Senate Budget and Fiscal Review—Nancy Skinner, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Susan Talamantes Eggman, Ph.D., Chair
Senator Melissa Melendez
Senator Richard Pan, M.D.

Friday, February 19, 2021
9:00 a.m.
State Capitol - Room 3191

Consultant: Scott Ogus

Item **Department** **Page**

PUBLIC COMMENT

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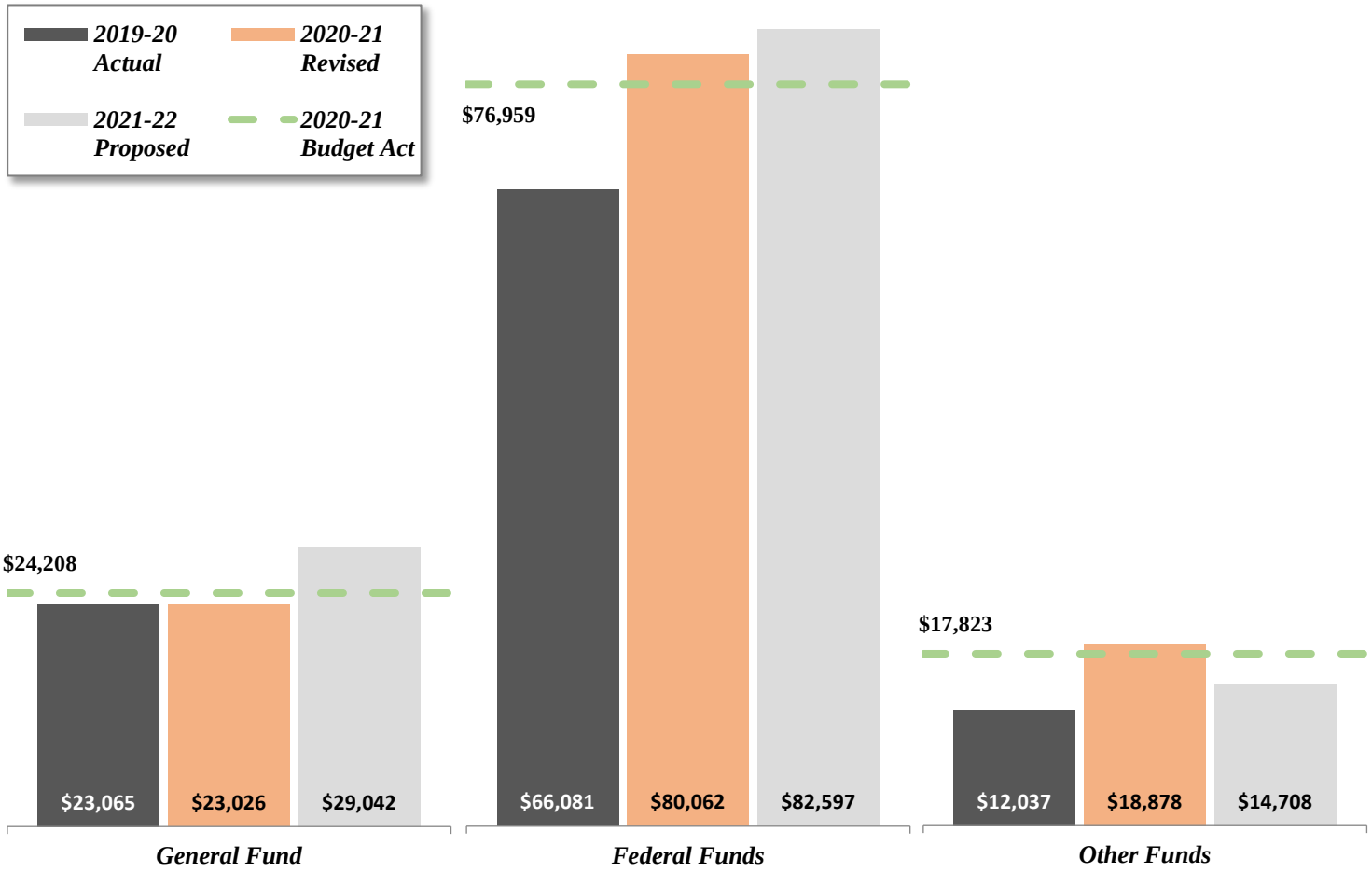
4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview

Department of Health Care Services – *Three-Year Funding Summary*
(dollars in millions)



Department of Health Care Services - *Department Funding Summary*			
Fund Source	**2019-20** ***Actual***	***2020-21*** ***Revised***	***2021-22*** ***Proposed***
General Fund	$23,065,202,000	$23,025,574,000	$29,042,240,000
Federal Funds	$66,080,794,000	$80,061,565,000	$82,596,990,000
Other Funds	$12,036,917,000	$18,878,071,000	$14,708,372,000
Total Department Funding:	**$101,182,913,000**	**$121,965,210,000**	**$126,347,602,000**
Total Authorized Positions:	**3600.0**	**3607.0**	**3752.5**
Other Funds Detail:			
Breast Cancer Control Account (0009)	*$9,652,000*	*$10,659,000*	*$10,848,000*
Childhood Lead Poisoning Prev Fund (0080)	*$1,058,000*	*$1,058,000*	*$1,058,000*

DUI Program Licensing Trust Fund (0139)	*$1,331,000*	*$1,253,000*	*$1,383,000*
Hospital Svc. Account, Prop 99 (0232)	*$130,657,000*	*$92,170,000*	*$77,295,000*
Physician Svcs. Account, Prop 99 (0233)	*$40,862,000*	*$26,639,000*	*$22,072,000*
Unallocated Account, Prop 99 (0236)	*$75,287,000*	*$57,071,000*	*$47,770,000*
Narc Treatment Prog Lic Trust Fund (0243)	*$1,882,000*	*$1,795,000*	*$1,913,000*
Perinatal Insurance Fund (0309)	*$19,761,000*	*$14,150,000*	*$17,177,000*
Audit Repayment Trust Fund (0816)	*$67,000*	*$67,000*	*$67,000*
Medi-Cal Inpt Payment Adj Fund (0834)	*$86,491,000*	*$105,103,000*	*$112,886,000*
Special Deposit Fund (0942)	*$71,501,000*	*$83,530,000*	*$82,796,000*
Reimbursements (0995)	*$1,413,182,000*	*$2,306,400,000*	*$1,347,799,000*
County Health Init Matching Fund (3055)	*$176,000*	*$176,000*	*$176,000*
Childrens Med Services Rebate Fund (3079)	*$61,815,000*	*$77,636,000*	*$24,600,000*
Mental Health Services Fund (3085)	*$2,168,649,000*	*$2,146,684,000*	*$2,309,484,000*
Nondesignated Public Hosp Supp. Fund (3096)	*$0*	*($236,000)*	*$0*
Priv Hospital Supplemental Fund (3097)	*$27,000,000*	*$116,255,000*	*$26,916,000*
Mental Heath Facility Lic Fund (3099)	*$382,000*	*$375,000*	*$386,000*
Residential/Outpatient Prog Lic Fund (3113)	*$8,100,000*	*$7,988,000*	*$8,655,000*
Childrens Health/Human Svcs Fund (3156)	*$0*	*$100,000,000*	*$0*
Hosp Qual Assurance Revenue Fund (3158)	*$2,890,616,000*	*$5,408,012,000*	*$3,863,457,000*
SNF Quality & Accountability Fund (3167)	*($2,279,000)*	*$2,128,000*	*($1,472,000)*
Emerg Air Trans/Children's Fund (3168)	*$6,660,000*	*$7,004,000*	*$3,446,000*
Public Hosp Invest, Improve, Inc Fund (3172)	*$860,655,000*	*$440,129,000*	*$0*
LongTerm Care Qual Assurance Fund (3213)	*$542,358,000*	*$628,556,000*	*$532,752,000*
Health and Human Svcs Spec Fund (3293)	*$640,730,000*	*$0*	*$0*
Healthcare Treatment Fund, Prop 56 (3305)	*$924,559,000*	*$992,281,000*	*$719,418,000*
Health Plan Fines/Penalties Fund (3311)	*$8,939,000*	*$26,439,000*	*$5,798,000*
Medi-Cal Emerg Med Transport Fund (3323)	*$70,896,000*	*$66,194,000*	*$69,848,000*
Medi-Cal Drug Rebate Fund (3331)	*($175,365,000)*	*$1,490,899,000*	*$1,456,697,000*
Health Care Services Special Fund (3334)	*$0*	*$2,769,657,000*	*$2,517,458,000*
Cannabis Tax Fund - DHCS (3350)	*$126,464,000*	*$206,782,000*	*$265,906,000*
PACE Oversight Fund (3362)	*$0*	*$460,000*	*$771,000*
Electronic Cigarette Products Tax Fund (3366)	*$0*	*$0*	*$0*
Loan Repayment Program Account (3375)	*$0*	*$0*	*$29,092,000*
Whole Person Care Pilot Spec Fund (8107)	*$468,356,000*	*$414,481,000*	*$273,790,000*
Global Payment Program Spec Fund (8108)	*$1,257,788,000*	*$716,011,000*	*$671,268,000*
Desig Public Hosp GME Spec Fund (8113)	*$276,859,000*	*$553,051,000*	*$206,862,000*
LIHP Fund (8502)	*$21,828,000*	*$7,214,000*	*$0*

Department of Health Care Services – *Changes to State Operations and Local Assistance*				
Fiscal Year:	**2019-20**	**2020-21 (CY)**	**2021-22 (BY)**	**CY to BY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$255,296,000	$250,029,000	$279,567,000	$29,538,000
Federal Funds[1]	$549,084,000	$476,743,000	$514,117,000	$37,374,000
Special Funds/Reimb	$173,803,000	$229,864,000	$279,567,000	$49,703,000
Total Expenditures	**$978,183,000**	**$956,636,000**	**$1,073,251,000**	**$116,615,000**
Total Auth. Positions	**3600.0**	**3607.0**	**3752.5**	**145.5**
LOCAL ASSISTANCE (*MEDI-CAL AND OTHER PROGRAMS)*				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$22,809,906,000	$22,775,545,000	$28,762,673,000	$5,987,128,000
Federal Funds[1]	$65,531,710,000	$79,584,822,000	$82,082,873,000	$2,498,051,000
Special Funds/Reimb	$11,863,114,000	$18,648,207,000	$14,428,805,000	($4,219,402,000)
Total Expenditures	**$100,204,730,000**	**$121,008,574,000**	**$125,274,351,000**	**$4,265,777,000**
[1]*Federal Funds include Funds 0890, 7502, and 7503*				

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

- ***Medi-Cal.*** DHCS serves as the single state agency for Medi-Cal, California's Medicaid program. Medi-Cal is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 13.2 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low-income people with specific diseases. As of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level are also eligible for services in Medi-Cal.

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

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations. Its programs include:

Indian Health Program, Rural Health Services Development Program, Seasonal Agricultural and Migratory Workers Program, State Office of Rural Health, Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program, Small Rural Hospital Improvement Program, and the J-1 Visa Waiver Program.

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

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

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 2: COVID-19 Pandemic – Medi-Cal Response

Oversight – COVID-19 Pandemic: Medi-Cal Response. The state of California, like much of the rest of the nation and the world, has been responding for more than a year to a pandemic outbreak of novel coronavirus (COVID-19), which causes respiratory illness with symptoms similar to the flu, including fever, cough, and shortness of breath. COVID-19 can also cause more severe respiratory illness, which may result in hospitalization and the need for mechanical ventilation or other critical medical interventions. The California Office of Emergency Services (CalOES), the Department of Public Health (DPH), and local health departments have been leading the public response to the pandemic, including mitigation strategies to slow the spread of COVID-19 such as stay-at-home orders and other restrictions, managing hospital and health system surge capacity, COVID-19 testing capacity and logistics, contact tracing of confirmed cases and contacts, and the distribution and administration of two recently approved COVID-19 vaccines. DHCS, as the single state agency for Medi-Cal, is responsible for administration of the program's COVID-19 response to ensure Medi-Cal beneficiaries are able to receive necessary health, oral health, behavioral health, long-term care, and home- and community-based services while maintaining appropriate public health interventions to protect against transmission of COVID-19. The Medi-Cal response to the COVID-19 pandemic has been comprised of new federal requirements contained in various Congressional relief packages, as well as waivers and other flexibilities sought by the department to address the delivery of care during the pandemic.

