final working drawings by the State Fire Marshall, due to the 2015 California fires.

According to DPH, in August 2017 the Department of General Services (DGS) received only one bid for the construction contract for the lab, which exceeded the award amount by 23 percent. DGS concluded the bid should be accepted as there was limited interest by other bidders, the specialized nature of the project limited potential bidders, the original construction estimate did not reflect Bay Area market conditions, and the bid that was received was competitive and reflected the current construction market. The 2018 Budget Act included additional resources to account for the higher costs for the contract, as well as funding to rebid the contract. In October 2018, DGS rebid the project and again received only one bid, which also exceeded expenditure authority by $1 million. According to DPH, this bid will be accepted.

DPH expects the contract to be awarded in August 2019, and expects to complete the project in August 2020. The total expected cost for the project is $7 million and would be fully funded by the requested General Fund resources.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 13: Infant Botulism Treatment and Prevention – Compliance Costs for BabyBIG

Budget Issue. DPH requests expenditure authority from the Infant Botulism Treatment and Prevention Fund of $7.8 million in 2019-20, $3.9 million in 2020-21, and $2.6 million in 2021-22 to support contract costs for the next production cycle of Human Botulism Immune Globulin (BabyBIG).

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0272 – Infant Botulism Treatment and Prevention Fund	$7,833,000	$3,917,000
Total Funding Request:	**$7,833,000**	**$3,917,000**

* Additional fiscal year resources requested: 2021-22: $2,564,000.

Background. The Infant Botulism Treatment and Prevention Program was created to provide and improve the treatment of infant botulism and to prevent infant botulism and related diseases. Prior to the production of BabyBIG, botulism was treated with a horse-derived (equine) botulism antitoxin. However, treatment with the equine antitoxin was accompanied by substantial serious adverse effects including allergic reactions, serum sickness and anaphylaxis. Beginning in the 1970s, the California Department of Health Services (DHS), the precursor to DPH, attempted to facilitate commercial production of a human botulism immune globulin (BIG) for the treatment of infant botulism, but was unsuccessful. With approval and assistance from the federal Office of Orphan Products Development, DHS organized a randomized clinical trial to test effectiveness of BIG in treating infant botulism. In May 1997, the drug received approval from the Food and Drug Administration (FDA).[6] DPH is currently the only producer of BabyBIG in the world, with only one contracted facility, Shire Biotechnology in Los Angeles, FDA-approved to produce the drug.

According to DPH, production of BabyBIG is difficult to schedule. BabyBIG is produced in a multi-year, multi-stage process that involves plasma collection, validation, production, and regulatory filings. BabyBIG is produced every five years in lots sufficient to treat the expected 500 to 750 patients with infant botulism in the United States each year. The current lot of BabyBIG, Lot 6, was completed in 2016. According to DPH, the next lot, Lot 7, must be completed by 2021 to ensure an uninterrupted supply of BabyBIG.

The 2018 Budget Act assumed a production timeline for BabyBIG in the 2019-20 fiscal year, but also included flexibility regarding the program's budget authority due to the uncertain timing for manufacturing. According to DPH, production on Lot 7 began in 2018-19 and is currently underway. The production of BabyBIG is funded by fees received by DPH for use of the drug. According to DPH, effective January 1, 2019, the fee for BabyBIG was increased by $12,000 from $45,300 to $57,300, which is the first fee increase since 2004.

DPH requests expenditure authority from the Infant Botulism Treatment and Prevention Fund of $7.8 million in 2019-20, $3.9 million in 2020-21, and $2.6 million in 2021-22 to support contract costs for production of Lot 7 of BabyBIG over the next three years.

[6] Stephen S. Arnon, MD. "Creation and Development of the Public Service Orphan Drug Human Botulism Immune Globulin". *Pediatrics*, Volume 119, Number 4, April 2007

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 14: Public Health Crisis Response Grant

Spring Finance Letter. DPH requests provisional language to allow augmentation of appropriation authority for federal funds to quickly accept public health emergency funding pursuant to a new Centers for Disease Control and Prevention (CDC) Public Health Crisis Response Grant.

Background. According to DPH, the department received approval in February 2018 to be placed on an "Approved-But-Unfunded" list of grantees, which stipulates its recipients have certified they can submit an amended budget to CDC within 14 days of notice of intent to make an award, and complete hiring and execute contracts within 30 days of the notice. The department's status on the "Approved-But-Unfunded" list was set to expire on January 31, 2019. However, the department received confirmation from CDC that it will continue to be placed on the list until August 1, 2020. The proposed provisional language would provide flexibility in the department's federal fund appropriation to allow the department to meet the requirements of the "Approved-But-Unfunded" grant in response to a public health emergency.

