Senate Budget and Fiscal Review—Nancy Skinner, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Tuesday, May 17, 2023
9:00 am
1021 O Street – Room 1200

Consultant: Scott Ogus

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PUBLIC COMMENT

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling (916) 651-1505. Requests should be made one week in advance whenever possible.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: May 2023 Medi-Cal Local Assistance Estimate

Local Assistance Estimate – May Revision. The May 2023 Medi-Cal Local Assistance Estimate includes $135.4 billion ($30.9 billion General Fund, $91.2 billion federal funds, and $13.3 billion special funds and reimbursements) for expenditures in 2022-23, and $151.2 billion ($37.6 billion General Fund, $90.5 billion federal funds, and $23.1 billion special funds and reimbursements) for expenditures in 2023-24.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2022-22 (CY)**	**2023-24 (BY)**	**CY to BY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$29,491,225,000	$35,770,521,000	$6,279,296,000
Federal Funds	$86,497,317,000	$85,286,563,000	($1,210,754,000)
Special Funds/Reimbursements	$13,142,601,000	$22,945,415,000	$9,802,814,000
Total Expenditures	**$129,131,143,000**	**$144,002,499,000**	**$14,871,356,000**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$1,225,544,000	$1,683,150,000	$457,606,000
Federal Funds	$4,384,623,000	$4,758,803,000	$374,180,000
Special Funds and Reimbursements	$126,520,000	$175,277,000	$48,757,000
Total Expenditures	**$5,736,687,000**	**$6,617,230,000**	**$880,543,000**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$179,357,000	$157,076,000	($22,281,000)
Federal Funds	$315,884,000	$432,818,000	$116,934,000
Special Funds and Reimbursements	$0	$0	$0
Total Expenditures	**$495,241,000**	**$589,894,000**	**$94,653,000**
TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$30,896,126,000	$37,610,747,000	$6,714,621,000
Federal Funds	$91,197,824,000	$90,478,184,000	($719,640,000)
Special Funds and Reimbursements	$13,269,121,000	$23,120,692,000	$9,851,571,000
Total Expenditures	**$135,363,071,000**	**$151,209,623,000**	**$15,846,552,000**

Caseload. In 2022-23, the May Revision assumes annual Medi-Cal caseload of 15.3 million, an increase of 0.3 percent compared to assumptions in the January budget. The department estimates 89 percent of Medi-Cal beneficiaries, or 13.6 million, will receive services through the managed care delivery system while 11.2 percent, or 1.7 million, will receive services through the fee-for-service delivery system.

In 2023-24, the May Revision assumes annual Medi-Cal caseload of 14.2 million, a decrease of 1.7 percent compared to assumptions in the January budget, and a decrease of 7.2 percent compared to the revised caseload estimate for 2022-23. The department estimates 93.7 percent of Medi-Cal beneficiaries, or 13.3 million, will receive services through the managed care delivery system while 6.3 percent, or 897,342, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The May 2023 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures in 2022-23:

- Shift in timing for previously estimated expenditures ($3 billion savings), including:

  - Approximately $1 billion for the Behavioral Health Continuum Infrastructure Program (BHCIP) would shift from the 2022-23 fiscal year, with $262.5 million shifting to 2023-24 and the remaining funds shifting to later years.
  - $817 million for Behavioral Health Bridge Housing would shift from the 2022-23 fiscal year, with $484 million shifting to 2023-24 and the remaining funds shifting to later years.
  - $405 million for the School Behavioral Health Partnerships and Capacity component of the Children and Youth Behavioral Health Initiative would shift from the 2022-23 fiscal year, with $291.3 million shifting to 2023-24 and the remaining funds shifting to later years.
  - $388.5 million for the Evidence-Based Behavioral Health Practices component of the Children and Youth Behavioral Health Initiative would shift from the 2022-23 fiscal year, with $287.5 million shifting to 2023-24 and the remaining funds shifting to later years.
  - $170 million for the Behavioral Health Services and Supports component of the Children and Youth Behavioral Health Initiative would shift from the 2022-23 fiscal year, with all funds shifting to 2023-24.
  - $130 million for the Providing Access and Transforming Health (PATH) component of the California Advancing and Innovating Medi-Cal initiative would shift from the 2022-23 fiscal year, with $30.4 million shifting to 2023-24 and the remaining funds shifting to later years.
  - $70 million for Equity and Practice Transformation Payments would shift from the 2022-23 fiscal year, with $30.4 million shifting to 2023-24 and the remaining funds shifting to later years.
  - $58.5 million for the Urgent Needs and Emerging Issues component of the Children and Youth Behavioral Health Initiative would shift from the 2022-23 fiscal year, with all funds shifting to 2023-24.

- Changes to General Fund impacts for repayment of federal funds for state-only populations ($68.3 million savings)

- Medi-Cal Drug Rebate Fund transfers to the General Fund ($91.1 million savings)

These savings are offset by increased costs attributable to:

- Updated COVID-19 impacts ($704.1 million costs)
- Non-emergency funding adjustment for state-only populations ($347.9 million costs)
- Revised reconciliation estimate for In-Home Supportive Services in the Coordinated Care Initiative ($277.1 million costs)
- Changes in the impact of federal deferrals ($151.7 million costs)
- Legislative priorities adopted in the 2022 Budget Act ($89.3 million costs)
- Updates to Proposition 56 supplemental provider payments ($44.1 million costs)
- Federal repayment of disallowed nursing facility claims under the Preadmission Screening and Resident Review ($41.8 million costs)
- Various other changes ($98.6 million costs)

The May 2023 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures in 2023-24:

- Revision and expansion of the tax on managed care organizations ($3.2 billion savings)
- Medi-Cal Drug Rebate Fund transfers to the General Fund ($707.7 million savings)
- Shift of Behavioral Health Bridge Housing and CalHOPE from the General Fund to the Mental Health Services Fund ($550.5 million savings)
- Changes in the impact of federal deferrals ($338.4 million savings)
- Drawdown of reserve in the Medi-Cal Drug Rebate Fund ($222 million savings)
- Changes in transfers from the Hospital Quality Assurance Fee to the General Fund ($152.5 million savings)
- Revised reconciliation estimate for In-Home Supportive Services in the Coordinated Care Initiative ($31 million savings)
- Various other changes ($60.8 million savings)

These costs are offset by increased costs attributable to:

- Shift in timing for previously estimated expenditures ($1.5 billion costs)

- Changes to General Fund impacts for repayment of federal funds for state-only populations ($982 million costs)
- Updated costs for expansion of Medi-Cal regardless of immigration status ($578.3 million costs)
- Non-emergency funding adjustment for state-only populations ($347.9 million costs)
- Reversal of the delay of the Behavioral Health Bridge Housing program ($250 million costs)
- Updates to Proposition 56 supplemental provider payments ($165.8 million costs)
- Updated COVID-19 impacts ($128 million costs)
- Medi-Cal provider rate increases ($89.6 million costs)
- Updated CARE Court County Behavioral Health Department funding and Los Angeles County start-up funding ($50.8 million costs)
- Costs for a third party administrator for the fee schedule for youth behavioral health services implemented as part of the Children and Youth Behavioral Health Initiative ($10 million costs)
- Federal repayment of disallowed nursing facility claims under the Preadmission Screening and Resident Review ($5 million costs)

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of the significant General Fund changes in the Medi-Cal program at May Revision for the 2022-23 and 2023-24 fiscal years.

Issue 2: May 2023 Family Health Local Assistance Estimate

Local Assistance Estimate – May Revision. The May 2023 Family Health Local Assistance Estimate includes $238 million ($197.1 million General Fund, $5 million federal funds, and $35.9 million special funds and reimbursements) for expenditures in 2022-23, and $253.1 million ($220 million General Fund, $5.5 million federal funds, and $27.7 million special funds and reimbursements) for expenditures in 2023-24.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2022-23 (CY)**	**2023-24 (BY)**	**CY to BY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$78,195,000	$83,133,000	$4,938,000
Special Funds/Reimbursements	$7,692,000	$7,692,000	$0
County Funds [non-add]	[$82,590,000]	[$86,365,000]	[$3,775,000]
Total CCS Expenditures	**$85,887,000**	**$90,825,000**	**$4,938,000**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$112,223,000	$128,739,000	$16,516,000
Special Funds and Reimbursements	$8,312,000	$393,000	($7,919,000)
Total GHPP Expenditures	**$120,535,000**	**$129,132,000**	**$8,597,000**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$6,726,000	$8,079,000	$1,353,000
Federal Funds	$4,970,000	$5,513,000	$543,000
Special Funds and Reimbursements	$19,913,000	$19,598,000	($315,000)
Total EWC Expenditures	**$31,609,000**	**$33,190,000**	**$1,581,000**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$197,144,000	$219,951,000	$22,807,000
Federal Funds	$4,970,000	$5,513,000	$543,000
Special Funds and Reimbursements	$35,917,000	$27,683,000	($8,234,000)
County Funds [non-add]	[$82,590,000]	[$86,365,000]	[$7,988,000]
Total Family Health Expenditures	**$238,031,000**	**$253,147,000**	**$15,116,000**

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

The programs included in the Family Health Estimate are:

- **California Children's Services (CCS)**: The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.

  Caseload Estimate (Medi-Cal): The May Revision estimates Medi-Cal CCS caseload of 198,920 in 2022-23 and 188,521 in 2023-24.
  Caseload Estimate (State-Only): The May Revision estimates state-only CCS caseload of 9,682 in 2022-23 and 12,134 in 2023-24.

- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington's, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal. GHPP costs for Medi-Cal eligible individuals are reflected in the Medi-Cal Local Assistance Estimate

  Caseload Estimate (Medi-Cal): The May Revision estimates Medi-Cal GHPP caseload of 944 in 2022-23 and 936 in 2023-24.
  Caseload Estimate (State-Only): The May Revision estimates state-only GHPP caseload of 668 in 2022-23 and 674 in 2023-24.

- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).

  Caseload Estimate: The May Revision estimates EWC caseload of 19,835 in 2022-23, and 20,561 in 2023-24.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the significant changes in Family Health Estimate programs at May Revision for the 2022-23 and 2023-24 fiscal years.

Issue 3: Doula Services Implementation Evaluation

Trailer Bill Language – May Revision. DHCS requests trailer bill language to align workgroup timelines for examination of implementation of the doula benefit in Medi-Cal with an anticipated one-year delay in implementation of the benefit.