Families First Coronavirus Response Act (FFCRA) – Increased FMAP and Continuous Coverage. The federal Families First Coronavirus Response Act (FFCRA) provided an increase in the federal medical assistance percentage (FMAP) for state Medicaid programs, including Medi-Cal, of 6.2 percent for Medi-Cal expenditures and 4.34 percent for Children's Health Insurance Program (CHIP) expenditures. According to DHCS, this increase in FMAP will offset General Fund expenditures in the Medi-Cal program by $2.9 billion in 2020-21 and $2.2 billion in 2021-22. DHCS assumes the enhanced FMAP will be available until December 31, 2021.

As a condition of the enhanced FMAP in the FFCRA, Medi-Cal beneficiaries may not be disenrolled from the program, except under limited circumstances, during the public health emergency. As a result, DHCS expects caseload impacts from the continuous coverage requirement to result in additional Medi-Cal costs of $5.2 billion ($1.7 billion General Fund and $3.6 billion federal funds) in 2020-21 and $12 billion ($3.9 billion General Fund and $8.1 billion federal funds in 2021-22.

Federal Flexibilities Approved for Medi-Cal Through Waivers and Other Authorities. Since the beginning of the public health emergency, DHCS has sought approval from the federal Centers for Medicare and Medicaid Services (CMS) for various program flexibilities to allow the continued delivery of Medi-Cal services while maintaining appropriate public health interventions to prevent the transmission of COVID-19. DHCS has sought these flexibilities through State Plan Amendments, as well as under Sections 1115 and 1135 of the Social Security Act, and Appendix K amendments to 1915(c) home- and community-based waiver programs.

State Plan Amendments. The Medicaid State Plan is a comprehensive written document that describes the nature and scope of the state's Medicaid program, known as Medi-Cal. The State plan is a contractual agreement between California and CMS and requires administration of the Medi-Cal program in conformity with federal Medicaid laws and regulations. States may request changes to a State Plan

through State Plan Amendments (SPAs). During the pandemic, California received CMS approval, or approval is pending, for the following SPAs:

- Child and Pregnancy Coverage Rules (SPA 17-0043) – Under a previously approved SPA (17-0043), DHCS used its existing authority to waive monthly premiums and other cost-sharing, such as co-pays, and to implement temporary adjustments to enrollment, eligibility determination, or determination policies for the following programs: Lower-Income Unborn Option, Medi-Cal Access Program (MCAP), Medi-Cal Access Infant Program (MCAIP), and the County Children's Health Initiative Program (CCHIP). Allows self-attestation of eligibility for application or renewal and waives monthly premiums.
- Clinical Laboratory and Long-Term Care Reimbursement (20-0024) - Allows Medi-Cal to do the following: 1) reimburse all COVID-19 related laboratory testing and collection procedures at 100 percent of Medicare reimbursement; and 2) allow a 10 percent per diem rate increase for certain long-term care facilities.
- COVID-19 Vaccination Coverage and Reimbursement (20-0040, pending CMS approval) - Seeks to add coverage for COVID-19 vaccine administration for Medi-Cal beneficiaries, and establish Medicare reimbursement rates for COVID-19 vaccine administration for all providers when furnished within their scope of practice in accordance with California state law, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Service Memorandum of Agreement (IHS-MOA) providers. FQHCs, RHCs, and IHS-MOA providers would receive the payment outside their all-inclusive, per-visit reimbursement.
- COVID-19 Testing in Schools (20-0046, pending CMS approval) - Seeks to establish rates at 70 percent of Medicare reimbursement for COVID-19 testing when provided to Medi-Cal children in Transitional Kindergarten through 12th grade when provided in schools.
- Crisis Stabilization Units (21-0003, pending CMS approval) - Seeks to allow Medi-Cal beneficiaries to receive crisis stabilization services for up to four days (96 hours), rather than the current limit of less than 24 hours per episode. Also seeks to reimburse crisis stabilization services providers up to 20 hours for each 24 hour period for up to four consecutive days, or 80 total hours in a 96 hour period.
- Durable Medical Equipment Reimbursement (21-0016, pending CMS approval) - Seeks to increase reimbursement rates for durable medical equipment (DME) oxygen and respiratory equipment to 100 percent of the corresponding Medicare rate, for dates of service on or after March 1, 2020.

Section 1115 Waivers. Section 1115 of the Social Security Act provides CMS broad authority to allow experimental, pilot, or demonstration projects likely to assist in promoting the objectives of Medicaid. California's 1115 Waiver, Medi-Cal 2020, recently extended by one year until December 31, 2021, provides authority for a broad array of Medi-Cal programs including its managed care delivery system, the Drug Medi-Cal Organized Delivery System, Community-Based Adult Services, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, the Global Payment Program (GPP), Whole Person Care (WPC) pilots, and the Dental Transformation Initiative (DTI). Changes to the 1115 Waiver may be made through waiver amendments. During the pandemic, California received approval, or approval is pending, for the following 1115 Waiver amendments:

- Drug Medi-Cal Organized Delivery System - Allows the following changes to the Drug Medi-Cal Organized Delivery System (DMC-ODS): 1) suspends limitations on two non-continuous 90 day residential treatment regimens per year during the public health emergency; 2) suspends current 30 day (for adolescents) and 90 day (for adults) maximums for a single residential treatment stay during

the public health emergency; 3) modifies the rate-setting methodology of the DMC-ODS Certified Public Expenditure; 4) allows services to be provided in locations recognized as temporary extensions of qualified residential settings; and 5) suspends minimal clinical service hour and disallowance requirements for intensive outpatient and residential substance use disorder treatment.

- Public Hospital Redesign and Incentives in Medi-Cal and Global Payment Program - Allows modifications to the distribution of incentive payments under the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, and adjusts thresholds for the Global Payment Program (GPP).
- Community-Based Adult Services - Allows the following changes to community-based adult services (CBAS): 1) allows CBAS providers to provide limited in-center activities, as well as telephonic, telehealth, and in-home services; 2) expands settings where CBAS may be provided; and 3) allows assessments to be conducted telephonically using self-reported information by participants or caregivers.
- COVID-19 Vaccines (pending CMS approval) - Seeks to extend coverage of COVID-19 vaccines and administration to the following limited-scope benefit populations in Medi-Cal: 1) individuals eligible for tuberculosis-related benefits; 2) individuals eligible for the optional COVID-19 testing group; 3) non-citizen individuals eligible for restricted-scope benefits; 4) individuals eligible for family planning benefits under the Family Planning Access, Care and Treatment (Family PACT) program. Also seeks to allow delivery of COVID-19 vaccines through the Medi-Cal fee-for-service delivery system, rather than managed care contracts, to standardize delivery of vaccines to beneficiaries.
- COVID-19 Testing (pending CMS approval) - Seeks to extend coverage of COVID-19 testing in school settings under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening provisions for children in Transitional Kindergarten through 12th grade. Also seeks to allow delivery of COVID-19 testing through the Medi-Cal fee-for-service delivery system, rather than managed care contracts, to standardize delivery of the testing benefit.

Section 1135 Waivers. Section 1135 of the Social Security Act permits CMS to temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements during a federally declared public health emergency to ensure sufficient health care items and services are available to meet the needs of individuals enrolled in public programs in the emergency area and time periods, and providers who give such services in good faith can be reimbursed and exempted from sanctions. During the pandemic, California received CMS approval for the following 1135 Waivers:

- 1135 Waiver Approval (March 2020) - Allows Medi-Cal to do the following: 1) temporarily suspend Medicaid fee-for-service prior authorization and medical necessity processes; 2) extend pre-existing authorizations a beneficiary previously received until the end of the public health emergency; 3) modify timeframe for managed care entities to resolve appeals of adverse benefit determinations prior to a fair hearing process to no less than one day; 4) modify timeframe for beneficiaries to exercise appeal rights to allow an additional 120 days to request a fair hearing; 5) waive certain provider enrollment requirements for the duration of the public health emergency; and 6) allow facilities to be fully reimbursed for services rendered in an unlicensed alternative care setting, as long as the state determines it meets minimum reasonable standards in the context of the public health emergency.
- 1135 Waiver Approval – Telehealth (August 2020) - Allows Medi-Cal to waive clinic facility requirements to permit services via telehealth.
- 1135 Waiver Approval – Fair Hearings (December 2020) - Allows Medi-Cal to do the following: 1) temporarily extend the timeframe to reinstate services and benefits after a fair hearing beyond 10 days,

but should reinstate the services and benefits as quickly as practicable, 2) allow managed care plans to continue benefits if requested within the current 10 day time frame or reinstate benefits for the beneficiary upon request between 11 and 30 days if the plan has not yet made a decision on the appeal and a fair hearing is pending.

Appendix K of 1915(c) Home- and Community-Based Services Waivers. Appendix K of the state's 1915(c) Home- and Community-Based Services Waivers allows states to request waiver amendments to respond to emergencies. Services provided under 1915(c) waivers include the Developmental Disabilities (DD) Waiver, the Home- and Community-Based Alternatives Waiver, the Assisted Living Waiver, the HIV/AIDS Waiver, and Multipurpose Senior Services Program. During the pandemic, California received CMS approval for the following Appendix K waiver amendments:

- Multi-purpose Senior Services Program - Allows Multi-purpose Senior Services Programs (MSSP) sites to conduct telephonic assessments, video conferencing, or live video interactions in lieu of face-to-face visits, in accordance with HIPAA requirements.
- HIV/AIDS Waiver – Allows the following for the HIV/AIDS Waiver: 1) telephonic or live virtual video conferencing in lieu of, or as an option for, face-to-face visits, in accordance with HIPAA requirements; 2) care management activities (level of care evaluations, home visits, and home environment assessments) to be conducted via telephonic or live video assessments in lieu of face-to-face visits; 3) digital signatures for forms that require participant or legal representatives' signatures; 4) waiver agencies to extend the time in which they have to complete level of care re-evaluations and ongoing comprehensive nursing and psychosocial reassessments by an additional 120 days beyond the current 180 day requirement.
- Assisted Living Waiver - Allows Assisted Living Waiver (ALW) Care Coordination Agencies (CCAs) to: 1) conduct telephonic or video conferencing interactions in lieu of, or as an option for, face-to-face visits for initial assessments or enrollments, in accordance with HIPAA requirements; 2) conduct telephonic or live video virtual assessments in lieu of face-to-face assessments for level of care; 3) temporarily modify incident reporting requirements for CCAs to allow facility staff to submit incident reports on non-standard forms as long as all elements of the form are present; 4) temporarily suspend the 60 day enrollment period for applicants unable to complete the application due to COVID-19 impacts; 5) temporarily allow for an extension of the 31 to 60 day re-enrollment period of waiver participants who moved from assisted living for hospitalization to retain their slot or enrollment in the waiver; 6) temporarily allow digital signature for forms that require participant or legal representatives' signatures; and 7) allows prioritization of enrollment and intake processing for applicants in an inpatient facility stay within areas of the state designated as "hot spots", without having been in an institution for 60 days.
- Home- and Community-Based Alternatives Waiver – Allows the following changes for the Home- and Community-Based Alternatives Waiver: 1) permits payment for servcies rendered by family caregivers or legally responsible individuals; 2) modifies provider qualifications to permit unlicensed waiver personal care services providers as long as they are currently in-home supportive services providers; 3) modify provider types to allow certified nurse assistants to provide private duty nursing; 4) modify licensure or other requirements for settings where waiver services are furnished, allowing telehealth (including telephonic or virtual live video conferencing) as an alternative option to face-to-face interactions; 5) modify processes for waiver eligibility level of care evaluations and re-evaluations via telephonic or virtual live video conferencing as an alternative option to face-to-face interactions, in accordance with HIPAA requirements; 6) pause waiver disenrollments of participants who are re-

institutionalized, beyond the 30 day limit, because a caregiver contracts COVID-19 or it is unsafe for them to return to the community; 7) temporarily allow digital signature for forms that require participant or legal representatives' signatures; 8) allows prioritization of enrollment and intake processing for applicants in an inpatient facility stay within areas of the state designated as "hot spots", without having been in an institution for 60 days; and 9) aligns rates with requirements in the FFCRA to allow two weeks of emergency paid sick leave when a waiver personal care service provider is unable to work due to the COVID-19 pandemic.