Provisional Language. DPH requests the following provisional language:

Item 4265-001-0890

1. Notwithstanding any other law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by the State Department of Public Health that additional funds are available funds pursuant to a United States Department of Health and Human Services, Centers for Disease Control and Prevention Cooperative Agreement for Emergency Response: Public Health Crisis Response grant. Within 10 working days of authorizing that augmentation, the Department of Finance shall provide written notification of the augmentation to the chairpersons of the fiscal committees in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee.

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3. Notwithstanding any other law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by the State Department of Public Health that additional funds are available funds pursuant to a United States Department of Health and Human Services, Centers for Disease Control and Prevention Cooperative Agreement for Emergency Response: Public Health Crisis Response grant. Within 10 working days of authorizing that augmentation, the Department of Finance shall provide written notification of the augmentation to the chairpersons of the fiscal committees in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 15: Additional Proposals for Investment

Stakeholder Proposals for Investment. Stakeholders have proposed the following additional investments in DPH programs.

Farmworker Health Study. The California Rural Legal Assistance Fund (CRLAF) requests expenditure authority of $1.5 million over three years to provide funding for a comprehensive study to improve farmworker health. According to CRLAF, the last and only comprehensive assessment of agricultural workers, the California Agricultural Workers Survey, was conducted in 1999. The study's publication as "Suffering in Silence" by The California Endowment and California Institute for Rural Studies found that nearly one in five male California agricultural workers had at least two or three risk factors for chronic disease: high serum cholesterol, high blood pressure and/or obesity. Nearly 70 percent lacked any form of health insurance, and one third of males said that they had never been to a doctor or clinic in their lives (half had never been to a dentist). To develop effective policy interventions, we need up to date comprehensive data on access to care and coverage, as well as prevalence data on health status.

Office of Healthy and Safe Communities. The RYSE Center requests expenditure authority of $6 million for the creation of an Office of Healthy and Safe Communities. According to the RYSE Center, this investment would support approximately eight core staff to carry out the functions of the office. The Governor and the Surgeon General would appoint a Director of the office to carry out the following responsibilities: 1) Assemble a staff team and an advisory committee, 2) Develop, implement, and monitor a California vision and plan for violence prevention, safety, and healing, 3) Establish and manage a statewide community of practice for leaders working on these issues throughout California, 4) Strengthen and professionalize community violence intervention and prevention as a licensed occupation, and 5) Steward alignment, coordination, and synergy across statewide departments and agencies.

Little by Little Early Literacy Program. Heluna Health requests expenditure authority of $36.4 million to support statewide expansion of the Little by Little School Readiness Program, a Los Angeles-based early literacy pilot project delivered at service sites for the Women, Infants, and Children (WIC) program, and that creates a stimulating home environment, fosters literacy, and improves school readiness for underserved and low-income children. According to Heluna Health, the program begins in the third trimester of pregnancy and continues until the child's fifth birthday. Families receive information about the importance of strengthening literacy practices within the home, each child is able to choose a new age-appropriate book at each visit, and parents are given informational handouts which provide parental guidance tied to their children's developmental milestones.

Sickle Cell Disease Center Funding. The Sickle Cell Disease Foundation of California (SCDFC) and the Center for Inherited Blood Disorders (CIBD) request one-time General Fund expenditure authority of $15 million, available over three years, to create an integrated network of primary and specialty care providers to improve the quality of care for individuals with sickle cell disease. According to SCDFC and CIBD, Californians with sickle cell disease (SCD) suffer poor health, die at younger ages and at higher rates, and have higher emergency room visits and hospitalizations compared to people SCD who live in other states. Currently, the average life expectancy for Californians with sickle cell disease is

about 43, and under 40 in Los Angeles. Compare that to 63 years, the life expectancy for people with SCD in the rest of the United States. Despite that, adults with SCD in California suffer from inattention and inadequate resources, resulting in terrible personal and social costs that are tragically invisible to most because SCD is a rare disorder. This proposal would create a "hub and spoke" model of care and would:

- Build the regional infrastructure needed to develop six new comprehensive adult clinics.
- Foster outreach and education to affected individuals and families as well as healthcare providers.
- Develop initiatives to build the medical workforce of clinicians who are knowledgeable about evidence informed diagnosis and treatment.
- Enhance statewide surveillance to track outcomes, utilization, and costs.
- Support oversight.
- Scale up our award-winning primary-specialty care healthcare delivery model, recognized by the Centers for Disease Control and Prevention (CDC), the National Association of Counties, and Health Resources and Services Administration (HRSA).
- Expand into SCD the nation's successful regional hemophilia network model supported by HRSA and CDC.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends these proposals for investment be held open pending further discussions on their fiscal impact and pending release of updates to the state's General Fund condition at the May Revision.