Background. The 2021 Budget Act included expenditure authority of $403,000 ($152,000 General Fund and $251,000 federal funds) in 2021-22 to support implementation of doula services as a covered benefit in the Medi-Cal program, beginning January 1, 2022. DHCS estimated total annual costs of $4.4 million for the benefit when fully implemented. In addition, SB 65 (Skinner), Chapter 449, Statutes of 2021, requires DHCS to convene a workgroup, no later than April 1, 2022, through December 31, 2023, to examine the implementation of the doula benefit in Medi-Cal. The workgroup is required to be comprised of doulas, health care providers, consumer and community advocates, health plans, county representatives, and other stakeholders with experience with doula services. The workgroup is required to consider the following:

1) Ensuring that doula services are available to Medi-Cal beneficiaries who are eligible for and want doula services.
2) Minimizing barriers and delays in payments to a Medi-Cal doula or in reimbursement to Medi-Cal recipients for doula services received.
3) Making recommendations for outreach efforts so that all Medi-Cal recipients within the eligible and other target populations are aware of the option to use doula services.

DHCS held its first meeting with the doula workgroup on March 30, 2023

SB 65 also requires DHCS to publish a report, no later than July 1, 2024, with utilization, demographic, language, payer, and other data regarding the doula benefit. The date of the report, and the timeline for the workgroup, were based on the expected implementation timeline of January 1, 2022. However, the benefit was delayed and was not implemented until January 1, 2023.

Trailer Bill Language Proposal. DHCS requests trailer bill language to align workgroup timelines for examination of implementation of the doula benefit in Medi-Cal with an anticipated one-year delay in implementation of the benefit. DHCS proposes to extend the end date of the workgroup by 18 months, until June 30, 2025, extend the deadline for the required DHCS report from July 1, 2024, to July 1, 2025, and extend the sunset date from January 1, 2025, to January 1, 2026.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this trailer bill language proposal.

Issue 4: Medical Interpreters Pilot Project - Extension

Trailer Bill Language – May Revision. DHCS requests trailer bill language to extend availability of funding and extend the sunset date for the Medical Interpreter Pilot Project (MIPP), a pilot project for interpretation services in the Medi-Cal program, pursuant to SB 635 (Atkins), Chapter 600, Statutes of 2016.

Background. SB 635 (Atkins), Chapter 600, Statutes of 2016, requires DHCS to work with stakeholders to conduct a study to: 1) identify current requirements for medical interpretation services as well as education, training, and licensure requirements; 2) analyze other state Medicaid programs; and 3) make recommendations on strategies, including possible pilot projects, that may be employed regarding the provision of medical interpretation services for Medi-Cal beneficiaries with limited English proficiency. SB 165 (Atkins), Chapter 365, Statutes of 2019, amended SB 635 to require a pilot program at up to four sites to evaluate whether disparities in care are reduced for beneficiaries with limited English proficiency compared to those proficient in English, whether Medi-Cal managed care plans identify improvements in quality of care, and the utilization of medical interpreters by providers and Medi-Cal managed care plans.

Trailer Bill Language Proposal. DHCS requests trailer bill language to extend availability of funding and extend the sunset date for the Medical Interpreter Pilot Project, a pilot project for interpretation services in the Medi-Cal program, pursuant to SB 635 (Atkins), Chapter 600, Statutes of 2016. According to DHCS, due to difficulty recruiting clinic sites to participate in the pilot, the implementation of interpretation services was delayed. In addition, the COVID-19 public health emergency had a sever effect on the capacity of potential sites. Interpretation services were implemented in Contra Costa County on March 28, 2022, San Diego on April 11, 2022, and Los Angeles on August 8, 2022. As a result of the delay of these services, DHCS proposes to extend the expenditure authority and sunset date for the program from June 30, 2024, to June 30, 2025. In addition, DHCS proposes to extend the sunset date from January 1, 2025, to January 1, 2026.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this trailer bill language proposal.

Issue 5: Whole Child Model – Remove Single Plan Counties

Trailer Bill Language – May Revision. DHCS requests to update its trailer bill language proposal, included in the January budget, to expand the Whole Child Model (WCM) for California Children's Services (CCS) beneficiaries, to only expand to County Organized Health System counties. The updated language would not expand to Single Plan Counties, such as Alameda, Contra Costa, and Imperial Counties.

Background. SB 586 (Hernandez), Chapter 625, Statutes of 2016, authorized DHCS to establish the Whole Child Model program in designated County Organized Health System (COHS) or Regional Health Authority counties. Services previously provided to CCS beneficiaries on a fee-for-service basis are delivered by Medi-Cal managed care plans in Whole Child Model counties. The Whole Child Model

program has been implemented in 21 counties with 5 health plans, with the goal to improve care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.

The 21 counties and 5 health plans that participate in the Whole Child Model are as follows:

- Participating Counties: San Luis Obispo, Santa Barbara, Merced, Monterey, Santa Cruz, San Mateo, Orange, Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Siskiyou, Shasta, Solano, Sonoma, Trinity, and Yolo
- Participating Health Plans: CenCal Health, Central California Alliance for Health, Health Plan of San Mateo, CalOptima, Partnership Health Plan of California

Whole Child Model Pilot Evaluation. SB 586 also requires DHCS to contract with an independent entity to conduct an evaluation to assess Medi-Cal managed care plan performance and the outcomes and experience of CCS-eligible children and youth participating in the Whole Child Model program. The evaluation is required to: (1) compare plan performance to performance of the CCS program prior to implementation in each county; (2) compare plan performance in participating counties to CCS program performance in non-participating counties; and (3) evaluate whether inclusion of CCS services in managed care improves access, quality, and the patient experience. The evaluation must also, when possible, disaggregate results based on the child's or youth's race, ethnicity, and primary language spoken at home.

The 2019 Budget Act included expenditure authority of $1.6 million ($800,000 General Fund and $800,000 federal funds), available for expenditure or encumbrance until June 30, 2021 to conduct the program evaluation of the Whole Child Model required pursuant to SB 586.

DHCS released the Whole Child Model evaluation at the end of March 2023.

Managed Care Procurement and Model Changes. On February 9, 2022, DHCS released a Request for Proposal (RFP) for its commercial managed care plan contracts, seeking managed care plans committed and able to advance equity, quality, access, accountability, and transparency to reduce health disparities and improve health outcomes for Californians. While the RFP is only for commercial plans, DHCS indicated the updated contract released with the RFP would be executed with all Medi-Cal managed care plans, including local initiatives and County Organized Health Systems, as of January 1, 2024.

During the procurement process, counties were permitted to change their model for Medi-Cal managed care plans. The following counties made changes to their plan models:

- Alameda – From Two Plan Model to a Single Plan with Alameda Alliance
- Contra Costa – From Two Plan Model to a Single Plan with Contra Costa Health Plan
- Imperial – From Regional Model to a Single Plan with California Health and Wellness
- Mariposa – From Regional Model to County Organized Health System with Central California Alliance for Health
- San Benito – From Regional Model to County Organized Health System with Central California Alliance for Health
- Butte – From Regional Model to County Organized Health System with Partnership Health Plan
- Colusa – From Regional Model to County Organized Health System with Partnership Health Plan

- Glenn – From Regional Model to County Organized Health System with Partnership Health Plan
- Nevada – From Regional Model to County Organized Health System with Partnership Health Plan
- Placer – From Regional Model to County Organized Health System with Partnership Health Plan
- Plumas – From Regional Model to County Organized Health System with Partnership Health Plan
- Sierra – From Regional Model to County Organized Health System with Partnership Health Plan
- Sutter – From Regional Model to County Organized Health System with Partnership Health Plan
- Tehama – From Regional Model to County Organized Health System with Partnership Health Plan
- Yuba – From Regional Model to County Organized Health System with Partnership Health Plan
- Alpine – From Regional Model to Two Plan Model with Health Plan of San Joaquin
- El Dorado – From Regional Model to Two Plan Model with Health Plan of San Joaquin

Trailer Bill Language Proposal – Expand Whole Child Model and Mandatory Enrollment for Foster Children. In the January budget, DHCS proposed trailer bill language to expand the Whole Child Model for California Children's Services (CCS) to the 15 counties converting to County Organized Health System (COHS) or Single Plan models, and to mandatorily enroll foster children in Single Plan counties in the Whole Child Model. In the May Revision, DHCS has updated its trailer bill language proposal to only expand into COHS counties, which would include Butte, Colusa, Glenn, Nevada, Plumas, Sierra, Sutter, Tehama, Yuba, Mariposa, and San Benito Counties.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this updated trailer bill proposal.

Issue 6: Long-Term Care Facilities Rate Year Shift

Trailer Bill Language – May Revision. DHCS requests trailer bill language to shift reimbursement for certain long-term care facilities from a rate year that begins in August to a calendar year rate year, beginning January 1, 2024.

Background. The Medi-Cal program reimburses Intermediate Care Facilities – Developmental Disabilities (ICF-DDs), Distinct Part Nursing Facilities (DP-NFs), Distinct Part Subacute (DP-SAs), and Nursing Facilities-Level A (NF-As) on a rate year basis that runs from August 1 through July 31. Through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, these facilities will be carved into managed care with varying effective dates on or after January 1, 2023. Managed care rates are set on a calendar year rate year. DHCS proposes to align the rate years for these facilities to those for managed care to promote consistency and reduce administrative complexity.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this trailer bill proposal.

Issue 7: Assisted Living Waiver Expansion Permanent Workload

Budget Change Proposal – May Revision. DHCS requests 15 positions and expenditure authority of $933,000 ($308,000 General Fund and $625,000 federal funds) in 2023-24 and $2.3 million ($772,000 General Fund and $1.6 million federal funds) annually thereafter. If approved, these positions and resources would support administrative, operational, and monitoring and oversight needs for the expansion of the Assisted Living Waiver Program.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$308,000	$772,000
0890 – Federal Trust Fund	$625,000	$1,566,000
Total Funding Request:	**$933,000**	**$2,338,000**
Total Requested Positions:	**15.0**	**15.0**

* Positions and resources ongoing after 2024-25.

Background. The Assisted Living Waiver (ALW) provides eligible Medi-Cal beneficiaries the choice to reside in an assisted living facility setting as an alternative to long-term placement in a nursing facility. The waiver facilitates the transition of institutionalized beneficiaries back to a home- or community-based setting, as an alternative to nursing facility placement.

Section 9817 of the federal American Rescue Plan (ARP) Act provides qualifying states with a temporary 10 percentage point increase to federal matching funds for certain home- and community-based services (HCBS). The increased federal match is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to this increased federal match to enhance, expand, or strengthen HCBS under the state's Medicaid program. Unlike other federally funded programs, programs supported by this additional federal funding are eligible for federal matching funds in the Medicaid program as if they were supported by non-federal funding.