- Developmental Disabilities Waiver - Allows the following changes for Department of Developmental Services waiver programs: 1) temporarily changes service locations to allow services such as day services to be provided in the participant's home; 2) temporarily modify provider qualifications if a participant decides to self-direct to an individual to provide a service, as long as the individual is at least 18 years of age and possesses the skills and experience to provide the service; 3) temporarily modify service plan development requirements for in-person attendance of service plan development and monitoring meetings, allowing the option for telephonic or live virtual video conferencing; 4) temporarily allow retainer payments for habilitation, behavioral intervention services, and day services due to absences for the emergency; and 5) allows provision of technology, equipment, and training to assist waiver consumers in accessing services remotely.
- Multiple Waiver Programs – Personal Care Services – Allows a waiver personal care service provider to exceed the maximum workday limit of 12 hours per day, without penalty, when necessary to reduce a waiver participant's potential exposure to COVID-19 or when providers are unavailable as a result of the public health emergency. Also allows retainer payments for services that provide support for personal care or activities of daily living including residential habilitation, behavior intervention and day services, which include personal care or components of personal care.

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of the state and federal flexibilities for eligibility, enrollment, delivery of health care services, provider reimbursement, or other activities authorized during the pandemic.

2. Please provide a brief accounting of the fiscal and programmatic impacts of these flexibilities or other federal requirements authorized during the pandemic.

Issue 3: November 2020 Medi-Cal Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2020 Medi-Cal Local Assistance Estimate includes $117.9 billion ($22.5 billion General Fund, $79 billion federal funds, and $16.4 billion special funds and reimbursements) for expenditures in 2020-21, and $122.2 billion ($28.4 billion General Fund, $81.8 billion federal funds, and $12 billion special funds and reimbursements) for expenditures in 2021-22.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2020-21 (CY)**	**2021-22 (BY)**	**CY to BY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$21,344,400,000	$27,622,057,000	$6,277,657,000
Federal Funds	$75,062,866,000	$77,513,294,000	$2,450,428,000
Special Funds/Reimbursements	$16,346,739,000	$12,013,747,000	($4,332,992,000)
Total Expenditures	**$112,754,005,000**	**$117,149,098,000**	**$4,395,093,000**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$1,002,510,000	$633,742,000	($368,768,000)
Federal Funds	$3,700,064,000	$3,922,743,000	$222,679,000
Special Funds and Reimbursements	$9,698,000	$5,269,000	($4,429,000)
Total Expenditures	**$4,712,272,000**	**$4,561,754,000**	**($150,518,000)**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$124,477,000	$144,153,000	$19,676,000
Federal Funds	$260,491,000	$319,600,000	$59,109,000
Special Funds and Reimbursements	$0	$0	$0
Total Expenditures	**$384,968,000**	**$463,753,000**	**$78,785,000**
TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$22,471,387,000	$28,399,952,000	$5,928,565,000
Federal Funds	$79,023,421,000	$81,755,637,000	$2,732,216,000
Special Funds and Reimbursements	$16,356,437,000	$12,019,016,000	($4,337,421,000)
Total Expenditures	**$117,851,245,000**	**$122,174,605,000**	**$4,323,360,000**

Caseload. In 2020-21, the budget assumes annual Medi-Cal caseload of 14 million, a decrease of 1.9 percent compared to assumptions in the 2020 Budget Act. The department estimates 83.5 percent of Medi-Cal beneficiaries, or 11.7 million, will receive services through the managed care delivery system while 16.5 percent, or 2.3 million, will receive services through the fee-for-service delivery system.

In 2021-22, the budget assumes annual Medi-Cal caseload of 15.6 million, an 11.7 percent increase compared to the revised caseload estimate for 2020-21. The department estimates 84.4 percent of Medi-Cal beneficiaries, or 13.2 million, will receive services through the managed care delivery system while 15.6 percent, or 2.4 million, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The November 2020 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

2020-21 General Fund Savings - The budget includes decreased General Fund expenditures in the Medi-Cal program of $1.2 billion in 2020-21 compared to the 2020 Budget Act. These savings are primarily attributable to the following factors:

- Reduced estimated caseload impact of COVID-19 – $665 million savings
- Savings from enhanced federal medical assistance percentage (FMAP) – $366 million savings
- Reduced estimated repayments of inappropriately claimed federal financial participation – $418 million savings)
- Increased Hospital Quality Assurance Fee payments – $176 million savings
- Various other adjustments – $245 million savings

These savings are offset by the following increased General Fund costs in 2020-21:

- Vaccine administration and other COVID-19 related costs – $80.8 million cost
- Reduced savings from delay of Medi-Cal Rx Implementation – $121 million cost
- Increase in deferrals of federal financial participation – $322 million cost
- Managed care capitation payment corrections – $335 million cost

2021-22 COVID-19 Impacts – The budget includes increased General Fund expenditures $3.6 billion related to the impact of the COVID-19 pandemic on the Medi-Cal program. Specifically, these impacts include the following factors:

- Caseload impacts – According to DHCS, the federal Families First Coronavirus Relief Act (FFCRA) prohibits states from disenrolling Medi-Cal beneficiaries, except under limited circumstances, during the public health emergency declaration. The estimate assumes the public health emergency declaration will continue until December 31, 2021. DHCS expects caseload to grow during this period as fewer individuals exit the program. In addition, DHCS expects caseload to grow due to pandemic-related job loss and other economic dislocations. The budget estimates General Fund expenditures associated with caseload to increase by $2.6 billion compared to revised expenditure estimates for 2020-21.
- Enhanced FMAP savings – DHCS assumes COVID-related enhanced FMAP will continue until December 31, 2021. Consequently, only six months of additional savings would be available in

the 2021-22 fiscal year, resulting in an estimated reduction of General Fund savings of $689 million compared to the revised estimates for 2020-21.

- Vaccine administration costs – The budget estimates the Medi-Cal program will experience increased General Fund expenditures of $107 million to reimburse Medi-Cal providers for the administration of COVID-19 vaccines to beneficiaries. The represents an increase of General Fund expenditures of $97 million compared to the revised estimates for 2020-21, consistent with the acceleration of vaccine distribution as supplies increase.
- Various other COVID-19 impacts – The budget estimates the cumulative impact of COVID-19 changes to the Medi-Cal program will result in increased General Fund expenditures of approximately $220 million compared to the revised estimates for 2020-21.

Behavioral Health Continuum Infrastructure Funding – The budget includes General Fund expenditure authority of $750 million, available over three years, to provide a continuum of behavioral health services to address short-term crisis stabilization, acute needs, peer respite, and other clinically enriched longer-term treatment and rehabilitation services for persons with behavioral health disorders. Counties would receive funding for these investments through a competitive grant process, which includes a match of local funds, with a goal of adding at least 5,000 beds, units, or rooms to existing behavioral health capacity.

California Advancing and Innovating in Medi-Cal (CalAIM) – The budget includes $1.1 billion ($541.9 million General Fund) in 2021-22, growing to $1.5 billion ($755.5 million General Fund), as well as proposed statutory changes to the Medi-Cal program to implement the California Advancing and Innovating in Medi-Cal (CalAIM) initiative, a comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program. The budget proposes allocation of this funding to the following CalAIM components in 2021-22:

- $187.5 million ($93.7 million General Fund) to support the new enhanced care management (ECM) benefit in Medi-Cal managed care plans, beginning January 1, 2022.
- $47.9 million ($24 million General Fund to support in-lieu-of services (ILOS) benefits adopted by Medi-Cal managed care plans, beginning January 1, 2022.
- $300 million ($150 million General Fund) to fund incentives for managed care plans to invest in voluntary ILOS programs and partner with community-based organizations and providers, including but not limited to community clinics, public hospital systems, and county behavioral health systems.
- $401.6 million ($174.7 million General Fund) to support transitions of populations between the fee-for-service and managed care delivery systems, as part of the CalAIM transformation of Medi-Cal.
- $113.5 million ($57 million General Fund) for enhanced reimbursements for dental services previously included in the Dental Transformation Initiative component of Medi-Cal 2020, California's federal 1115 Medicaid Waiver.
- $21.8 million General Fund for the behavioral health quality improvement program, which helps county behavioral health programs make technical and other improvements to facilitate future behavioral health integration and payment reform efforts.
- $23.9 million ($11 million General Fund) for state operations costs related to CalAIM.

General Fund Support for Proposition 56 Supplemental Provider Payments – The budget includes General Fund expenditures of $275.3 million to support supplemental payments to Medi-Cal providers

previously supported by Proposition 56 tobacco tax revenue. According to DHCS, the reduction in available revenue is attributable to the assumed implementation of the state's ban on flavored tobacco and vaping products.

Student Behavioral Health Services Incentive Program –The budget includes $400 million ($200 million General Fund) and proposed trailer bill language to implement an incentive program for Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase utilization of preventive and early intervention behavioral health services by students. Of this expenditure authority, $389 million ($194.5 million General Fund and $194.5 million federal funds) is allocated for the incentive program in the Medi-Cal Local Assistance Estimate.

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

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

1. Please provide a brief overview of the significant General Fund changes in the Medi-Cal program in the 2020-21 and 2021-22 fiscal years.

Issue 4: November 2020 Family Health Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2020 Family Health Local Assistance Estimate includes $332.1 million ($181.9 million General Fund, $44.6 million federal funds, and $105.6 million special funds and reimbursements) for expenditures in 2020-21, and $268.9 million ($212.3 million General Fund, $5.1 million federal funds, and $51.5 million special funds and reimbursements) for expenditures in 2021-22.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2020-21 (CY)**	**2021-22 (BY)**	**CY to BY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$96,679,000	$78,514,000	($18,165,000)
Federal Funds	$39,519,000	$0	($39,519,000)
Special Funds/Reimbursements	$12,664,000	$3,992,000	($8,672,000)
County Funds [non-add]	[$80,243,000]	[$81,696,000]	[$1,453,000]
Total CCS Expenditures	**$148,862,000**	**$82,506,000**	**($66,356,000)**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$70,007,000	$114,380,000	$44,373,000
Special Funds and Reimbursements	$70,390,000	$25,026,000	($45,364,000)
Total GHPP Expenditures	**$140,397,000**	**$139,406,000**	**($991,000)**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$15,182,000	$19,387,000	$4,205,000
Federal Funds	$5,128,000	$5,128,000	$0
Special Funds and Reimbursements	$22,504,000	$22,504,000	$0
Total EWC Expenditures	**$42,814,000**	**$47,019,000**	**$4,205,000**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$181,868,000	$212,281,000	$30,413,000
Federal Funds	$44,647,000	$5,128,000	($39,519,000)
Special Funds and Reimbursements	$105,558,000	$51,522,000	($54,036,000)
County Funds [non-add]	[$84,124,000]	[$86,088,000]	[$1,964,000]
Total Family Health Expenditures	**$332,073,000**	**$268,931,000**	**($63,142,000)**

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

The programs included in the Family Health Estimate are:

- **California Children's Services (CCS)**: The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 168,446 in 2020-21, an increase of 359 or 0.2 percent, compared to the 2020 Budget Act. The budget estimates Medi-Cal CCS caseload of 168,540 in 2021-22, an increase of 94 or 0.06 percent, compared to the revised 2021-22 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 14,571 in 2020-21, an increase of 154 or one percent, compared to the 2020 Budget Act. The budget estimates state-only CCS caseload of 14,571 in 2021-22, unchanged compared to the revised 2020-21 estimate.
- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington's, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal. GHPP costs for Medi-Cal eligible individuals are reflected in the Medi-Cal Local Assistance Estimate
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal GHPP caseload of 702 in 2020-21, an increase of 14 or two percent, compared to the 2020 Budget Act. The budget estimates Medi-Cal GHPP caseload of 710 in 2021-22, an increase of eight or 0.1 percent, compared to the revised 2020-21 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 660 in 2020-21, a decrease of two or 0.3 percent, compared to the 2020 Budget Act. The budget estimates state-only GHPP caseload of 668 in 2021-22, an increase of eight or 1.2 percent, compared to the revised 2020-21 estimate.
- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).
  Caseload Estimate: The budget estimates EWC caseload of 24,919 in 2020-21, a decrease of 2,702 or 9.8 percent, compared to the 2020 Budget Act. The budget estimates EWC caseload of 27,425 in 2021-22, an increase of 2,506 or 10.1 percent compared to the revised 2020-21 estimate.

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

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

1. Please provide a brief overview of the significant changes in Family Health Estimate programs in the 2020-21 and 2021-22 fiscal years.

Issue 5: California Advancing and Innovating in Medi-Cal (CalAIM)

Local Assistance, Budget Change Proposal, and Trailer Bill Language – Governor's Budget. DHCS requests expenditure authority of $1.1 billion ($520.8 million General Fund and $552.9 million federal funds) for local assistance costs. If approved, these resources would allow DHCS to implement the California Advancing and Innovating in Medi-Cal (CalAIM) initiative, which seeks to transform the Medi-Cal delivery, program, and payment systems to improve beneficiary health outcomes and result in long-term cost savings.

DHCS also requests 33 positions and expenditure authority of $23.9 million ($11 million general Fund and $12.8 million federal funds) in 2021-22, 40 positions and expenditure authority of $28.2 million ($13.2 million General Fund and $15 million federal funds) in 2022-23, $25.2 million ($12 million General Fund and $13.2 million federal funds) in 2023-24, $23.9 million ($11.6 million General Fund and $12.3 million federal funds) in 2024-25, and $20.3 million ($9.8 million General Fund and $10.5 million federal funds) in 2025-26. If approved, these positions and resources would support the state operations costs of implementing the CalAIM initiative.

In addition, DHCS proposes trailer bill language to make statutory changes necessary to implement the components of the CalAIM initiative.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$520,832,000	$520,832,000
0890 – Federal Trust Fund	$552,913,000	$552,913,000
Total Funding Request:	**$1,073,745,000**	**$1,073,745,000**

* Resources ongoing after 2022-23.

Program Funding Request Summary – Budget Change Proposal		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$11,041,000	$13,230,000
0890 – Federal Trust Fund	$12,819,000	$14,960,000
Total Funding Request:	**$23,860,000**	**$28,190,000**
Total Requested Positions:	**33.0**	**40.0**

* Additional fiscal year resources requested – 2023-24: $25,193,000; 2024-25: $23,927,000; 2025-26: $20,250,000

Background. During the fall of 2019, the Administration released a comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program, known as the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. Due to the pandemic, the Administration delayed implementation of CalAIM in the 2020-21 fiscal year. In 2021, the Governor's January budget includes funding and proposed trailer bill language to commence a comprehensive effort to transform the Medi-Cal program. CalAIM is an ambitious effort to incorporate evidence-based investments in prevention, case management, and non-traditional services into the Medi-Cal program. Many of these investments were piloted during the state's most recent 1115 Waiver, Medi-Cal 2020, and the Administration is seeking to incorporate these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for Medi-Cal managed

care plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD), and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity.

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

CURRENT MEDI-CAL STRUCTURE AND DEMONSTRATION PROJECTS

California's Section 1115 Waiver – Medi-Cal 2020. Section 1115 of the Social Security Act authorizes the federal Department of Health and Human Services to allow experimental, pilot, or demonstration projects likely to assist in promoting the objectives of Medicaid. The broad authority under Section 1115 allows states to request a waiver of Medicaid coverage requirements, such as the requirement that Medicaid benefits be offered uniformly statewide, which allows operation of demonstration components in specified counties or provision of benefits to specific populations. States may also request waiver of restrictions on expenditure authority, which allows states to receive federal financial participation for certain benefits not ordinarily eligible for federal Medicaid funds.

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

The most recent Waiver renewal, "Medi-Cal 2020", was originally approved until December 31, 2020, but was extended by one year during the COVID-19 pandemic, and contains four primary demonstration components: Whole Person Care Pilots, Public Hospital Redesign and Incentives in Medi-Cal, the Global Payment Program, and the Dental Transformation Initiative.

Whole Person Care Pilots. The Whole Person Care (WPC) Pilots coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and well-

being through more efficient and effective use of resources. WPC Pilots allow individual public entities or a consortium of public entities to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. WPC Pilot entities identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population progress. Allowable target populations include one or more of the following:

- High Utilizers – Individuals with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement
- Chronic Conditions – Individuals with two or more chronic conditions
- MH/SUDS – Individuals with mental health and/or substance use disorders
- Homelessness – Individuals currently experiencing homelessness
- At-Risk-Of Homelessness – Individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutional settings
- Justice-Involved – Individuals recently released from institutions, including jail or prison

WPC Pilots are permitted to provide services that would best fit the needs of their target populations and could be delivered with existing infrastructure and resources. The eight categories of services provided by the pilots are as follows[1]:

- Outreach – Outreach services to identify prospective enrollees and assess their eligibility in the field or in clinical and other settings.
- Care Coordination – Coordination of medical, behavioral health, and social services to improve health and reduce unnecessary utilization in high-risk, high utilizer target populations.
- Housing Support – Assistance in accessing and obtaining sustainable housing solutions to maximize the number of enrollees living in healthy, stable living situations. Financial assistance used to maintain and/or achieve healthy, stable living situations.
- Peer Support – WPC staff with lived experience similar to the target populations who provide knowledge, guidance, and emotional, social, or practical support to WPC enrollees. These individuals often provide care coordination and housing support services, as well as guiding and supporting enrollees through behavioral health and social services.
- Benefit Support – Assistance with applying for, obtaining, and/or appealing for public benefits (e.g., Supplemental Security Income, Cal-Fresh, etc.).
- Employment Assistance – Workforce training on resume building, interview skills, and/or other supports necessary in order to obtain a job.
- Sobering Center – A safe environment for intoxicated individuals to receive detoxification services.
- Medical Respite – Post-acute respite services for enrollees discharged from the hospital and other inpatient settings, which allow enrollees to recuperate in a safe environment until they have the resources to care for themselves.

[1] Pourat N, Chuang E, Chen X, O'Masta B, Haley LA, Lu C, Huynh MP, Albertson E, and Huerta DM. Interim Evaluation of California's Whole Person Care (WPC) Program. Los Angeles, CA: UCLA Center for Health Policy Research, September 2019.

DHCS approved 25 applications for WPC Pilots from the following entities[2]:

Lead Entity	Estimated Five-year Beneficiary Count	Total Five-Year Budget
Alameda County Health Care Services Agency	20,000	$283,453,400
City of Sacramento	4,386	$64,078,680
Contra Costa Health Services	15,600	$203,958,160
County of Marin, Dept. of Health and Human Services	3,516	$20,000,000
County of Orange, Health Care Agency	9,303	$31,066,860
County of San Diego, Health & Human Services Agency	1,049	$43,619,950
County of Santa Cruz, Health Services Agency	625	$20,892,336
County of Sonoma, Dept. of Health Services	3,040	$16,704,136
Kern Medical Center	2,000	$157,346,500
Kings County Human Services Agency	600	$12,848,360
L.A. County Department of Health Services	154,044	$1,260,352,362
Mendocino County Health and Human Services Agency	600	$10,804,720
Monterey County Health Department	500	$34,035,672
Napa County	800	$22,921,433
Placer County Health and Human Services Department	450	$20,126,290
Riverside University Health System - Behavioral Health	38,000	$35,386,995
San Bernardino Co. - Arrowhead Regional Med. Center	2,000	$24,537,000
San Francisco Department of Public Health	16,954	$161,750,000
San Joaquin County Health Care Services Agency	2,255	$18,365,004
San Mateo County Health System	5,000	$165,367,710
Santa Clara Valley Health and Hospital System	10,000	$250,191,859
Small County WPC Collaborative (San Benito, Mariposa)	287	$10,362,176
Shasta County Health and Human Services Agency	600	$19,403,550
Solano County Health & Social Services	250	$4,667,010
Ventura County Health Care Agency Pl	2,280	$107,759,837
TOTAL	**294,139**	**$3,000,000,000**

The total budget for the WPC Pilots is $3 billion ($1.5 billion local funds and $1.5 billion federal matching funds). WPC Pilots targeting individuals at risk of or experiencing homelessness were permitted to implement housing interventions, such as tenancy-based care management services or county housing pools, with the non-federal portion of pilot funding. In addition, the 2019 Budget Act included a one-time General Fund investment of $100 million to assist WPC Pilots with funding for the costs of long-term and short-term housing, such as hotel vouchers and rental subsidies, as well as capital investment for housing projects for Medi-Cal beneficiaries who are mentally ill and are experiencing homelessness, or are at risk of homelessness. These funds were distributed as follows[3]:

[2] Department of Health Care Services. "California Whole Person Care Applications Statistics". February 2019.

[3] Department of Health Care Services. "One Time Housing Fund Overview and Methodology". August 8, 2019.

ALLOCATION OF 2019 BUDGET ACT WHOLE PERSON CARE HOUSING FUNDING			
Pilot	***Allocation***	***Pilot***	***Allocation***
Alameda	$ 4,647,159.90	City of Sacramento	$ 3,059,351.17
Contra Costa	$ 2,058,505.04	San Benito	$ 1,600,251.33
Kern	$ 1,213,867.52	San Bernardino	$ 1,646,279.96
Kings	$ 1,166,795.01	San Diego	$ 5,327,990.32
Los Angeles	$ 36,139,682.34	San Francisco	$ 8,130,059.30
Marin	$ 2,522,162.80	San Joaquin	$ 1,366,774.54
Mariposa	$ 1,033,636.00	San Mateo	$ 2,340,849.14
Mendocino	$ 1,137,158.69	Santa Clara	$ 5,680,408.35
Monterey	$ 2,407,786.57	Santa Cruz	$ 2,642,337.19
Napa	$ 1,491,766.53	Shasta	$ 1,198,355.90
Orange	$ 3,413,986.51	Solano	$ 1,603,827.17
Placer	$ 1,318,475.78	Sonoma	$ 3,284,476.48
Riverside	$ 1,999,856.42	Ventura	$ 1,568,200.04
		TOTAL	**$100,000,000.00**

Interim Evaluation of WPC Pilots[4]. In January 2020, researchers at the UCLA Center for Health Policy Research released a draft interim evaluation of California's WPC program, conducted under a contract with DHCS to fulfill the evaluation requirements included in the state's 1115 Waiver. The UCLA researchers surveyed the WPC pilots to identify populations served, pilot infrastructure, and whether the pilots are improving the delivery of care, improving beneficiary health, lowering costs and building a sustainable, collaborative program.

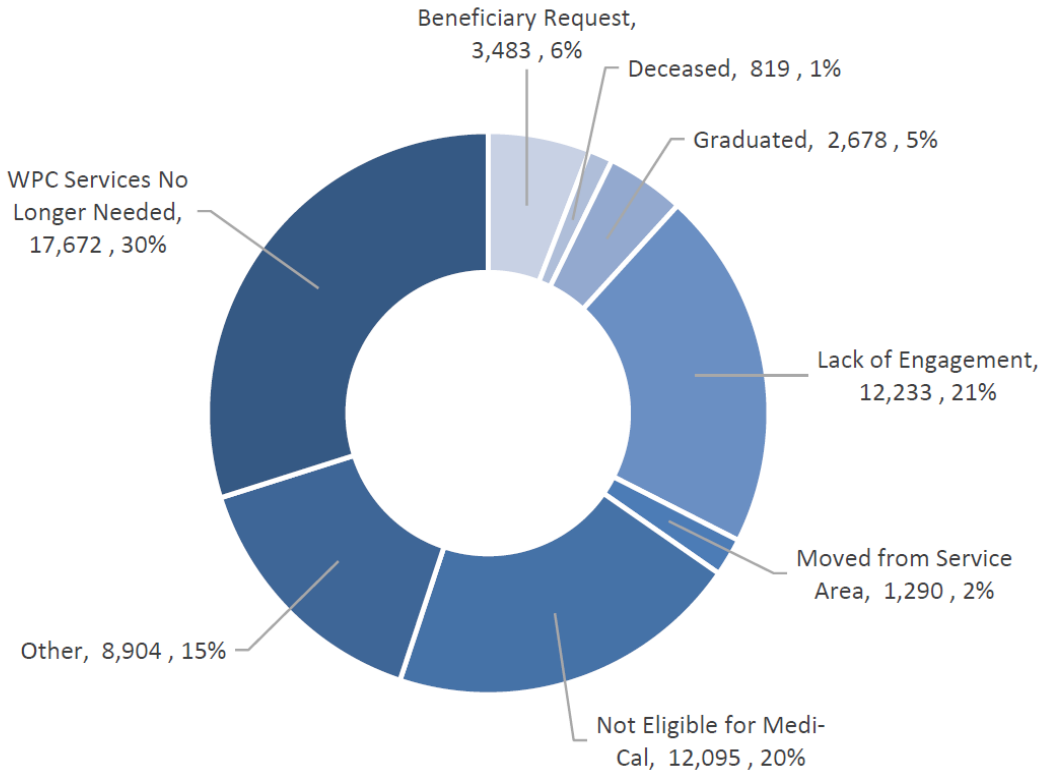
The 25 WPC Pilot programs each identified different target populations, with nine targeting just one of the six eligible populations, and one (Los Angeles) targeting all six. 16 pilots targeted High Utilizers, five targeted Chronic Conditions, 11 targeted MH/SUDS, 15 targeted Homelessness, 10 targeted At-Risk-Of Homelessness, and four targeted Justice-Involved.