The 2021 Budget Act included Control Section 11.95, which authorized expenditure of $3 billion of HCBS funding received under the provisions of ARP. In July 2021, DHCS submitted California's $4.6 billion HCBS Spending Plan to the federal Centers for Medicare and Medicaid Services for review and approval. DHCS estimated that the $3 billion investment of HCBS funds would draw down an additional $1.6 billion of federal Medicaid matching funds. Among the investments included in the HCBS Spending Plan was the Assisted Living Waiver Expansion. The Spending Plan included $10.8 million ($3 million HCBS funds) in 2021-22 and $32.4 million ($8.9 million HCBS funds) annually to support expansion of the Assisted Living Waiver to eliminate the waiting list, which would add an additional 7,000 slots, with 5,000 available for individuals residing in the community. DHCS received limited term resources equivalent to 15 positions to administer the program. As the expansion of the waiver is expected to be permanent, DHCS is proposing to make these positions permanent.

Staffing and Resource Request. DHCS requests 15 positions and expenditure authority of $933,000 ($308,000 General Fund and $625,000 federal funds) in 2023-24 and $2.3 million ($772,000 General Fund and $1.6 million federal funds) annually thereafter. If approved, these positions and resources would support administrative, operational, and monitoring and oversight needs for the expansion of the Assisted Living Waiver Program. Specifically, DHCS requests the following positions:

Integrated Systems of Care Division – 15 positions

- **One Staff Services Manager I** position, **two Health Program Specialist I** positions, **four Nurse Evaluator II** positions, **seven Associate Governmental Program Analysts,** and **one Research Data Analyst II** position would focus on provider enrollment, waiver program eligibility determinations, facility review, program policy, data and reporting, program development, waitlist management, and compliance.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 8: Control Section 4.05 Adjustment, Budget Act of 2021

Technical Adjustment – May Revision. DHCS requests a net-zero shift of expenditure authority from federal funds to the Special Deposit Fund of $650,000, associated with Control Section 4.05 of the 2021 Budget Act. Control Section 4.05 allows items of appropriation provided outside of the Budget Act to be adjusted to reflect net savings achieved through operational efficiencies and other cost-reduction measures.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this technical adjustment.

Issue 9: Dental Procurement

Budget Change Proposal – Governor's Budget. DHCS requests six positions (conversion of four limited-term to permanent and two new positions) and expenditure authority of $1.8 million ($443,000 General Fund and $1.3 million federal funds) in 2023-24 and $1.7 million ($438,000 General Fund and $1.3 million federal funds) annually thereafter. If approved, these positions and resources would support a procurement effort, contract transition, and other workload to secure a new Fiscal Intermediary Dental Information Technology Maintenance and Operations contract in support of dental services for Medi-Cal.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$443,000	$438,000
0890 – Federal Trust Fund	$1,323,000	$1,310,000
Total Funding Request:	**$1,766,000**	**$1,748,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2024-25.

Background. The Medi-Cal Dental Services Division administers the Medi-Cal dental benefit through two delivery systems: dental fee-for-service and dental managed care. The dental fee-for-service system is supported by two contracted vendors: a dental Administrative Services Organization (ASO) and a Fiscal Intermediary Dental Information Technology Maintenance and Operations (FI-DITMO) vendor. The FI-DITMO's primary role is to operate and maintain the California Dental Medicaid Management Information System (CD-MMIS), which processes dental claims and treatment authorization requests, and issues payments. According to DHCS, the FI-DITMO contract is a four-year contract with up to five optional one-year extensions. The maximum term of the contract runs through June 30, 2026.

The 2020 Budget Act included resources equivalent to four positions to conduct a reprocurement of the ASO contract. According to DHCS, by the time it must reprocure the FI-DITMO contract, the ASO contract would be operational. As a result, DHCS is proposing to convert the limited-term resources to permanent and add additional staff to support reprocurement of the FI-DITMO contract.

Staffing and Resource Request. DHCS requests six positions (conversion of four limited-term to permanent and two new positions) and expenditure authority of $1.8 million ($443,000 General Fund and $1.3 million federal funds) in 2023-24 and $1.7 million ($438,000 General Fund and $1.3 million federal funds) annually thereafter to support a procurement effort, contract transition, and other workload to secure a new Fiscal Intermediary Dental Information Technology Maintenance and Operations contract in support of dental services for Medi-Cal. Specifically, DHCS requests the following positions and resources:

<u>Medi-Cal Dental Services Division</u> – Three positions and $750,000 contract resources

- **One Staff Services Manager I** position would be responsible for procurement efforts, providing direction to staff, reviewing staff recommendations, provide recommended actions to leadership, guide the process for procurements, oversee development of language and provisions for the Request for Proposal (RFP), coordinate procurement activities, coordinate with the Contract Services Division, interact and consult with Office of Legal Services, and participate in the turnover/takeover of current and new contracts.
- **Two Associate Governmental Program Analysts** would perform a wide range of analytical tasks associated with the procurement, including: gathering, compiling, and analyzing information to define the scope and methodology of the procurements; make recommendations to leadership; develop business requirements to include in the RFP; serve as subject matter expert for the procurement; perform research and analysis to ensure contract terms are in alignment with state and federal laws and regulations; and participate in all phases of procurement.
- Expenditure authority of $750,000 ($187,000 General Fund and $563,000 federal funds) annually would support consultant resources for project management, business analysis, and independent verification and validation.

<u>Office of Legal Services</u> – One position

- **One Attorney III** position would review and approve all RFPs or Requests for Application (RFAs) related to ASO procurement documents.

<u>CA-MMIS Operations</u> – Two positions

- **Two Information Technology Specialist I** positions would provide technical expertise, be responsible for assuring compliance with Medicaid and privacy requirements, participate in development of procurement strategies and risk mitigation plans, issue papers and other documents, act as lead technical experts and as technology leads and security liaisons for the project.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of this proposal.

Issue 10:BH Comm-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)

Local Assistance – May Revision. DHCS requests updates to expenditure authority for the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) over five years, as follows:

- General Fund – increased expenditure authority of $4.5 million
- Federal Funds – increased expenditure authority of $104.1 million
- Mental Health Services Fund – decreased expenditure authority of $87.5 million.

Background. Federal Medicaid law prohibits federal matching funds to state Medicaid programs for care provided in an institution for mental disease (IMD). An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes substance use disorders (SUDs).

In November 2018, the federal Centers for Medicare and Medicaid Services (CMS) issued guidance detailing options to adopt innovative delivery system reforms for adults living with serious mental illness or children living with serious emotional disturbance. This new authority is available to states through application for a Section 1115 Waiver and is focused on building out a full continuum of mental health services while also permitting states to secure federal matching funds for services provided during short-term stays in psychiatric hospitals or residential treatment settings that are considered IMDs. Federal matching funds are available for stays in IMDs up to 60 days, but states must meet a statewide average length of stay of 30 days for all stays included in the demonstration.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration. (Previously the California Behavioral Health Community-Based Continuum, or CalBH-CBC). DHCS proposes to strengthen the provision, coordination, and integration of mental health and SUD services across the continuum by building on the federal requirements contained in the 2018 CMS guidance. DHCS' approach reflects the state's ongoing commitment to ensuring that services are provided in the least restrictive setting appropriate for a beneficiary's needs. The demonstration includes five key components:

Strengthening the Statewide Continuum of Community-Based Services. The demonstration aims to expand and strengthen the continuum of community-based care, especially for children, youth, and their families. DHCS intends to establish clear guidance and clarify statewide coverage requirements to support access to at least three specific evidence-based services that can be delivered at home:

- Multisystemic Therapy (MST) – MST is an evidence-based intensive family- and community-based intervention for children and young people aged 11 to 17 who are at risk of out-of-home placement in either care or custody due to a history of arrest or behavioral health issues. DHCS intends to issue guidance to counties that clarifies and streamlines Medi-Cal coverage of and reimbursement for MST as a bundled service for qualifying children and youth.
- Functional Family Therapy (FFT) – FFT is a family-based prevention and intervention program for high-risk youth between the ages of 11 and 18 that addresses complex and multidimensional problems with a flexibly structured and culturally responsive practice. DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement for FFT.
- Parent-Child Interaction Therapy (PCIT) – PCIT is an evidence-based, short-term treatment designed to teach parents strategies that will promote positive behaviors in children and youth who exhibit disruptive or externalizing behavioral problems. DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement for PCIT.

DHCS also indicates it may request authority to make targeted improvements for children in the child welfare system, including: 1) a cross-sector incentive pool to reward plans and county agencies for meeting outcome measures for children and youth in the child welfare system; 2) activity stipends; and 3) initial specialty mental health assessment at entry into the child welfare system.

Supporting Statewide Practice Transformations. DHCS proposes to invest in workforce capacity, service infrastructure, information technology, and data exchange, including the following:

- Statewide Centers of Excellence (COEs) – DHCS proposes to establish and fund COEs to provide training and technical assistance to providers and counties on demonstration implementation, including orientation, training, coaching, mentoring, fidelity monitoring, and other supports.
- Statewide Incentive Program – DHCS proposes to incentivize county mental health plans and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties to build a robust quality improvement program to improve performance and reduce disparities in access and outcomes.
- Statewide Tools to Connect Beneficiaries to Appropriate Care – DHCS proposes to review the required use of standardized, evidence-based level-of-care tools and develop resources to help individuals who require inpatient treatment find an appropriate facility, including: 1) a patient assessment tool that builds on the current Child and Adolescent Needs and Strengths (CANS) tool; and 2) a treatment bed availability platform to track the availability of inpatient and crisis stabilization units.
- Promotion and Standardization of Quality of Care in Residential and Inpatient Settings – DHCS proposes to require all mental health inpatient and residential facilities to screen and address beneficiaries' comorbid physical conditions and SUDs either directly or through the facilitation of referrals. DHCS also proposes to require facilities and counties to employ a utilization review process to ensure access to appropriate levels of care and appropriate inpatient/residential admissions and length of stay, conduct intensive predischarge care coordination, incorporate housing needs during discharge planning, make referrals to community services before discharge, and follow up within 72 hours of discharge. As part of the demonstration, DHCS proposes to provide up to six months of rent

or temporary housing for beneficiaries who meet access criteria for behavioral health services and who are homeless or at risk of homelessness after receiving treatment in an institutional setting.

Improving Statewide County Accountability. DHCS proposes to design a transparent monitoring approach to ensure beneficiaries are able to access a wide array of community-based care options. DHCS would amend county mental health plan contracts to: 1) establish key performance expectations and accountability standards, 2) build on goals and standards included in the state's Medi-Cal Comprehensive Quality Strategy and other quality and evaluation initiatives, and 3) outline incentive payment opportunities. DHCS would provide significant support to counties and providers through investments in training and technical assistance through development of COEs and incentive programs. DHCS may also utilize corrective action plans or sanctions for persistent gaps in performance, consistent with existing policies.