Pilots reported using a wide range of outreach strategies to identify eligible beneficiaries, including use of administrative and electronic medical record data, referrals and warm hand-offs from partner organizations, self-referrals, and street outreach.

Between January 2017 and December 2018, cumulative enrollment in WPC Pilots was 108,667 unique individuals, with 60,776 currently enrolled at that point in time. 49.4 percent of enrollees (53,697) had been enrolled continuously, 43.9 percent of enrollees (47,755) disenrolled permanently, and 6.9 percent (7,461) enrolled and disenrolled multiple times. The primary reasons for disenrollment were: 1) WPC Services No Longer Needed (30 percent), 2) Lack of Engagement (21 percent), 3) Not Eligible for Medi-

[4] Pourat N, et al., September 2019.

Cal (20 percent), 4) Other (15 percent), 5) Beneficiary Request (6 percent), 6) Graduated (5 percent), 7) Moved from Service Area (2 percent), and 8) Deceased (1 percent).



During the evaluation period, WPC Pilot enrollees were more likely to be male (55 percent), age 50-64 (35 percent), and white (28 percent). Most target populations were consistent with these overall results with some notable exceptions, including: 1) High Utilizers were the only population that were majority female (53 percent), while other populations ranged from 56 percent male (Chronic Conditions) to 74 percent (Justice-Involved); 2) Justice-Involved were the only population whose enrollees were most often age 18-34 (48 percent), as well as more often Latino (38 percent).

WPC Enrollee Demographics – Gender

Gender	**Male**	**Female**
OVERALL	**55%**	**45%**
High Utilizers	47%	53%
Chronic Conditions	56%	44%
MH/SUDS	59%	41%
Homelessness	66%	34%
At-Risk-Of Homelessness	65%	35%
Justice-Involved	74%	26%

WPC Enrollee Demographics – Race/Ethnicity

Race/ Ethnicity	White	African American	Latino	Asian American/ Pacific Islander	American Indian/ Alaska Native	Other/ Unknown
OVERALL	**28%**	**25%**	**23%**	**6%**	**<1%**	**16%**
High Utilizers	29%	22%	24%	8%	<1%	17%
Chronic Conditions	35%	11%	33%	7%	<1%	12%
MH/SUDS	40%	10%	27%	6%	<1%	15%
Homelessness	31%	28%	21%	4%	<1%	16%
At-Risk-Of Homelessness	32%	24%	32%	2%	<1%	9%
Justice-Involved	35%	17%	38%	1%	<1%	9%

WPC Enrollee Demographics – Age Group

Age Group	0-17	18-34	35-49	50-64	65+
OVERALL	**1%**	**27%**	**28%**	**35%**	**9%**
High Utilizers	1%	29%	26%	33%	12%
Chronic Conditions	<1%	25%	28%	41%	6%
MH/SUDS	<1%	26%	29%	38%	8%
Homelessness	<1%	24%	31%	38%	6%
At-Risk-Of Homelessness	<1%	30%	32%	35%	3%
Justice-Involved	<1%	48%	33%	17%	1%

Despite differences in target populations, WPC Pilots offered many of the same categories of benefits to beneficiaries, offering between three and seven of the eight services. 100 percent of pilots offered both Care Coordination and Housing Support services, 80 percent offered Peer Support, 72 percent offered

Benefit Support, 52 percent offered Outreach, 40 percent offered Medical Respite, 28 percent offered Sobering Centers, and 20 percent offered Employment Assistance. The percentages of pilot beneficiaries in each category that received each type of service were as follows:

Percentage of WPC Populations Receiving Services by Category[5]

	Outreach Services	Care Coordination	Housing Support	Peer Support
WPC Population:				
Enrolled	11%	77%	69%	46%
Not Enrolled	84%	0%	0%	0%
Enrolled Target Populations:				
High Utilizers	14%	83%	75%	70%
Chronic Conditions	41%	61%	32%	34%
MH/SUDS	31%	71%	50%	45%
Homelessness	21%	68%	59%	19%
At-Risk-Of Homelessness	46%	24%	19%	10%
Justice-Involved	79%	26%	18%	16%

	Benefit Support	Employment Assistance	Sobering Centers	Medical Respite
WPC Population:				
Enrolled	69%	45%	5%	3%
Not Enrolled	0%	0%	16%	0%
Enrolled Target Populations:				
High Utilizers	72%	60%	8%	1%
Chronic Conditions	28%	10%	1%	1%
MH/SUDS	34%	10%	24%	3%
Homelessness	51%	23%	5%	5%
At-Risk-Of Homelessness	47%	9%	3%	2%
Justice-Involved	20%	15%	3%	1%

In addition to these characteristics of the WPC Pilots, the UCLA evaluation made the following key observations:

1) Progress on Care Coordination – By the end of the evaluation period, Pilots had successfully formed care coordination teams, established data sharing protocols across service agencies, and standardized care coordination processes. Areas for further improvement included more formal data sharing

[5] Pourat N, et al., September 2019.

agreements, encouraging systematic use of universal consent forms, promoting field-based outreach and service delivery, using peers with lived experience on care coordination teams, training staff to improve quality and outcomes, and leveraging resources and partnerships to address structural housing problems.

2) Improvements in Care Delivery – The evaluation found substantial evidence the Pilots successfully provided better care to enrollees. Outcomes data demonstrated success in follow-up after hospitalization for mental illness at 7 and 30 days, improvements in rates of initiation and engagement in SUD treatment, and increased rates of timely provision of comprehensive care plans and suicide risk assessments.
3) Health Improvements – The evaluation found some evidence of improved health, which could not be fully attributed to the Pilot, including improvements in rates of emergency department (ED) visits, hospitalizations and all-cause readmissions in the second and third years. However, these data were not significantly different than the control group. There were also clear improvements in beneficiaries' overall and emotional health, controlled blood pressure, and A1C levels.
4) Housing Services Delivered, But Permanent Solutions Challenging – The evaluation found substantial evidence of success in delivery of housing services and potential success in reducing ED visits. However, there were challenges in retaining permanent housing, including lack of funding for direct housing provision and lack of adequate housing supply. Some Pilots worked with external partners to mitigate these challenges.

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

- **Domain 1: Outpatient Delivery System Transformation and Prevention**. These projects are meant to: 1) ensure patients experience timely access to high-quality, efficient, and patient-centered care; 2) identify and increase rates of cost-effective standard approaches to prevention services for a select group of high-impact clinical conditions and populations such as cardiovascular disease, breast, cervical and colorectal cancer, and obesity; and 3) reduce disparities and variation in performance of targeted prevention services within their systems.
- **Domain 2: Targeted High-Risk or High-Cost Populations.** These projects are focused on specific populations that would benefit most significantly from care integration and alignment. Particular attention will be focused on managing and coordinating care during transitions from inpatient to outpatient and post-acute settings.
- **Domain 3: Resource Utilization Efficiency.** These projects are meant to reduce unwarranted variation in use of evidence-based diagnostics and treatments, targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects will also eliminate the use of ineffective or harmful targeted clinical services.

DHCS has approved a total of 17 plans submitted by DPHs and 37 submitted by DMPHs to become PRIME entities. These entities are eligible to receive up to $3.7 billion combined in federal Medicaid funding over five years for achieving metrics in implementing clinical projects designed to change the

way care is delivered. 1115 Waiver financing regulations require these funds to be matched with a non-federal share of funding, which is provided by other governmental health entity funds that are transferred to DHCS as intergovernmental transfers (IGTs).

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

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

Dental Transformation Initiative. DHCS implemented four dental "domains", collectively referred to as the Dental Transformation Initiative (DTI) in order to improve the quality of care and increase utilization of dental services. The four domains of the DTI program are:

1. Increase Preventive Services Utilization for Children - This domain aims to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The domain's goal is to increase utilization among children by at least 10 percent over a five year period. DHCS offers financial incentives for dental service office locations that increase delivery of preventive oral care to Medi-Cal eligible children.
2. Caries Risk Assessment and Disease Management – Under this domain, dental providers receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under.
3. Increase the Continuity of Care - This domain aims to encourage continuity of care among Medi-Cal beneficiaries age 20 and under. Dental provider service office locations receive an incentive payment for maintaining continuity of care for enrolled child beneficiaries for two, three, four, five, and six year continuous periods. Incentive payments are made annually.
4. Local Dental Pilot Programs (LDPPs) – 15 LDPPs were approved, although two have been withdrawn, to address one or more of the previous three domains through alternative programs, using strategies focused on rural areas including local case management initiatives and education partnerships. DHCS requires LDPPs to have broad-based provider and community support and collaboration including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three domains.

Health Homes Program. AB 361 (Mitchell), Chapter 642, Statues of 2013, authorizes DHCS to implement the Medicaid Health Home Program (HHP) Services benefit, which provides enhanced care coordination benefits for members with chronic conditions with the goal of reducing state Medi-Cal costs by decreasing avoidable emergency department and inpatient stays, and improving health outcomes for Medi-Cal's most vulnerable beneficiaries. Established under Section 2703 of the federal Affordable Care

Act, states that adopt the HHP benefit receive a 90 percent federal match for program services for two years. After two years, the federal match converts to the 50 percent federal matching rate.

HHP benefits are structured to be provided by a network including the managed care plan, one or more Community-Based Care Management Entities (CB-CMEs), and Community-Based Organizations (CBOs). Plans are responsible for the overall administration of HHP, including payment, member assignment to providers, oversight, data sharing and analytics, training, and ensuring timely access to care. CB-CMEs, selected and certified by the plan, serve as the single community-based entity with responsibility for ensuring access to services, either directly, or through subcontracting arrangements with other entities, including CBOs, or individuals.

To be eligible for HHP, a member must be a full-scope Medi-Cal beneficiary with no share of cost and meet the following eligibility criteria:

1. Chronic condition – A chronic condition in at least one of the following categories:
   a. At least two of the following: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal disease, dementia, substance use disorders
   b. Hypertension and one of the following: chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure
   c. One of the following: major depression disorders, bipolar disorder, osychotic disorders
   d. Asthma

2. Acuity/Complexity Criteria – Has three or more eligible chronic conditions, at least one hospital stay in the last year, three or more emergency department visits in the last year, or is chronically homeless.

The six core HHP services are as follows:

1. Comprehensive Care Management – Activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP).
2. Care Coordination – Services to implement the HHP member's HAP including, but not limited to, navigation and coordination of health, behavioral health, and social services systems, including housing; monitoring and supporting treatment adherence; monitoring and coordinating referrals and follow ups; and sharing information with all involved parties and providers.
3. Health Promotion – Services to encourage and support HHP members to make lifestyle choices based on healthy behavior.
4. Comprehensive Transitional Care – Services to facilitate HHP members' transitions from and among treatment facilities to reduce avoidable HHP member admissions and readmissions.
5. Individual and Family Support Services – Activities that ensure the HHP member and family/support persons are knowledgeable about the member's conditions to facilitate adherence to treatment and medication management.
6. Referral to Community and Social Supports – Determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources and providers, and following up with members.

DHCS began implementing HHP in 12 counties beginning July 1, 2018, in three groups. As of September 30, 2019, a total of 14,300 members enrolled in HHP including 539 in Group 1 (San Francisco), 7,436 in Group 2 (Riverside, San Bernardino), and 6,325 in Group 3 (Alameda, Imperial, Kern, Los Angeles, Sacramento, San Diego, Santa Clara, Tulare).

Behavioral Health Services in Medi-Cal. Behavioral health services are provided to Medi-Cal beneficiaries through several different delivery systems. Three separate systems provide mental health services to Medi-Cal beneficiaries including county mental health plans, Medi-Cal managed care plans, and the fee-for-service delivery system. Three systems provide Drug Medi-Cal services including the Drug Medi-Cal Organized Delivery System, county-administered Drug Medi-Cal, and state-administered Drug Medi-Cal.

Medi-Cal Mental Health. There are three systems that currently provide mental health services to Medi-Cal beneficiaries:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal specialty mental health services (SMHS) under a federal 1915(b) waiver that includes outpatient SMHS, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's SMHS is provided under the federal requirements of the EPSDT benefit for persons under age 21. County mental health plans are responsible for the provision of SMHS and Medi-Cal enrollees must obtain SMHS through the county. SMHS is a Medi-Cal entitlement for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria.
2. **Managed care plans –** The Affordable Care Act expanded the scope of Medi-Cal mental health benefits and required these services to be provided by Medi-Cal managed care plans excluding those benefits provided by county mental health plans under the SMHS waiver. Generally these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by managed care plans include:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

3. **Fee-For-Service Provider System -** Effective January 1, 2014 the mental health services listed below are also available through the fee-for-service provider system:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

Drug Medi-Cal. Established in 1980, the Drug Medi-Cal program provides medically necessary substance use disorder (SUD) treatment services to eligible Medi-Cal beneficiaries for specific, approved services. Beginning in 2011, administration of the Drug Medi-Cal program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS and the program was realigned to the counties as part of 2011 Realignment. Drug Medi-Cal had previously been funded with General Fund and federal funds. 2011 Realignment redirected funding for both Drug Medi-Cal and discretionary SUD programs, including those supported by the Substance Abuse Prevention and Treatment block grant, to the counties. Counties provide the non-federal share of expenditures, which are matched with federal funds, for Drug Medi-Cal services as they existed in 2011 and for individuals eligible for Drug Medi-Cal under 2011 Medi-Cal eligibility rules in place before implementation of the optional expansion of Medi-Cal.

Both DHCS and counties have specific oversight requirements for Drug Medi-Cal. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for Drug Medi-Cal services directly, or contract with DHCS, which then directly contracts with providers to deliver Drug Medi-Cal services. Counties that elect to contract with DHCS to provide services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement. DHCS has also implemented the Drug Medi-Cal Organized Delivery System Waiver, a pilot project to test organized delivery of an expanded benefit package for substance use disorder services.

Drug Medi-Cal Organized Delivery System. The Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver is a voluntary pilot program that offers California counties the opportunity to expand access to high-quality care for Medi-Cal enrollees with SUD. The goal of the DMC-ODS Waiver is to demonstrate how organized SUD care improves beneficiary health outcomes, while decreasing system-wide health care costs. Counties that choose to participate in the DMC-ODS Waiver are required to provide access to a full continuum of SUD benefits modeled after criteria developed by the American Society of Addiction Medicine (ASAM). Counties are required to submit implementation plans and proposed interim rates for all county-covered SUD services, except NTP rates, which are set by DHCS.

To receive services through the DMC-ODS Waiver, beneficiaries must meet the following criteria:

1. The beneficiary must be enrolled in Medi-Cal
2. The beneficiary must reside in a county that is participating in the DMC-ODS Waiver
3. The beneficiary must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with certain exceptions, or for youth under 21, be assessed as "at-risk" for developing a SUD
4. The beneficiary must meet the ASAM Criteria definition of medical necessity for services (or ASAM adolescent treatment criteria for youth under 21).

County Reimbursement for Behavioral Health Services in Medi-Cal. Through reforms implemented in the 1991 and 2011 Realignments, counties are responsible for the non-federal share of specialty mental health and Drug Medi-Cal services provided to most Medi-Cal beneficiaries. Counties provide for the delivery of services and submit expenditure reports to DHCS to receive federal matching funds. Claims are paid to counties on an interim basis, pending cost reporting after the end of the fiscal year. DHCS

reconciles the interim payments made to counties with the submitted cost reports and recoups from counties that received excess interim payments or makes additional payments to counties that received insufficient interim payments. In addition, DHCS audits each cost report, which may result in additional adjustments. Counties are permitted to appeal audit findings, which may lead to still more adjustments to reimbursements. The cost-based reimbursement structure for behavioral health services can often take several years to resolve, leading to uncertainty for county behavioral health system financing.

Eligibility for Specialty Mental Health and Substance Use Disorder Services. Medi-Cal beneficiaries must demonstrate medical necessity to be eligible to receive specialty mental health services or substance use disorder services from county service delivery systems. State law defines a service as medically necessary for individuals 21 years of age and older when it is reasonable and necessary to protect life, to prevent significant illness or significant disability.[6] For individuals under 21 years of age, a service is medically necessary if the service is necessary to correct or ameliorate mental illnesses and conditions.[7,8]

CALIFORNIA ADVANCING AND INNOVATING IN MEDI-CAL INITIATIVE

California Advancing and Innovating in Medi-Cal (CalAIM). In January 2021, the Administration released its updated CalAIM proposal, which would resume the previously delayed efforts to significantly reform the delivery of physical health, behavioral health, and oral health care services in the Medi-Cal program. The Administration has moved to transition many of its existing programs into managed care benefits under a new 1915(b) Waiver, maintain some programs under the previous 1115 Waiver authority, and make other changes through amendments to the State Plan. DHCS plans to submit these requests in April 2021. While the managed care authorities provided by the two waivers are similar, there are key differences. For example, while 1115 Waivers require budget neutrality (federal expenditures must not be greater under the waiver than they would have been without the waiver), 1915(b) Waivers only require the demonstration of cost effectiveness and efficiency (actual expenditures cannot exceed projected expenditures)[9].

MANAGED CARE REFORMS

Benefit Standardization. Under the Administration's CalAIM proposal, DHCS would standardize which Medi-Cal benefits are provided in the managed care delivery system and which benefits are provided in another delivery system. The proposed changes, beginning April 1, 2021, are as follows:

Managed Care Benefits ("Carved In")

- Long-term care – Effective January 1, 2023, all institutional long-term care services would become the responsibility of a beneficiary's managed care plan including skilled nursing facilities, pediatric and adult subacute care facilities, intermediate care facilities for individuals with developmental

[6] California Welfare and Institutions Code, Section 14059.5

[7] 42 United States Code Section 1396d(r)(5)

[8] California Welfare and Institutions Code, Section 14059.5

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

disabilities, disabled/habilitative/nursing services, and specialized rehabilitation in a skilled nursing facility or intermediate care facility.

- Organ transplants – Effective January 1, 2022, all major organ transplants would become the responsibility of a beneficiary's managed care plan.

Fee-for-Service Benefits ("Carved Out")

- Pharmacy – Consistent with the Governor's 2019 Executive Order, and the Administration's Medi-Cal Rx proposal, all prescription drugs and/or pharmacy services billed on a pharmacy claim would be provided in the fee-for-service delivery system. This carve-out was originally scheduled to be effective April 1, 2021, but has been delayed indefinitely by DHCS due to unforeseen conflict issues arising from the merger of its pharmacy benefit contractor with a company that oversees health plans and pharmacies. When implemented, this carve-out would not apply to SCAN Health Plan, Programs for All-Inclusive Care for the Elderly (PACE), Cal MediConnect plans, and the Major Risk Medical Insurance Program (MRMIP).
- Specialty mental health services (Solano and Sacramento) – Effective January 1, 2022, specialty mental health services currently the responsibility of Kaiser health plans in Solano and Sacramento counties, would be provided by the county mental health plans.
- Multipurpose Senior Services Program – Effective January 1, 2022, the Multipurpose Senior Services Program, which had previously been scheduled to become the responsibility of Medi-Cal managed care plans in Coordinated Care Initiative counties, will instead remain a benefit under the existing 1915(c) Home- and Community-Based Services Waiver.

Standardization of Mandatory Managed Care and Fee-for-Service Populations. Under CalAIM, the Administration proposes to standardize which categories of Medi-Cal beneficiaries would be required to enroll in a managed care plan to receive benefits and which beneficiaries would be required to receive benefits in the fee-for-service delivery system. According to DHCS, standardization would enhance coordination of care and reduce complexity across the Medi-Cal program. Implementation of this change would occur in two phases: 1) non-dual-eligible populations would transition in January 1, 2022; and 2) dual-eligible populations would transition in January 1, 2023.

Transitions from Fee-for-Service to Mandatory Managed Care. Populations currently receiving benefits in the fee-for-service delivery system that would be required to enroll in a Medi-Cal managed care plan are as follows:

- Trafficking and Crime Victims Assistance Program beneficiaries, except those with a share of cost
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal
- American Indians
- Beneficiaries with other health care coverage
- Beneficiaries living in rural ZIP codes
- Individuals eligible for long-term care services, including those with a share of cost, beginning January 1, 2023

- All dual-eligible beneficiaries, not including those with a share of cost or with restricted-scope benefits, beginning January 1, 2023

Transitions from Managed Care to Mandatory Fee-for-Service. Populations currently receiving benefits in the managed care delivery system that would be required to receive benefits in the fee-for-service delivery system:

- Individuals receiving restricted-scope benefits
- Individuals with a share of cost, including in county organized health systems, Coordinated Care Initiative counties, Trafficking and Crime Victims Assistance Program, but excluding long-term care
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal, not including Medi-Cal Access Infant Program enrollees
- Omnibus Budget Reconciliation Act (OBRA) beneficiaries currently in managed care in Napa, Solano, and Yolo counties

According to DHCS, enrollment requirements for foster care children and youth will remain unchanged pending discussions and recommendations of its Foster Care Workgroup on future delivery system reforms for this population.

Long-Term Services and Supports Integration. Under CalAIM, DHCS proposes to make several changes to the delivery system for long-term services and supports (LTSS) that build upon the state's duals demonstration project, the Coordinated Care Initiative (CCI). DHCS intends to use selective contracting to move toward aligned enrollment in a Medi-Cal managed care plan and a dual-eligible special needs plan (D-SNP) operated by one integrated organization. In the seven CCI demonstration counties, all Medi-Cal beneficiaries in a Cal MediConnect plan would transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product, beginning January 1, 2023. Aligned enrollment would occur in non-CCI counties as plans are ready, but no later than the 2025 contract year. Dual-eligible beneficiaries already in a non-aligned D-SNP (not affiliated with their managed care plan) would be allowed to maintain their enrollment, but new enrollment in non-aligned D-SNPs would be closed. DHCS will also limit enrollment in Medicare Advantage plans that are D-SNP "look-alikes" beginning in 2022.

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

Beginning January 1, 2023, DHCS would implement mandatory enrollment of full- and partial-benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible long-term care residents. Long-term care benefits would be integrated into Medi-Cal managed

care statewide. Cal MediConnect plans and the Coordinated Care Initiative would also be discontinued at this time.

National Committee for Quality Assurance Accreditation. The National Committee for Quality Assurance (NCQA) is a private, non-profit organization that reports measures of healthcare quality and offers accreditation for managed care plans. NCQA is responsible for the Healthcare Effectiveness Data and Information Set (HEDIS), which evaluates more than 90 measures across six domains of care for managed care plans, consumers, and public agencies to encourage performance improvement. NCQA also offers accreditation to managed care plans and other health care-related entities in the areas of quality improvement, population health management, network management, utilization management, credentialing, member rights and responsibilities, and member connections.

Under CalAIM, DHCS would require all Medi-Cal managed care plans to be accredited by the NCQA by 2026. Currently, 26 states require Medicaid managed care plans to achieve NCQA accreditation. 17 of the 24 full-scope Medi-Cal managed care plans are currently NCQA accredited. In addition to requiring accreditation, DHCS would use information obtained from the accreditation review to satisfy certain state and federal oversight requirements of Medi-Cal managed care plans. DHCS would no longer conduct independent oversight of these requirements, but would instead focus on more robust oversight of other requirements, such as annual medical audits. While NCQA accreditation would not be required until 2026, DHCS may consider implementing deeming of select elements sooner than 2026 for plans that are already accredited.