County Option to Provide Enhanced Community-Based Services. DHCS proposes to provide counties the option to provide one or more evidence-based, community-based service including:

- Assertive Community Treatment (ACT) – ACT provides a person-centered, comprehensive approach to care with individuals with a serious mental illness, using a multidisciplinary team that typically consists of a psychiatrist, a nurse, case managers, peers, and other professionals.
- Forensic Assertive Community Treatment (FACT) – FACT builds on ACT by making adaptations based on criminal justice issues, particularly by addressing criminogenic risks and needs.
- Coordinated Specialty Care for First Episode Psychosis (CSC-FEP) – CSC-FEP is an evidence-based practice that improves outcomes for youth and young adults following an initial psychotic episode.
- Supported Employment – Supported employment is an evidence-based practice that helps individuals living with serious mental illness obtain and maintain paid competitive jobs through vocational assessment, job-finding assistance, and job skills training.
- Rent/Temporary Housing – DHCS proposes to allow counties to cover rent or temporary housing for up to six months for beneficiaries that meet access criteria for behavioral health services and are homeless or at risk of homelessness.
- Community Health Worker Services – DHCS proposes to cover community health worker services to support county behavioral health providers to perform outreach and support engagement of beneficiaries in behavioral health and treatment services.

County Option to Receive Federal Financial Participation for Short-Tem Stays in IMDs. The BH-CONNECT demonstration allows counties that agree to certain conditions to opt in to receive federal matching funds for services provided during short-term stays in IMDs. Counties must agree to cover the enhanced set of community-based services, reinvest savings generated by federal matching funds into community-based care, and meet robust accountability requirements to ensure IMDs are used only when medically necessary and provide high quality care. DHCS would also establish an incentive program to help counties that opt in to prepare for and sustain implementation of demonstration related services.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 11: Withdrawal of Delay and Fund Source Change for Behavioral Health Bridge Housing

Local Assistance – May Revision. DHCS requests expenditure authority from the Mental Health Services Fund of $500 million and a reduction of General Fund expenditure authority of $250 million. If approved, these funding changes would allow DHCS to withdraw its January budget proposal to delay funding and implementation for Behavioral Health Bridge Housing.

Background. The 2022 Budget Act included General Fund expenditure authority of $1 billion in 2022-23 and $500 million in 2023-24 to support bridge housing projects to address the immediate housing and treatment needs of people experiencing unsheltered homelessness with serious behavioral health conditions. Funding will be administered through the Behavioral Health Continuum Infrastructure Program (BHCIP) process and used to purchase and install tiny homes with time-limited operational supports, as well as other bridge housing settings, such as assisted living. DHCS expects county behavioral health departments and Medi-Cal managed care plans to improve coordination to serve people with acute behavioral health challenges and those needing housing, treatment, and services, including medication, peer and family supports.

Due to the General Fund shortfall, the Governor's January budget proposed to delay $250 million the $500 million of funding, scheduled to be awarded in 2023-24, until 2024-25.

Local Assistance Request. DHCS requests expenditure authority from the Mental Health Services Fund of $500 million and a reduction of General Fund expenditure authority of $250 million to withdraw its January budget proposal to delay funding and implementation for Behavioral Health Bridge Housing. The resources from the Mental Health Services Fund would be allocated from the State Administration Account of the fund. These resources would offset General Fund expenditures of $250 million expected to be spent in 2023-24, as well as replacing and withdrawing the delay of $250 million proposed to be awarded in 2024-25 in the January budget.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 12: Fund Source Change for CalHOPE

Local Assistance – May Revision. DHCS requests expenditure authority from the Mental Health Services Fund of $50.5 million and a reduction of General Fund expenditure authority of $40 million in 2023-24. If approved, these changes would shift funding for CalHOPE from General Fund to Mental Health Services Fund.

Background. CalHOPE is a Crisis Counseling Assistance and Training Program that delivers crisis support for communities impacted by a national disaster. The program was originally supported by federal funds through the Federal Emergency Management Agency (FEMA) during the COVID-19 pandemic, and is currently supported by DHCS through General Fund resources. CalHOPE services include: 1)

individual and group crisis counseling and support; 2) individual and public education; 3) community networking and support; 4) connection to resources; and 5) media and public service announcements.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposed funding shift.

Issue 13: Behavioral Health Modernization

Budget Change Proposal – May Revision. DHCS requests expenditure authority of $40 million ($20 million General Fund and $20 million federal funds) in 2023-24. If approved, these resources would support modernization of the behavioral health system, consistent with reform to the Mental Health Services Act proposed by the Governor.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25**
0001 – General Fund	$20,000,000	$-
0890 – Federal Trust Fund	$20,000,000	$-
Total Funding Request:	**$40,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. In March 2023, the Governor announced an effort to modernize the state's behavioral health system, as well as the Mental Health Services Act (Proposition 63, 2004). The components of this modernization effort would be as follows:

1) A $3 to $5 billion general obligation bond to support funding for unlocked community behavioral health residential settings. The bond would support thousands of beds for Californians with mental illness and substance use disorders, as well as homeless veterans.

2) Make changes to the Mental Health Services Act, including changing the allocation of county funding, broadening the target population to include individuals with substance use disorders, increase fiscal accountability for county expenditures on behavioral health, and transfer the MHSOAC to CalHHS. The changes to county funding would include:

   a. 30 percent of funding would support housing and enhanced care in residential settings for individuals with serious mental illness, serious emotional disturbance, or substance use disorder.
   b. 35 percent would support full service partnerships (FSP).
   c. 35 percent would support existing categories including non-FSP community services and supports, prevention and early intervention, capital facilities and technological needs, workforce education and training, and a prudent reserve.

Resource Request. DHCS requests expenditure authority of $40 million ($20 million General Fund and $20 million federal funds) in 2023-24 to support modernization of the behavioral health system, consistent with reform to the Mental Health Services Act proposed by the Governor. As of the publication of this agenda, DHCS has not released details of this proposal.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of this proposal

Issue 14: Behavioral Health Payment Reform

Trailer Bill Language Update – May Revision. DHCS proposes amendments to its January budget trailer bill language proposal to implement behavioral health payment reform. In particular, these amendments would authorize DHCS, rather than the Department of Finance, to submit the offset and transfer schedule to the Controller, to transfer certain funds into the Medi-Cal County Behavioral Health Fund, and govern the process of providing the schedule to the Controller.

Background. The 2022 Budget Act included General Fund expenditure authority of $21.8 million in 2021-22 and $45.4 million in 2022-23 to support the Behavioral Health Quality Improvement Program (BH-QIP), as part of behavioral health payment reform efforts under the California Advancing and Innovating Medi-Cal (CalAIM) initiative. CalAIM seeks to reform behavioral health payment methodologies in a multi-step process from the current cost-based reimbursement process to a rate-based and value-based structure using intergovernmental transfers to fund the non-federal share of services. The first step in the process, supported by the BH-QIP, will transition behavioral health services from the current claims coding system, Healthcare Common Procedure Coding System (HCPCS) Level II, to HCPCS Level I. According to DHCS, this transition will allow for more granular claiming and reporting of services provided, as well as more accurate reimbursements.

DHCS expects that, concurrent with the transition to HCPCS Level I, DHCS will transition to a rate-setting process for behavioral health services by peer groups of counties with similar costs of doing business. The non-federal share of rates would be provided by counties via intergovernmental transfer (IGT), rather than the current, cost-based certified public expenditure (CPE) process. DHCS would make annual updates to established rates to ensure reimbursement reflects the costs of providing services. DHCS would, at first, make payments to counties on a monthly basis, and would eventually transition to a quarterly payment schedule.

CalAIM also modified the previous medical necessity criteria for behavioral health services to ensure behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties. These changes separate the concept of eligibility for services from that of medical necessity, allowing counties to provide services to meet a beneficiary's behavioral health needs prior to diagnosis of a covered condition, clarify that treatment in the presence of a co-occurring substance use disorder is appropriate and reimbursable when medical necessity is met, implement a standardized screening tool to facilitate accurate determinations of which delivery system

(specialty mental health, Medi-Cal managed care, or Medi-Cal fee-for-service) is most appropriate for care, implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system in which they seek care, and make other revisions and technical corrections. These changes will ensure that eligibility criteria, largely being driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, will be the driving factor for determining the delivery system in which a beneficiary should receive services. DHCS has been phasing in these changes since January 1, 2022.

Trailer Bill Language Proposal – Behavioral Health Payment Reform. In the January budget, DHCS requested General Fund expenditure authority of $375 million in 2023-24 and proposed trailer bill language to authorize transition of county behavioral health plans from a certified public expenditure (CPE) protocol to intergovernmental transfers (IGTs), and to establish the Medi-Cal County Behavioral Health Fund to receive IGTs from counties to serve as the non-federal share of Medi-Cal behavioral health services.

In the May Revision, DHCS proposes amendments to its January budget trailer bill language proposal to implement behavioral health payment reform. In particular, these amendments would authorize DHCS, rather than the Department of Finance, to submit the offset and transfer schedule to the Controller, to transfer certain funds into the Medi-Cal County Behavioral Health Fund, and govern the process of providing the schedule to the Controller.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of this proposal

Issue 15: Behavioral Health Federal Funds Adjustment

Technical Adjustment – May Revision. DHCS requests federal fund expenditure authority of $21.1 million in 2023-24. If approved, these resources would allow DHCS to administer the following grants:

- Item 4260-115-0890 - $15,209,000 to support an increase in the federal Community Mental Health Services Block Grant awarded in 2022-23.
- Item 4260-116-0890 - $5,848,000 to support an increase in the federal Substance Abuse Prevention and Treatment Block Grant awarded in 2022-23.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of this adjustment.

Issue 16: Children and Youth BH Initiative – Fee Schedule Third Party Administrator

Local Assistance – May Revision. DHCS requests General Fund expenditure authority of $10 million in 2023-24 to create statewide infrastructure for provider management and to manage billing for behavioral health services furnished to student under the Children and Youth Behavioral Health Initiative statewide fee schedule.

Program Funding Request Summary – Local Assistance		
Fund Source	**2023-24**	**2024-25**
0001 – General Fund	$10,000,000	$-
Total Funding Request:	**$10,000,000**	**$-**

Background. As part of the Children and Youth Behavioral Health Initiative, the Legislature approved trailer bill language to require DHCS to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student 25 years of age or younger at a school site. A health care service plan, including a Medi-Cal managed care plan, or an insurer will, commencing January 1, 2024, be required to reimburse school-based services provided to one of its members according to the fee schedule, regardless of whether the provider is within the plan's or insurer's contracted provider network.