According to DHCS, certain categories of oversight would be likely candidates for the department to use accreditation review to deem managed care plans in compliance, as the NCQA requirements exceed both federal and state compliance requirements. These categories are as follows:

- Information Requirements
- Access to Care – Availability of Services
- Access to Care – Coordination and Continuity of Care
- Access to Care – Coverage and Authorization of Services
- Structure and Operations - Confidentiality
- Quality Measurement and Improvement – Practice Guidelines
- Quality Measurement and Improvement – Quality Assessment and Performance Improvement Program
- Grievances – General Requirements
- Grievances – Timely and adequate notice of adverse benefit determination
- Grievances – Handling of grievances and appeals
- Grievances – Expedited resolution of appeals
- Grievances – Recordkeeping requirements
- Grievances – Continuation of benefits while appeal and state fair hearing are pending

In addition to these likely candidates for deeming under CalAIM, DHCS is considering, pending further analysis, the following categories of requirements that meet or exceed either the federal or state standard, or both:

- Access to Care – Emergency and post-stabilization services
- Access to Care – Availability of Services
- Access to Care – Assurances of Adequate Capacity and Services
- Access to Care – Coverage and Authorization of Services
- Structure and Operations – Provider Selection
- Structure and Operations – Subcontractual relationships and delegation
- Quality Measurement and Improvement – Health Information Systems
- Grievances

Regional Managed Care Rate-Setting. Under CalAIM, DHCS would move towards a regional managed care rate-setting methodology to simplify capitation payments for Medi-Cal managed care plans. DHCS reports it currently calculates more than 4,000 individual rates, one for each beneficiary category in each managed care plan. According to DHCS, this level of complexity limits the ability to advance value-based and outcomes-focused rate setting methodologies and complicates annual federal approval of managed care rates. The department believes regional rate-setting would incentivize efficiencies through competition with other regional plans and provide a larger, multi-county base for averaging rate components. The Administration proposes a two phased approach to the transition to regional capitated rate-setting:

- Phase I: Targeted Counties – During calendar years 2020 and 2021, DHCS would engage and collaborate with Medi-Cal managed care plans to advance new regional rate-setting approaches and streamline rate processes and methodologies in targeted counties. Beginning January 1, 2022, DHCS would implement regional rate-setting in targeted counties and Medi-Cal managed care plans. The CalAIM proposal does not identify these counties or what aspects of a county would determine eligibility to participate in this targeted approach.

- Phase II: Statewide – After evaluating and refining the regional rate-setting processes implemented in Phase I, DHCS would implement regional rate-setting statewide beginning no sooner than January 1, 2024.

Population Health Management Program. Under the Administration's CalAIM proposal, Medi-Cal managed care plans would be required to develop and maintain a population health management (PHM) program, defined as a model of care and a plan of action designed to address member health needs at all points along the continuum of care. The PHM program would adhere to NCQA standards and additional requirements established by the department. The implementation of this requirement would occur as part of the new Medi-Cal managed care plan contracts expected to begin on January 1, 2023, and the required PHM plan would be filed with the state annually. The PHM program would include assessment and risk stratification of plan members, integration of wellness and prevention services, case management, identification and delivery of in-lieu-of services, and care transition management.

ENHANCED CARE MANAGEMENT AND IN-LIEU-OF SERVICES

Enhanced Care Management. Under CalAIM, DHCS proposes to require Medi-Cal managed care plans to provide an enhanced care management benefit that addresses the clinical and non-clinical needs of high-cost or high-need beneficiaries. As part of its population health management program requirements, health

plans would be required to submit an Enhanced Care Management Model of Care proposal and complete readiness for delivery of the benefit to the following mandatory target populations:

1) High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits;
2) Individuals at risk for institutionalization with serious mental illness, children with serious emotional disturbance or substance use disorder with co-occurring chronic health conditions;
3) Individuals at-risk for institutionalization and eligible for long-term care;
4) Nursing facility residents who want to transition to the community;
5) Children or youth with complex physical, behavioral, developmental, and oral health needs;
6) Individuals experiencing chronic homelessness or at risk of becoming homeless; and
7) Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

The goals of the enhanced care management benefit would be to improve care coordination, integrate services, facilitate community resources, improve health outcomes, address social determinants of health, and decrease inappropriate utilization. The benefit would be delivered by community-based providers ("ECM Providers") contracting with Medi-Cal managed care plans. Through face-to-face visits, ECM providers would coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. In addition to care coordination, the benefit would include health promotion, comprehensive transitional care, member and family supports, and referral to community and social services.

According to DHCS, this benefit would build upon the efforts of the Whole Person Care and Health Homes pilots and eventually replace those programs. However, managed care plans would be mandated to contract with all existing local providers offering Health Homes and Whole Person Care services, with few contractual exceptions. Plans would also be mandated to contract with community-based providers that have experience serving the target populations and who have expertise in providing enhanced care management services.

Beginning January 1, 2022, all Medi-Cal managed care plans in counties with Whole Person Care pilots or Health Homes Programs would begin implementation of the enhanced care management benefit for those target populations currently receiving services in those programs. Beginning July 1, 2022, these counties would be required to implement enhanced care management for the remaining target populations. The 28 counties with Whole Person Care pilots or Health Homes Programs subject to these implementation timelines include: Alameda, Contra Costa, Imperial, Kern, Kings, Los Angeles, Marin, Mariposa, Mendocino, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Tulare, and Ventura.

For counties without Whole Person Care pilots or Health Homes Programs, implementation of enhanced care management for select target populations would begin July 1, 2022. By January 1, 2023, all Medi-Cal managed care plans in all counties would be required to have implemented enhanced care management for all target populations. The 30 counties without Whole Person Care pilots or Health Homes Programs subject to these implementation timelines include: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Inyo, Lake, Lassen, Madera, Merced, Modoc, Mono, Nevada,

Plumas, San Luis Obispo, Santa Barbara, Sierra Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolomne, Yolo, and Yuba.

In-Lieu-Of Services. Under CalAIM, the Administration proposes to allow plans to voluntarily include one or more in-lieu-of services (ILOS) in their population health management plans. According to federal rules[10], ILOS are medically appropriate and cost-effective alternatives to covered Medi-Cal services and are typically delivered by a different provider, or in a different setting than a traditional Medi-Cal service. DHCS is proposing to allow plans to choose from the following 14 services:

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

[10] 42 Code of Federal Regulations Section 438.3. "Standard contract requirements". May 6, 2016.

environment. These services may include training or assistance with the use of public transportation, personal skills development in conflict resolution, community participation, developing and maintaining interpersonal relationships, daily living skills, community resource awareness (e.g. police, fire, other local services), selecting and moving into a home, locating and choosing suitable housemates, locating household furnishings, settling disputes with landlords, managing personal financial affairs, managing needs for personal attendants, dealing with and responding to governmental agencies and personnel, asserting rights through self-advocacy, and coordinating health and human services benefits.

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

- Asthma Remediation – These services are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home without acute asthma episodes that could result in emergency utilization or hospitalization. These services would include allergen-impermeable mattress and pillow dustcovers, high-efficiency particulate air filtered vacuums, integrated pest management, de-humidifiers, air filters, other moisture-controlling interventions, minor mold removal and remediation, ventilation improvements, asthma-friendly cleaning products and supplies, and other interventions identified to be medically appropriate and cost-effective.

BEHAVIORAL HEALTH PAYMENT REFORM AND ELIGIBILITY CRITERIA

Behavioral Health Payment Reform. Under CalAIM, DHCS proposes 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 would 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 would allow for more granular claiming and reporting of services provided, as well as more accurate reimbursements. This transition would occur no sooner than July 1, 2022.

DHCS expects that, concurrent with the transition to HCPCS Level I, DHCS would 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.

Medical Necessity Criteria Reforms. Under CalAIM, DHCS proposes to modify the existing 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. The proposed changes would separate the concept of eligibility for services from that of medical necessity, allow 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 would 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, would be the driving factor for determining the delivery system in which a beneficiary should receive services. DHCS proposes to make these changes effective January 1, 2022.

Administrative Integration of Specialty Mental Health and Substance Use Disorder Services. Under CalAIM, DHCS proposes to integrate administrative activities of specialty mental health and substance

use disorder (SUD) services into one behavioral health managed care program, beginning with the approval of the next 1915(b) waiver in 2027. DHCS plans to work with counties that participate in DMC-ODS to integrate the two behavioral health programs into one single behavioral health plan structure responsible for all specialty mental health and SUD services. DHCS would also work with Drug Medi-Cal fee-for-service counties to integrate with specialty mental health, though the structure would be different due to federal requirements.

Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements. DHCS proposes to update and improve the Drug Medi-Cal Organized Delivery System (DMC-ODS), including extending the program and providing non-participating counties with another opportunity to opt-in. The improvements being considered by DHCS include the following:

- Remove the restrictions limiting residential treatment length of stay to be determined based on the individual's condition, rather than a set number of days.
- Update the definition of residential treatment to remove adolescent length-of-stay limitations, add mandatory provisions for referral to medication assisted treatment, and remove certain distinctions between adults and adolescents for these requirements.
- Clarify policies related to recovery services, including specific services, when and how the services may be accessed, and ensure beneficiaries are not prohibited from receiving long-term medication assisted treatment after accessing recovery services.
- Require SUD managed care providers demonstrate that they offer or provide referral to medication assisted treatment.
- Clarify terms of clinician consultation and remove the limitation that clinician consultation services can only be billed by certified Drug Medi-Cal providers.
- Add contingency management as an evidence-based practice available for use by providers to meet requirements.
- Remove rarely used provider appeal process, which is already addressed under federal regulatory appeals processes.
- Increase access to SUD treatment for American Indians and Alaska Natives.
- Clarify access language for individuals leaving incarceration who have a known substance use disorder.
- Allow reimbursement for SUD assessments before a final diagnosis is determined, in alignment with the changes to specialty mental health medical necessity criteria.
- Clarify requirements for initial assessment and medical necessity determinations.
- Add a new level of care for beneficiaries under 21 to allow early intervention as an organized service that may be delivered in a wide variety of settings.

OTHER PROPOSED CHANGES

Full Integration Plans. Under CalAIM, DHCS proposes to, in consultation with stakeholders, test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. DHCS indicates that topics for consideration of this proposal would include identifying which delivery systems would be part of the plan, determining the participation criteria for entities, identifying the challenges and opportunities of a fully integrated plan, planning the steps and timelines necessary for

implementation, evaluating impacts on other non-Medi-Cal programs, consideration of blending of complex funding streams, and mechanisms for accountability. DHCS expects to implement full integration plans no sooner than January 2026 to allow sufficient time for planning and preparation, in partnership with counties, plans, and other stakeholders.

Future of Other 1115 Waiver Programs. While many elements of the Whole Person Care program would be transitioned to the enhanced care management and ILOS benefit structure under the CalAIM proposal, DHCS is proposing to transition other elements of the state's expiring 1115 Waiver, Medi-Cal 2020 into new programs under the State Plan, the state's new 1915(b) Waiver, or a limited 1115 Waiver Renewal.

- PRIME Transition to Quality Incentive Program – DHCS transitioned the PRIME funding structure into the Quality Incentive Program (QIP), which provides directed payments to hospitals that achieve specified improvement targets, beginning July 1, 2020.
- Global Payment Program – DHCS proposes to extend the Global Payment Program through a limited 1115 Waiver renewal, beginning January 1, 2022.
- Dental Transformation Initiative Transition to State Plan – DHCS proposes to transition certain incentive payments that were part of the Dental Transformation Initiative to the State Plan. Providers would receive incentive payments for: 1) a caries risk assessment bundle for ages zero to six; 2) silver diamine fluoride treatment of ages zero to six, and specified high-risk and institutional populations; and 3) pay for performance incentives for preventive services and establishing continuity of care through dental homes, available statewide for children and adults.