According to DHCS, there are significant operational complexities around provider management and claims submission for school-based or school-linked providers, as well as credentialing and provider oversight. Many school-based providers have no experience with billing commercial or self-insured plans for services provided to students. These resources would support development and implementation of the infrastructure for provider, billing, and claiming management for the behavioral health services provided to students as part of the Children and Youth Behavioral Health Initiative.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal

Issue 17: 988 Suicide and Crisis Lifeline (AB 988)

Budget Change Proposal – May Revision. DHCS requests expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund of $15 million in 2023-24. If approved, these resources would support eligible 988 behavioral health crisis services.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25**
3414 – 988 State Suicide and BH Crisis Svcs Fund	$15,000,000	$-
Total Funding Request:	**$15,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The National Suicide Hotline Designation Act of 2020 designated 988 as the new three-digit number for the national suicide prevention and mental health crisis hotline. To support the 988 system, the act authorized states to impose a fee on access lines for providing 988 related services. Revenue from the fee must be held in a designated account to be spent only in support of 988 services, including 1) ensuring the efficient and effective routing of calls made to the 988 national suicide prevention and mental health crisis hotline to an appropriate crisis center; and 2) the provision of acute mental health crisis outreach and stabilization by directly responding to the 988 national suicide prevention and mental health crisis hotline.

AB 988 (Bauer-Kahan), Chapter 747, Statutes of 2022, implements the 988 system in California, establishing 988 as the three-digit number for the National Suicide Prevention Hotline, which is now known as the 988 Suicide and Crisis Lifeline. Among other provisions, AB 988 requires the following:

- Requires the California Governor's Office of Emergency Services (CalOES) to appoint a 988 system director and convene an advisory board to guide how 988 is implemented and made interoperable with 911, including the creation of a new surcharge for 988 to fund the crisis services.
- Requires CalHHS to participate in the State 988 Technical Advisory Board convened by CalOES no less than quarterly until December 31, 2028.
- Requires CalHHS to convene a state 988 policy advisory group to advise on a set of recommendations for the implementation and administration of the five-year implementation plan for the 988 System;
- Requires CalHHS to convene the state 988 policy advisory group at least quarterly until December 31, 2023. The advisory group may be disbanded at the discretion of the CalHHS, but shall not be disbanded before January 1, 2024.
- Requires health plan and insurer coverage of 988 center services when medically necessary and without prior authorization;
- Establishes a 988 surcharge for the 2023 and 2024 calendar years at $0.08 per access line per month, and for years beginning January 1, 2025, at an amount based on a specified formula, but not greater than $0.30 per access line per month;
- States the intent of the Legislature that, by June 30, 2024, CalHHS and CalOES develop a plan for the statewide coordination of 988, 911, and behavioral health crisis services.
- Specifies the plan will be based on a five-year implementation plan that includes a landscape analysis of existing services and describes how to expand, improve, and link services with the goal of fully implementing the 988 system by January 1, 2030.
- Appropriates $300,000 from the General Fund to the 988 State Suicide and Behavioral Health Crisis Services Fund (previously the State Mental Health and Crisis Services Special Fund) to the Department of Tax and Fee Administration (CDTFA) for purposes of implementing this bill, and
- Contains an urgency clause to verify that the provisions of this bill go into immediate effect upon enactment.

The January budget included a total of 17.5 positions (7.5 for DMHC and ten for DHCS), and total expenditure authority of $13.2 million ($10.3 million 988 State Suicide and Behavioral Health Crisis Services Fund or 988 Fund, $2.2 million Managed Care Fund, and $773,000 federal funds) in 2023-24, $16 million ($13.2 million 988 Fund, $2.1 million Managed Care Fund, and $728,000 federal funds) in 2024-25, and $16.3 million ($13.2 million 988 Fund, $2.3 million Managed Care Fund, and $728,000 federal funds) annually thereafter to support implementation of 988.

Resource Request. DHCS requests expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund of $15 million in 2023-24 to support eligible 988 behavioral health crisis services. These resources would support workforce expansion to handle increased call volume, efficient and effective routing of telephone calls, personnel, and the provision of acute mental health services through telephone call, text, and chat to the 988 Lifeline.

Combined with the January budget request, the total requested resources from the 988 Fund for this purpose would be $19 million in 2023-24 and $12.5 million annually thereafter.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal

Issue 18: Los Angeles County CARE Court Start-Up Funding

Budget Bill Language – May Revision. DHCS requests budget bill language to authorize the use of $15 million of existing General Fund expenditure authority to support Los Angeles County planning and preparation to implement the Community Assistance, Recovery, and Empowerment (CARE) Act.

Background. SB 1338 (Umberg and Eggman), Chapter 319, Statutes of 2022, the Community Assistance, Recovery, and Empowerment (CARE) Act, is a new civil court process to deliver community-based behavioral health services and supports to Californians living with untreated schizophrenia spectrum or other psychotic disorders. The CARE Act is intended to serve as an upstream intervention for the most severely impaired Californians to prevent avoidable psychiatric hospitalizations, incarcerations, and conservatorships under the Lanterman-Petris-Short (LPS) Act. The CARE Act connects a person in crisis with a court-ordered care plan for up to 12 months, with the possibility to extend for an additional 12 months.

The 2022 Budget Act included General Fund expenditure authority of $57 million to be distributed to counties to support implementation of the CARE Act, including hiring, training, development of policies and procedures, information technology costs, and new billing processes, consistent with SB 1338. Of this amount, $26 million is available for the first cohort of counties to implement the CARE Act. In January 2023, Los Angeles County announced it would accelerate its implementation of the CARE Act and would join the first cohort of counties and implement the act by December 1, 2023. These proposed resources are meant to support Los Angeles County as it implements the CARE Act, which was not previously reflected in the proposed January budget.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this budget bill language proposal.

Issue 19: Contingency Management Pilot Extension

Budget Change Proposal – May Revision. DHCS requests 11 positions and expenditure authority of $1.5 million ($755,000 General Fund and $755,000 federal funds) in 2023-24, $5 million ($2.5 million General Fund and $2.5 million federal funds) in 2024-25 and 2025-26, $3.8 million ($1.9 million General Fund and $1.9 million federal funds) in 2026-27, and $2.2 million ($1.1 million General Fund and $1.1 million federal funds) in 2027-28. If approved, these positions and resources would support conversion of the contingency management program from a pilot project to a waiver demonstration benefit.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$755,000	$2,475,000
0890 – Federal Trust Fund	$755,000	$2,475,000
Total Funding Request:	**$1,510,000**	**$4,950,000**
Total Requested Positions:	**11.0**	**11.0**

* Additional fiscal year resources requested – 2025-26: $4,9750,000; 2026-27: $3,815,000; 2027-28: $2,180,000.

Background. The federal Centers for Medicare and Medicaid Services (CMS) approved the addition of contingency management as a new benefit to California's Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration. Contingency management uses small financial incentives combined with behavioral treatment and has been shown in repeated meta-analyses to be the most consistently effective treatment for stimulant use disorder. The launch of the pilot program was funded by the American Rescue Plan (ARP) Act of 2021, which provided qualifying states with a temporary 10 percent increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home- and community-based services (HCBS) from April 1, 2021, through March 31, 2024. State funds equivalent to the amount of federal funds attributable to the increased FMAP were deposited in the Home and Community-Based Services American Rescue Plan (HCBS ARP) Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan including the costs associated with the contingency management program, proposed to begin services in the fall of 2022. DHCS is proposing to convert the pilot to a waiver benefit under the California Advancing and Innovating Medi-Cal (CalAIM) initiative through the end of the CalAIM waiver in December 2026.

Staffing and Resource Request. DHCS requests 11 positions and expenditure authority of $1.5 million ($755,000 General Fund and $755,000 federal funds) in 2023-24, $5 million ($2.5 million General Fund and $2.5 million federal funds) in 2024-25 and 2025-26, $3.8 million ($1.9 million General Fund and $1.9 million federal funds) in 2026-27, and $2.2 million ($1.1 million General Fund and $1.1 million federal funds) in 2027-28 to support conversion of the contingency management program from a pilot project to a waiver demonstration benefit. Specifically, DHCS requests the following positions and resources:

Audits and Investigations – One position

- **One Health Program Auditor IV** position would develop various data analytic algorithms, evaluate algorithms to determine if the data identifies beneficiaries or providers that warrant further review, and lead investigation staff on preliminary investigations of beneficiaries or providers.

<u>Business Operations Technology Services Division</u> – Two positions

- **One Information Technology (IT) Specialist I** position and **one IT Specialist II** position would analyze changes needed to support data coming from the incentive management vendor and DMC-ODS counties, develop secure and complex code to support the initiative, and function as a technical analyst to translate data requirements to system requirements.

<u>Data Analytics Division</u> – One position

- **One Research Data Scientist II** position would perform analyses on data to assess completeness, accuracy, timeliness of submission, and other quality measures; develop a process for ongoing monitoring of data quality; analyze data used for evaluation and quality improvement; support ongoing monitoring and oversight of the program through identifying outliers and signs of fraud or abuse.

<u>Health Information Management Division</u> – One position

- **One IT Specialist I** position would monitor and evaluate requirements and system changes to support data quality reporting; develop data quality business rules requirements, metrics, and service level expectations; and ensure data processing by vendors meet departmental standards and programmatic requirements.

<u>Local Government Financing Division</u> – One position

- **One Associate Governmental Program Analyst (AGPA)** would analyze fiscal claim and invoice data from counties and the vendor; approve, monitor and track invoices; generate and monitor fiscal reports; work with the vendor and contract management team to ensure contract compliance and address contract issues.

<u>Medi-Cal Behavioral Health Division</u> – Three positions and $7.1 million contract resources

- **Two Health Program Specialist II** positions and **one AGPA** would perform oversight and monitoring of contractors; develop and implement policies, guidance, and procedures; lead intra-departmental collaboration on data collection, reporting, quality monitoring, program integrity, and payment functions; and provide clarification, training, and administrative support to internal and external stakeholders.
- $1.6 million over four years would support a contractor to implement training and technical assistance for counties and providers.
- $5.5 million over four years would support a contractor to manage the calculation, management, tracking, and distribution of incentives in the contingency management program.

<u>Medi-Cal Enterprise System Modernization Division</u> – One position

- **One IT Specialist II** position would lead ongoing product discovery to identify needed enhancements or fixes in response to changes in business need; articulate and ensure appropriate prioritization of

enhancements, fixes, or change requests; establish and monitor performance measures; and lead and ensure successful adoption and implementation of new functionality for users.

Quality and Population Health Management – One position and $1.7 million contract resources

- **One AGPA** would provide oversight and monitoring of the program evaluation contractor to determine compliance with deliverables and coordinate evaluation activities with other divisions and the external evaluation contractor.
- $1.7 million over five years would support a contractor to conduct an evaluation of the contingency management project, consistent with CMS requirements in the 1115 Waiver.

Enterprise Technology Services/IT Strategy Services Division - $743,000 contract resources

- $743,000 over four years would support a contractor to manage the implementation of a new system or modification of an existing system through the project lifecycle phases to support the contingency management program.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of this proposal

Issue 20: Naloxone Distribution Project Expansion

Budget Change Proposal – May Revision. DHCS requests expenditure authority from the Opioid Settlements Fund of $58 million in 2023-24, $28 million in 2024-25 and 2025-26, and $27.3 million in 2026-27. If approved, these resources would support expansion of the Naloxone Distribution Project.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
3397 – Opioid Settlements Fund	$58,000,000	$28,000,000
Total Funding Request:	**$58,000,000**	**$28,00,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2025-26: $28,000,000; 2026-27: $27,317,000.

Background. The Naloxone Distribution Project (NDP) was created in 2018 in response to a sharp in overdoses and aims to reduce opioid overdose deaths through the provision of free naloxone in the form of a spray that can be used by laypeople. Eligible entities for the distribution of naloxone include law enforcement, fire departments, first responders, schools and universities, county public health and behavioral health departments, and community based organizations, such as harm reduction organizations or community opioid coalitions. As of November 2022, DHCS reports the NDP has distributed more than 1.7 million units of naloxone to all 58 counties in the state. As of December 2022, more than 112,000 opioid overdose reversals have been reported to DHCS through the NDP. However, DHCS notes this number is likely underreported.

In the January budget, DHCS requested expenditure authority from the Opioid Settlements Fund of $32 million in 2023-24, $23 million in 2024-25, and $12 million in 2025-26 and 2026-27 to support the NDP. DHCS reports the NDP has a total of $61 million ($35.8 million General Fund, $10.5 million federal Substance Abuse Block Grant Funds, and $14.8 million Opioid Settlements Fund) available in 2022-23. In addition, the NDP has a total of $35.5 million General Fund available in 2023-24. However, DHCS indicates the demand for naloxone requested through the NDP continues to increase, resulting in the need for additional funding proposed in this request and the January budget request.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 21: Virtual Services in Driving Under the Influence Programs

Trailer Bill Language – May Revision. DHCS proposes trailer bill language to clarify its authority to regulate Driving Under the Influence programs that offer services virtually.

Background. Existing law invests in DHCS the sole authority to issue, deny, suspend, or revoke the license of a driving-under-the-influence (DUI) program. A DUI program is defined as any firm, partnership, association, corporation, local governmental entity, agency, or place that is licensed to provide alcohol or drug recovery services to persons who have had their license suspended, revoked, or delayed, or who has been suspended, revoked, or convicted of various violations of the Vehicle Code.

The proposed trailer bill authorizes DHCS to regulate the program through all-county letters, plan letters, information notices, or other instructions until regulations are promulgated. The trailer bill requires DHCS to promulgate regulations by January 1, 2026, regarding provision of alcohol or drug recovery services in virtual settings.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this trailer bill language proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: COVID-19 Response – Reduced Resources

Budget Change Proposal – May Revision. CDPH requests reduction of General Fund expenditure authority of $50 million. These resources were previously requested in the January budget to support contingency for unanticipated costs related to the COVID-19 pandemic.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25**
0001 – General Fund	($50,000,000)	$-
Total Funding Request:	**($50,000,000)**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. According to CDPH, its efforts during the COVID-19 pandemic have played a crucial role in slowing community transmission and saving the lives of many Californians by providing vaccinations, diagnostic testing, contact tracing, medical surge staff support for facilities in need, and emergency response activities at the border. The changing nature of the COVID-19 pandemic and the end of certain state and federal policies enacted in response to the pandemic, have resulted in evolution of the state's response, including implementation of the SMARTER Plan approach to COVID-19. The components of the SMARTER Plan are as follows:

- **Shots** – Individuals are recommended to stay up to date with COVID-19 vaccinations and boosters.
- **Masks** – Individuals are recommended to wear a good fitting mask with good filtration, according to masking recommendations based on COVID-19 Community Levels published by the federal Centers for Disease Control and Prevention (CDC).
- **Awareness** – The state will maintain the ability to promote vaccination, masking, and other mitigation measures in all 58 counties, while supporting engagement with at least 150 community-based organizations.
- **Readiness** – The state will maintain wastewater surveillance in all regions and enhance respiratory surveillance in the healthcare system while continuing to sequence at least 10 percent of positive COVID-19 test specimens. The state will also maintain the ability to add 3,000 clinical staff within two to three weeks of need across various healthcare facility types.
- **Testing** – The state will maintain commercial and local public health capacity statewide to perform at least 500,000 tests per day for COVID-19.
- **Education** – Expand school-based vaccination sites by 25 percent as eligibility for vaccines expands.
- **Rx -** Ensure local entities can order effective therapeutics within 48 hours.

According to CDPH, to continue the critical work of responding and maintaining preparedness, the state will continue to supply test kits to high-risk populations, promote the bivalent booster campaign with a focus on vulnerable individuals who are at risk for severe disease and hospitalizations, and work with healthcare systems to improve their incorporation of testing and treatment for their patients. Several efforts are winding down, such as the gradual demobilization of community testing sites as demand decreases, the Public Testing Lab Network, staffing deployments, and COVID-19 therapeutics initiatives as this work will eventually transition to the health care system. CDPH's 2023-24 budget request prioritizes the most

critical activities that need to continue, including vaccinations, testing, operations support, and information technology, so that California's most vulnerable populations are protected and to maintain a state of readiness.

In the January budget, CDPH requested General Fund expenditure authority of $101.3 million in 2023-24 to continue the state's efforts to protect public health and safety against the spread of COVID-19, including vaccinations, testing, and operations support, as well as implementing the state's SMARTER Plan. The specific allocations, compared to those adopted in the 2022 Budget Act, were as follows:

Areas of Expenditure	2022 Budget Act	2023-24 Proposal
Vaccinations (including boosters)	$93,000,000	$8,000,000
Testing	$530,000,000	$28,000,000
Operations Support	$165,133,000	$15,000,000
Public Health Readiness and Response	$18,284,000	$0
Enhanced Surveillance	$16,465,000	$0
Test to Treat Therapeutics	$158,129,000	$0
Border Operations	$411,025,000	$0
IT Pandemic Response	$0	$300,000
Staffing	$140,000,000	$0
Emergency Contingency Funds	$250,000,000	$50,000,000
TOTAL	**$1,782,036,000**	**$101,300,000**

CDPH requests reduction of General Fund expenditure authority of $50 million. These resources were previously requested in the January budget to support contingency for unanticipated costs related to the COVID-19 pandemic. Combined with the January budget request, CDPH requests a total of $51.3 million for COVID-19 pandemic response.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of this proposal.

Issue 2: Public Health Workforce Investments Reversion - Withdrawal

Local Assistance – May Revision. CDPH requests to withdraw its proposed reversion of General Fund expenditure authority of $49.8 million over four years, approved in the 2022 Budget Act, to support public health workforce investments. These programs were originally proposed for reversion in the January budget to address the General Fund shortfall.

Background. The 2022 Budget Act included significant investments in health workforce development in the areas of behavioral health, primary care, public health, and reproductive health. The public health investments in the package were as follows:

- *Waive Public Health Nurse Certification Fees* - $3.3 million annually for three years to waive public health nurse certification fees for three years to reduce barriers to registered nurses entering the field of public health.

- *Public Health Incumbent Upskilling* - $3.2 million annually for four years to establish the Public Health Workforce Career Ladder Education and Development Program to provide education and training for existing employees within the public health workforce, including stipends to offset up to 12 hours per week to complete educational requirements and grants for local health departments for additional hiring.

- *California Public Health Pathways Training Corps* - $8 million annually for three years to expand the California Public Health Pathways Training Corps, which provides a workforce pathway for early-career public health professionals from diverse backgrounds and disproportionately impacted communities.

- *California Microbiologist Training* - $3.2 million annually for three years to increase the number of Public Health Microbiologist Trainee spots, which is a requirement to become certified in California as a public health microbiologist.

- *Public Health Lab Aspire* - $3.2 million annually for three years to restore funding for the Lab Aspire Program, to address the severe shortage of trained and qualified public health laboratory directors.

- *California Epidemiologic Investigation Service (Cal-EIS) Training* - $3.2 million annually for three years to increase the number of Cal-EIS fellows, which trains epidemiologists for public health leadership positions.

January Budget Reversion of Resources to Address General Fund Problem. In the January budget, CDPH requested reversion of General Fund expenditure authority of $49.8 million over four years, approved in the 2022 Budget Act, to support public health workforce investments, to help address the state's General Fund problem. However, CDPH plans to utilize savings from reducing its COVID-19 Response request by $50 million General Fund for contingencies, to support the restoration of these workforce programs.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of this proposal.

Issue 3: AIDS Drug Assistance Program (ADAP) Estimate

AIDS Drug Assistance Program (ADAP) Estimate. The Office of AIDS within CDPH 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) and post-exposure prophylaxis (PEP) for Californians at risk of 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. Participating clients generally fall into one of five categories:

1. *Medication-only clients* are people living with HIV who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals, who only receive services associated with medication costs.
2. *Medi-Cal Share of Cost clients* are persons living with HIV enrolled in Medi-Cal who have a share of cost for Medi-Cal services. ADAP covers the share of cost for medications for these clients, who only receive services associated with medication costs.
3. *Private insurance clients* are persons living with HIV who have some form of health insurance, including through Covered California, privately purchased health insurance, or employer-based health insurance and who receive services associated with medication costs, health insurance premiums and medical out-of-pocket costs.
4. *Medicare Part D clients* are persons living with HIV enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group of clients receives services associated with medication co-pays, medical out-of-pocket costs, Medicare Part D health insurance premiums, and has the option for premium assistance with Medigap supplemental insurance policies, which cover medical out-of-pocket costs.
5. *Pre-exposure prophylaxis (PrEP) Assistance Program (PrEP-AP) clients* are individuals who are at risk for, but not infected with, HIV and have chosen to take PrEP, or post-exposure prophylaxis (PEP), as a way to prevent infection. For insured clients, PrEP-AP pays for PrEP- and PEP-related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's co-payment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP- and PEP-related medical costs, as medication is provided free by the manufacturer's medication assistance program.

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 Estimate – May Revision. The May 2023 ADAP Local Assistance Estimate reflects revised 2022-23 expenditures of $372.3 million, a decrease of $68.2 million or 15.5 percent compared to the January budget. According to CDPH, this decrease is primarily due to lower than expected projected medication expenditures for medication-only clients and lower than expected premiums for insured client groups. For 2023-24, CDPH estimates ADAP expenditures of $398 million, a decrease of $42.1 million, or 9.6 percent compared to the January budget. According to CDPH, the continued relative reduction of expenditures between 2023-24 and 2022-23, compared to the January budget, is similarly due to lower than expected medication and premium expenditures.

ADAP Local Assistance Funding Summary		
Fund Source	**2022-23**	**2023-24**
0890 – Federal Trust Fund	$106,494,000	$102,102,000
3080 – AIDS Drug Assistance Program Rebate Fund	$265,778,000	$295,940,000
Total ADAP Local Assistance Funding	**$372,272,000**	**$398,042,000**

ADAP tracks caseload and expenditures by client group. CDPH estimates ADAP caseload and expenditures for 2022-23 and 2023-24 will be as follows:

Caseload by Client Group	**2022-23**	**2023-24**
Medication-Only	9,913	9,657
Medi-Cal Share of Cost	53	55
Private Insurance	9,893	9,901
Medicare Part D	7,244	7,246
PrEP Assistance Program	6,028	8,318
TOTAL	**33,132**	**35,179**

Expenditures by Client Group	**2022-23**	**2023-24**
Medication-Only	$255,816,221	$258,436,183
Medi-Cal Share of Cost	$395,481	$407,504
Private Insurance	$82,978,930	$83,607,076
Medicare Part D	$24,765,380	$26,784,768
PrEP Assistance Program	$11,009,028	$24,307,207
TOTAL	**$374,965,040**	**$393,542,738**

Costs for administration of ADAP are estimated to be $3.1 million in 2022-23 and $3.4 million in 2023-24. Costs for administration of PrEP-AP are estimated to be $620,741 in 2022-23 and $6.1 million in 2023-24. Enrollment costs are estimated to be $7 million in 2022-23 and $6.9 million in 2023-24.

Subcommittee Staff Comment and Recommendation—Hold Open

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

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

Issue 4: Genetic Disease Screening Program (GDSP) Estimate

Genetic Disease Screening Program Estimate – May Revision. The May 2023 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $166 million ($36.9 million state operations and $129.2 million local assistance) in 2022-23, and $187.6 million ($38.1 million state operations and $149.5 million local assistance) in 2023-24.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2022-23	**2023-24**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$36,856,000	$38,066,000	$1,210,000
Local Assistance:	$129,157,000	$149,542,000	$20,385,000
Total GDSP Expenditures	**$166,013,000**	**$187,608,000**	**$21,595,000**

Background. According to CDPH, the Genetic Disease Screening Program (GDSP) performs the following tasks to support its mission:

- Screens newborns and pregnant individuals for genetic and congenital disorders in a cost-effective and clinically effective manner. The screening programs provide testing, follow-up, and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.
- Ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance.
- Fosters informed participation in its programs in an ethical manner through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.
- Provides ongoing critical review, testing, and evaluation of existing programs to ensure program objectives and goals are being met.
- Develops programs to adopt new methods and implement new services that further enhance the effectiveness and efficiency of current and future prevention programs.
- Promotes use of high-quality consumer education materials on genetic disorders, screening for birth defects and genetic services.

GDSP operates two primary screening programs: the Newborn Screening Program and the Prenatal Screening Program. Caseload and expenditures for these programs are reflected in the GDSP Estimate along with operational support costs for the programs.

Newborn Screening (NBS) Program. Newborn screening, recognized nationally as an essential preventive health measure, began in California in 1966 with the testing of infants for phenylketonuria (PKU). In 1980, the program was expanded to include galactosemia, primary congenital hypothyroidism, and included a more comprehensive follow-up system. In 1990, screening for sickle cell disease was added

to the screening program, which allows for identification of related non-sickling hemoglobin disorders, including beta-thalassemia major, and Hb E/beta thalassemia. In 1999, the program implemented screening for hemoglobin H and hemoglobin H - Constant Spring disease. In 2005 the screening panel was expanded to include additional metabolic disorders and congenital adrenal hyperplasia (CAH), and in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

According to CDPH, disorders screened for by the program have varying degrees of severity and, if identified early, many can be treated before they cause serious health problems. Between 1980 and 2017, 18,920,529 babies were screened resulting in early identification of the following disorders:

Disorder	Cases
Phenylketonuria (PKU)	1,264
Primary Congenital Hypothyroidism	7,857
Galactosemia	1,018
Sickle Cell Disease and other clinically significant Hemoglobinopathies	5,006
Biotinidase Deficiency (BD)	209
Cystic Fibrosis (CF)	636
Congenital Adrenal Hyperplasia (CAH)	376
Metabolic Fatty Acid Oxidation Disorders	741
Metabolic Amino Acid Disorders (other than PKU)	203
Metabolic Organic Acid Disorders	518
Other Metabolic Disorders	62
Severe Combined Immunodeficiencies	75
X-Linked Adrenoleukodystrophy (ALD) and Other Peroxisomal Disorders	50
TOTAL	**18,015**

The NBS program currently screens infants in California for more than 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, were added to the screening panel in 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), SB 1095 requires them to be added to the NBS program screening panel within two years. The current fee for screening in the NBS program is currently $211.

<u>NBS Caseload Estimate:</u> The May Revision estimates NBS program caseload of 421,863 in 2022-23, a decrease of 1,428 or 0.3 percent, compared to 2021-22 actual total caseload of 423,291. The May Revision estimates NBS program caseload of 425,620 in 2023-24, an increase of 3,757 or 0.9 percent, compared to the revised 2022-23 estimate. These estimates are based on state projections of the number of live births in California. CDPH assumes 100 percent of children born in California will participate in the NBS program annually.

Prenatal Screening (PNS) Program. The Prenatal Screening (PNS) program provides prenatal screening services and follow-up diagnostic services, where indicated, to all pregnant individuals in California to detect birth defects during pregnancy. The program offers two types of prenatal screening:

- Cell-free DNA (cfDNA) Screening - Cell-free DNA (cfDNA) is a non-invasive screening test for fetal chromosomal abnormalities that relies on extraction of maternal and fetal cells from a pregnant individual's blood sample. cfDNA can detect chromosomal abnormalities and birth defects including trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome), and trisomy 13 (Patau syndrome). Compared to the metabolic screening methods previously used by PNS, cfDNA screening results in fewer false positives and better accuracy resulting in fewer pregnant individuals being referred for diagnostic follow-up services.

- Maternal Serum Alpha-Fetoprotein (MSAFP) Screening – Alpha-fetoprotein (AFP) is a protein mainly produced in the fetal liver and released into the maternal serum (MSAFP) and amniotic fluid. A small amount crosses the placenta and becomes measurable in the maternal serum towards the end of the first trimester. Levels rise steadily through the second trimester. This screening detects neural tube defects, such as open spina bifida or anencephaly, which result in higher than normal MSAFP in maternal serum.

For pregnant individuals with screening results indicating a high risk for a birth defect, the program provides free follow-up diagnostic services at state-approved Prenatal Diagnosis Centers (PDCs). Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation in the screening testing and follow-up services is voluntary and the fee for testing through the PNS program is $232. Of the $232 fee, $222 is deposited in the Genetic Disease Testing Fund to support PNS, and $10 is deposited into the California Birth Defect Monitoring Program Fund. There is also a separate fee for neural tube defect (NTD) screening of $85.

PNS Caseload Estimate: The May Revision estimates PNS program caseload of 199,571 cfDNA specimens and 185,591 Biochemical Screening test specimens in 2022-23. The May Revision estimates PNS program caseload of 313,920 cfDNA specimens and 291,282 Biochemical Screening test specimens in 2023-24. These estimates are based on state projections of the number of live births in California. CDPH estimates approximately 46 percent of projected births in California will participate in the PNS program in 2022-23 and 73 percent will participate in 2023-24.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of the caseload and expenditure changes for the Newborn Screening Program.

2. Please provide a brief overview of the caseload and expenditure changes for the Prenatal Screening Program.

Issue 5: Women, Infants, and Children (WIC) Program Estimate

WIC Program Estimate – May Revision. The May 2023 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.3 billion ($1.1 billion federal funds and $193.4 million

WIC manufacturer rebate funds) in 2022-23 and $1.4 billion ($1.2 billion federal funds and $217.3 million WIC manufacturer rebate funds) in 2023-24. The federal fund amounts include state operations costs of $64.5 million in 2022-23 and 2023-24.

Women, Infants, and Children (WIC) Funding Summary			
	2022-23	**2023-24**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0890 – Federal Trust Fund			
State Operations:	$64,502,000	$64,475,000	($22,000)
Local Assistance:	$1,066,203,000	$1,108,609,000	$42,406,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$193,360,000	$217,313,000	$23,953,000
Total WIC Expenditures	**$1,324,065,000**	**$1,390,397,000**	**$66,332,000**

Background. The WIC program provides nutrition services and food assistance for pregnant, breastfeeding, and non-breastfeeding individuals, infants, and children up to their fifth birthday at or below 185 percent of the federal poverty level. WIC program services include nutrition education, breastfeeding support, assistance with finding health care and other community services, and vouchers for specific nutritious foods that are redeemable at WIC-authorized retail food outlets throughout the state. The WIC program receives federal funds from the United States Department of Agriculture (USDA) under the federal Child Nutrition Act of 1966. Specific uses of WIC Program funds are governed by federal laws and regulations, and CDPH must report funds and expenditures monthly.

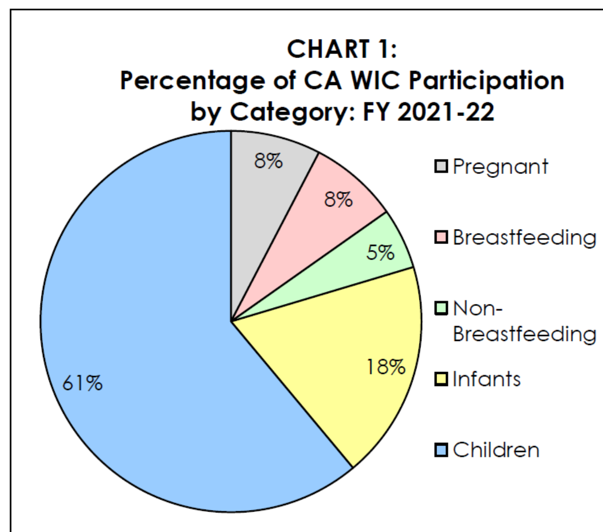
The WIC program's food expenditures are funded by a combination of federal grants and rebates from manufacturers of infant formula. Federal WIC regulations require that state WIC programs have sole supplier rebate contracts in place with infant formula manufacturers for milk-based and soy-based infant formula. As infant formula is provided to WIC recipients, the program receives a rebate from the manufacturer which is used to fund additional food expenditures. In addition to food expenditures, the program receives federal funds from the Nutrition Services and Administration (NSA) grant, which are used to contract with local agencies for direct services provided to WIC families including intake, eligibility determination, benefit issuance, nutrition education, breastfeeding support, and referrals to health and social services. The NSA grant also funds state operations for administering the WIC program.

WIC Participant Caseload. Food expenditures are divided into five participant categories, each with special nutrition needs that influence food costs:

- **Pregnant individuals** are eligible for the WIC program at any point in their pregnancy, and receive supplemental foods high in protein, calcium, iron, vitamin A, and vitamin C to support optimal fetal development.
- **Breastfeeding individuals** are eligible for benefits up to their infant's first birthday, and receive an enhanced supplemental food package with foods high in protein, calcium, iron, vitamin A, and vitamin C to support caloric needs during breastfeeding.

- **Non-breastfeeding individuals** are eligible for benefits up to six months after the birth of their infants, and receive a supplemental food package to help in rebuilding nutrient stores, especially iron and calcium, and achieving a healthy weight after delivery.
- **Infants** are eligible until one year of age. The WIC Program promotes breastfeeding as the optimal infant feeding choice due to its many health, nutritional, economical, and emotional benefits to parent and baby. Infants may also receive supplemental foods that are rich in protein, calcium, iron, vitamin A, and vitamin C during this critical period of development.
- **Children** are eligible from age one up to age five, and receive supplemental foods rich in protein, calcium, iron, vitamin A, and vitamin C. These nutrients have been shown to be lacking in the diets of children who qualify for WIC benefits and are needed to meet nutritional needs during critical periods of development. The food package also provides foods lower in saturated fat to reduce the risk of childhood obesity.

According to the WIC program Estimate, WIC participation by category, as of 2021-22, was as follows:



Caseload Estimates. The May Revision assumes 956,319 average monthly WIC participants in 2022-23, an increase of 13,082 or 1.4 percent compared to the average monthly WIC participants estimated in the January budget. The budget assumes 991,619 average monthly WIC participants in 2023-24, an increase of 45,267 or 4.8 percent compared to the average monthly WIC participants estimated in the January budget.

Food Expenditures Estimate. The May Revision includes $937.6 million ($744.2 million federal funds and $193.4 million rebate fund) in 2022-23 for WIC program food expenditures, an increase of $16.2 million or 1.8 percent, compared to the January budget. According to CDPH, the increase in costs is due to an increase in participation, an increase in the estimated cost of the fruits and vegetables benefit increase, offset by a reduction in projected rebate revenue.

The May Revision includes $1 billion ($786.6 million federal funds and $217.3 million rebate funds) in 2023-24 for WIC program food expenditures, an increase of $59.7 million or 6.3 percent compared to the food expenditures estimate in the January budget. According to CDPH, this increase in costs is driven by

an increase in participants, a higher food inflation rate, and estimated costs for the fruits and vegetables benefit increase.

Nutrition Services and Administration (NSA) Estimate. The May Revision includes $322 million for other local assistance expenditures for the NSA budget in 2022-23 and 2023-24, unchanged from the January budget. The budget also includes $64.5 million for state operations expenditures in 2022-23 and 2023-24, also unchanged from the January budget.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the caseload and expenditure changes for the WIC program.

Issue 6: Lead Renovation, Repair, and Painting Program (SB 1076)

Budget Change Proposal – May Revision. CDPH requests two positions and General Fund expenditure authority of $546,000. If approved, these positions and resources would support implementation of residential lead-based paint Renovation, Repair, and Painting Program required by SB 1076 (Archuleta), Chapter 507, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$546,000	$546,000
Total Funding Request:	**$546,000**	**$546,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2024-25.

Background. Lead is a highly neurotoxic heavy metal which does not degrade or break down in the environment. Lead exposure can cause a wide range of health problems and can result in lifelong damaging effects. At very high levels of exposure, lead can cause seizures, coma, and death. Lower levels of lead exposure affect the nervous system, decrease intelligence, and create learning deficits. The federal Centers for Disease Control and Prevention (CDC) has determined there is no safe level of lead exposure.

The federal Environmental Protection Agency (EPA) established the lead Renovation, Repair, and Painting (RRP) Rule to regulate the renovation of homes and child-occupied buildings constructed before the ban on the use of lead-based paint in 1978. EPA currently administers the RRP Rule in California. According to CDPH, EPA has less than ten staff assigned to administer the rule in EPA Region 9, which comprises Arizona, California, Hawaii, Nevada, the Pacific Islands, and 148 Tribal Nations. According to the EPA's Office of the Inspector General, this level of staff has led to a reduced ability of the EPA to adequately implement, enforce, and evaluate the success of the RRP rule. Less than one tenth of one percent of the 40,000 to 60,000 residential renovation contractors in California are inspected by EPA each year and between five and ten enforcement cases a year are taken by EPA in the state.

SB 1076 (Archuleta), Chapter 507, Statutes of 2022, requires CDPH to review and amend its regulations to comply with the RRP Rule. To comply with the requirements of SB 1076, CDPH would seek authorization from EPA to take over administration of the RRP Rule in California. Fourteen states are currently authorized to implement the RRP Rule and successfully perform a higher rate of RRP certification, inspections, and enforcement than the federal program. CDPH would need to establish a new system of fees to replace those of the EPA to support the new state-administered program. CDPH's Childhood Lead Poisoning Prevention Branch (CLPPB) and Occupational Health Branch (OHB) would administer the program, requiring an increase in staffing needs for both branches supported by the new fees.

Once CDPH becomes an RRP authorized state, CLPPB would expand training opportunities to residential renovation contractors to learn about lead-safe work practices, create a lead-safe residential renovation workforce, increase awareness of the threat of lead poisoning and associated screening, and support compliance with and enforcement of RRP requirements. The program would also require RRP training providers to become accredited in California, be subject to more frequent audits and inspections, and submit course completion forms to track students and minimize the potential for fraudulent certification.

CDPH would also require individual renovators and renovation firms that perform RRP work to become certified in California by receiving regular training in lead-safe work practices to minimize lead exposure to themselves and their customers, and by employing at least one RRP-certified individual renovator.

According to CDPH, the new fees implemented by the program would be as follows:

1) A fee of $400 for five year accreditation of a training provider for each RRP-related class type. This fee would replace fees currently charged by EPA
2) A fee of $36 for accredited RRP training providers for each Course Completion Form submitted to verify that a student took the class and passed the exam. This would be a new fee.
3) A fee of $375 for five year certification of an RRP firm. This fee would replace fees currently charged by EPA.
4) A fee of $270 for a two year RRP certification of an individual. This would be a new fee.

Staffing and Resource Request. CDPH requests two positions and General Fund expenditure authority of $546,000. If approved, these positions and resources would support implementation of residential lead-based paint Renovation, Repair, and Painting Program required by SB 1076 (Archuleta), Chapter 507, Statutes of 2022. However, as of the publication of this agenda, CDPH has not released details of this proposal.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of this proposal.

Issue 7: Center for Health Care Quality Estimate

Center for Health Care Quality Program Estimate – May Revision. The May Revision includes expenditure authority for the Center for Health Care Quality of $481.5 million ($7.7 million General Fund, $143.1 million federal funds, and $330.7 million special funds and reimbursements) in 2022-23, an increase of $32.3 million or 7.3 percent compared to the January budget, and $462.1 million ($5.2 million General Fund, $132.6 million federal funds, and $324.3 million special funds and reimbursements) in 2023-24, an increase of $29.3 million or 6.9 percent compared to the January budget. According to CDPH, the increase in 2022-23 is attributed to an increase in federal fund authority related to various awards of funding from various federal programs, while the increase in 2023-24 is attributed primarily to various budget adjustments for staffing audits and other quality improvement measures.

CHCQ Funding Summary, November 2022 Estimate		
Fund Source	**2022-23**	**2023-24**
0001 – General Fund	$7,677,000	$5,169,000
0890 – Federal Trust Fund	$143,080,000	$132,554,000
0942 – Special Deposit Fund		
Internal Departmental Quality Improvement Account	$3,686,000	$687,000
State Health Facilities Citation Penalty Account	$2,144,000	$2,144,000
Federal Health Facilities Citation Penalty Account	$7,141,000	$6,140,000
0995 – Reimbursements	$13,862,000	$14,789,000
3098 – Licensing and Certification Program Fund	$303,864,000	$300,581,000
Total CHCQ Funding	**$481,454,000**	**$462,064,000**
Total CHCQ Positions	**1536.4**	**1539.4**

Background. CDPH'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. 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.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of the changes to the Center for Health Care Quality Estimate for May Revision.

Issue 8: Various Technical Adjustments

Technical Adjustments – April Finance Letter and May Revision. CDPH requests the following technical adjustments at the May Revision:

- Internal Departmental Quality Improvement Account (April Finance Letter) – CDPH proposes budget bill language to authorize the Department of Finance to augment expenditure authority from the Internal Quality Improvement Account to support quality improvement activities in skilled nursing facilities, upon review of a request from CDPH. This account is supported by penalties paid by health facilities for violations that meet the definition of immediate jeopardy of death or serious harm to a patient, or administrative penalties associated with breaches of medical information.

- Information Technology, Data Science, and Informatics for a 21st Century Public Health System – CDPH proposes budget bill language to authorize General Fund augmentation of $15.9 million for planning activities associated with the Information Technology, Data Science, and Informatics for a 21st Century Public Health System proposal adopted in the 2022 Budget Act. The activities would be associated with Enterprise Planning and Strategy (Initiative 0), Dynamic Public Health Structure (Initiative 1), and Public Health Data Integration (Initiative 4). The expenditure of the funds would be contingent upon approval of enterprise planning and strategy documents by the California Health and Human Services Agency and the California Department of Technology.

- Public Health Regional Climate Planning Reversion – CDPH proposes budget bill language to specify the amounts associated with the reversion of Climate and Health Resilience Planning Grants proposed in the January budget. The language would specify reversion of General Fund expenditure authority of $1.3 million in the state operations item and $23.8 million in the local assistance item, for a total of $25 million.

- Domestic Violence Training and Education Fund Workload Adjustment – CDPH requests a net-zero shift between state operations and local assistance items of $135,000 in the Domestic Violence Training and Education Fund. These resources would fund community-based organizations and conduct community-level domestic violence primary prevention work.

- Increased Resources for the Vector-Borne Disease Section – CDPH requests expenditure authority of $68,000 from the Vectorborne Disease Account annually to right-size expenditures related to personnel who will oversee vector control technicians' certification criteria for public health pesticide applicators in California. According to CDPH, the program continues to experience increases in operational costs and expenditures, including higher employee salaries, indirect costs, and increasing overhead.

- Proposition 99 Adjustments – CDPH requests the following adjustments to accounts supported by the Proposition 99 tobacco tax:

    - Health Education Account – CDPH requests an increase of $5.3 million
    - Research Account – CDPH requests a decrease of $18,000
    - Unallocated Account – CDPH requests a decrease of $57,000

- Breast Cancer Research Account Adjustment – CDPH requests reduction in expenditure authority from the Breast Cancer Research Account of the Breast Cancer Fund of $27,000 to reflect available resources in the fund.

Subcommittee Staff Comment and Recommendation—Hold Open

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

1. Please provide a brief overview of these technical adjustments.