Local Assistance Resource Request. DHCS requests expenditure authority of $1.1 billion ($520.8 million General Fund and $552.9 million federal funds) for local assistance costs to implement the CalAIM initiative. Specifically, these resources would support the following components:

- $187.5 million ($93.8 million General Fund and $93.7 million federal funds) to support the new enhanced care management benefit in Medi-Cal managed care plans, beginning January 1, 2022.
- $47.9 million ($24 million General Fund and $24 million federal funds) to support in-lieu-of services benefits adopted by Medi-Cal managed care plans, beginning January 1, 2022.
- $300 million ($150 million General Fund and $150 million federal funds) to fund incentives for managed care plans to invest in voluntary in-lieu-of services programs and partner with community-based organizations and providers, including but not limited to community clinics, public hospital systems, and county behavioral health systems.
- $401.6 million ($174.7 million General Fund and $226.8 million federal funds) to support transitions of populations between the fee-for-service and managed care delivery systems, as part of the standardization of mandatory fee-for-service and managed care populations.
- $113.5 million ($56.7 million General Fund and $56.7 million federal funds) for enhanced reimbursements for dental services previously included in the Dental Transformation Initiative component of Medi-Cal 2020, California's federal 1115 Medicaid Waiver.
- $21.8 million General Fund for the behavioral health quality improvement program, which helps county behavioral health programs make technical and other improvements to facilitate future behavioral health integration and payment reform efforts.

State Operations - Staffing and Resource Request. DHCS requests 33 positions and expenditure authority of $23.9 million ($11 million general Fund and $12.8 million federal funds) in 2021-22, 40 positions and expenditure authority of $28.2 million ($13.2 million General Fund and $15 million federal funds) in 2022-23, $25.2 million ($12 million General Fund and $13.2 million federal funds) in 2023-24, $23.9 million ($11.6 million General Fund and $12.3 million federal funds) in 2024-25, and $20.3 million ($9.8 million General Fund and $10.5 million federal funds) in 2025-26. Specifically, these positions and resources would support the state operations costs of implementing the CalAIM initiative in the following areas:

Division	Purpose/Responsibilities
Administration Division **Effective 7/1/2021:** 1.0 Staff Services Manager I (SSM I) 1.0 Business Services Officer (BSO I) 2.0 Associate Governmental Program Analysts (AGPA) 4.0 Associate Personnel Analysts (APA) 1.0 Office Technician (OT)	1) Administrative support (contracting, human resources, facilities) for CalAIM proposals
California Medicaid Management Information System (CAMMIS) Division **Resources (7/1/2021 to 6/30/2023) equivalent to:** 1.0 Information Technology Specialist II (ITS II)	1) CA-MMIS System and CD-MMIS System change support for CalAIM proposals 2) Implement complex program policy in CA-MMIS and CD-MMIS systems 3) Modify benefit payment methodology in CA-MMIS and CD-MMIS systems. 4) Behavioral Health Payment Reform in CA-MMIS system.
Capitated Rates Development Division (CRDD) **Effective 7/1/2021:** 1.0 Research Data Analyst II (RDA II) 2.0 Research Data Specialist I (RDS I) 1.0 SSM I 2.0 AGPAs **Resources equivalent to (7/1/2021 to 6/30/2025):** 1.0 Staff Services Manager II (SSM II) 1.0 Health Program Specialist I (HPS I) 1.0 Research Data Specialist II (RDS II) 1.0 AGPA **Effective 7/1/2022:** 2.0 AGPAs 1.0 RDS I 1.0 SSM II 1.0 RDS II	Capitated Rate Development Modifications Related to: 1) Enhanced Care Management 2) In-Lieu-of-Services 3) Shared Risk, Shared Savings, and Incentive Payments 4) Managed Care Benefit Standardization

Resources equivalent to (7/1/2022 to 6/30/2025): 1.0 AGPA 1.0 RDS I 1.0 SSM I 1.0 RDA II	
Community Services Division **Resources equivalent to (7/1/2021 to 6/30/2025):** 1.0 Research Data Supervisor I (RD Sup. I) 1.0 Research Scientist III (RS III) 2.0 RDS I **Resources equivalent to (7/1/2022 to 6/30/2025):** 2.0 RDA II	Behavioral Health Data Systems and Data Analysis Support for Behavioral Health Proposals
Enterprise Data and Information Management **Resources equivalent to (7/1/2021 to 6/30/2023):** 1.0 ITS II	Data and Information support for CalAIM proposals
Enterprise Technology Services (ETS) **Effective 7/1/2021:** 1.0 ITM I 2.0 ITS II **Resources equivalent to (7/1/2021 to 6/30/2023):** 1.0 IT Sup II 1.0 ITS II 1.0 ITS I	System support for CalAIM proposals and long term support of required system changes, including, but not limited to Enhanced Care Management; Shared Risk, Shared Savings, and Incentive Payments; Managed Care Benefit Standardization; Mandatory Managed Care Enrollment; Transition to Statewide Long-Term Services and Supports, Long-Term Care & Dual Eligible Needs Plans; and Improving Beneficiary Contact and Demographic Information
Integrated Systems of Care Division **Effective 7/1/2021:** 1.0 SSM I 6.0 AGPA 1.0 HPS I	Enhancing County Oversight and Monitoring: California Children's Services and Child Health and Disability Prevention
Local Governmental Financing Division **Effective 7/1/2021:** 1.0 HPS I 1.0 AGPA	Behavioral Health Payment Reform
Managed Care Operations Division **Effective 7/1/2021:** 3.0 AGPAs 2.0 HPS I 1.0 HPS II 1.0 RDA II	Managed Care Benefit Standardization: 1) Mandatory Enrollment 2) Transition to Statewide Long-Term Services and Supports, Long-Term Care, and Dual Eligible Special Needs Plans

1.0 Research Data Manager (RDM) **Resources equivalent to (7/1/2021 to 6/30/2025):** 2.0 HPS I 1.0 Research Data Analyst I (RDA I) 1.0 RD Sup II **Resources equivalent to (7/1/2021 to 6/30/2025):** 2.0 AGPAs	
Mgd Care Quality and Monitoring Division **Effective 7/1/2021:** 8.0 AGPAs 2.0 Health Program Manager II (HPM II) 1.0 HPS II 3.0 Nurse Consultant III (NC III) 1.0 RS III 2.0 SSM I 1.0 SSM II **Resources equivalent to (7/1/2021 to 6/30/2025):** 2.0 HPS II 1.0 RDA II 2.0 RDS I 1.0 RDS II	Enhanced Care Management Benefit: 1) In Lieu of Services 2) National Committee for Quality Assurance (NCQA) Accreditation of Medi-Cal Managed Care Plans 3) Population Health Management Program 4) Transition to Statewide Long-Term Services and Supports, Long-Term Care, and Dual Eligible Special Needs Plans
Medi-Cal Behavioral Health Division **Resources equivalent to (7/1/2021 to 12/31/2027):** 2.0 SSM II 5.0 SSM I 5.0 HPS I 9.0 AGPA **Resources equivalent to (7/1/2021 to 6/30/2024):** 1.0 AGPA 1.0 HPS I	1) Integration of Infrastructure for Specialty Mental Health and Substance Use Disorder Services 2) Medical Necessity Criteria for Specialty Mental Health and Substance Use Disorder Services
Medi-Cal Dental Services Division **Effective 7/1/2021:** 1.0 SSM I **Effective 7/1/2022:** 1.0 SSM I 1.0 AMA 7.0 AGPA	New Dental Policies

1.0 Dental Hygienist Consultant (DHC)	
Medi-Cal Eligibility Division **Effective 7/1/2021:** 1.0 SSM II 1.0 SSM I 3.0 AGPA	Improving Medi-Cal Eligibility Oversight and Monitoring
Office of Administrative Hearings and Appeals **Effective 7/1/2021:** 1.0 Administrative Law Judge II	Hearings and appeals support for CalAIM
Office of Legal Services **Effective 7/1/2021:** 3.0 Attorney III **Effective 1/1/2022:** 1.0 Attorney III 1.0 Senior Legal Analyst (SLA)	Legal support for CalAIM proposals
Office of the Medical Director **Effective 7/1/2021** 2.0 AGPAs 1.0 Public Health Medical Officer III (PHMO III)	Transition of Public Hospital Redesign and Incentives in Medi-Cal (PRIME) to Quality Incentive Program (QIP)

In addition to these staffing resources, DHCS requests expenditure authority of $5.9 million in 2021-22 and $7.8 million in 2022-23 for the following contract resources for the CalAIM project:

- **Reporting and Business Intelligence** - $1 million annually for three years, beginning July 1, 2021
- **Drug Medi-Cal Evaluation** - $1.1 million annually for five years, beginning January 1, 2022
- **Drug Medi-Cal External Quality Review Organization** - $2.3 million annually for five years, beginning January 1, 2022
- **Drug Medi-Cal Technical Assistance to Counties** - $500,000 annually for five years, beginning January 1, 2022
- **SMI/SED Waiver** - $2 million annually for two years, beginning July 1, 2021
- **Contract to Maintain QIP Data Reporting Portal** - $250,000 annually ongoing
- **QIP Data Integrity** - $500,000 annually ongoing
- **QIP Annual Conference** - $150,000 annually ongoing

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

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

1. Please provide a brief overview of the following components of the department's CalAIM proposal:

    a. Managed Care Reforms
    b. Population Health Management
    c. Enhanced Care Management and other Case Management Services
    d. In-Lieu of Services
    e. LTSS Integration
    f. Behavioral Health Payment and Medical Necessity Reforms

2. Currently, counties have significant, cross-disciplinary fiscal and programmatic incentives to address the needs of the populations served by the Whole Person Care pilots and Health Homes Program. How would DHCS ensure that Medi-Cal managed care plans are effectively addressing the needs of these populations without shifting costs onto other service delivery systems?

3. Does the department have a plan for the future trajectory of in-lieu of services? For example, is there a long-term plan or timeline for counties to build up sufficient provider networks that these may become mandatory State Plan benefits? Would the department support providers of these services outside of the CalAIM framework in counties in which the managed care plans do not include them in their Model of Care planning?

4. Please describe the structure of the incentive payments for Medi-Cal managed care plans.

5. Please provide a brief overview of the state operations request for CalAIM implementation.

Issue 6: Delay or Repeal of Program and Benefit Suspensions

Budget Bill Language and Trailer Bill Language – Governor's Budget. DHCS proposes provisional budget bill language and trailer bill language to delay or repeal program and benefit suspensions first adopted in the 2019 Budget Act. Specifically, the proposed language would: 1) delay or repeal suspensions for certain supplemental payments for Medi-Cal providers supported by Proposition 56 tobacco tax revenue; 2) delay suspension of certain optional Medi-Cal benefits; 3) delay suspension of provisional post-partum extension of Medi-Cal eligibility; and 4) repeal suspension of screening, brief intervention, and referral to treatment (SBIRT) for opioids and other drugs.

Proposition 56 Provides Supplemental Reimbursements to Medi-Cal Providers. Proposition 56, approved by voters in 2016, increased the excise tax rate on cigarettes by $2 per pack, with an equivalent increase on other tobacco products, including electronic cigarettes, to provide funding for various public health and tobacco-related law enforcement programs. After allocations for administration, auditing, and backfills of other revenue streams, Proposition 56 requires 82 percent of remaining funds be transferred to the Healthcare Treatment Fund to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services in the Medi-Cal program.

The 2017 Budget Act allocated Medi-Cal funding for supplemental payments for certain physician services, dental services, women's health, intermediate care facilities for individuals with developmental disabilities (ICF-DDs), and provider serving beneficiaries of the AIDS Waiver. The 2018 Budget Act increased the allocation for physician and dental services by expanding eligible preventive service codes and the level of reimbursement for each code, as well as funding for home health services, pediatric day health centers, free-standing pediatric subacute facilities, and certain qualified community-based adult services programs, and a one-time allocation for loan repayments for physicians and dentists who serve Medi-Cal beneficiaries. The 2019 Budget Act included ongoing supplemental payments for family planning services, early developmental screenings for children, trauma screenings for children and adults, provider trainings for trauma screenings, a three-year value-based payment program for providers that meet certain quality metrics, and a second allocation for physician and dentist loan repayments.

The budget includes $3.2 billion ($975.8 million Proposition 56 and $2.3 billion federal funds) in 2020-21 and $3.2 billion ($275.3 million General Fund, $717.9 million Proposition 56 and $2.2 billion federal funds) in 2021-22 for supplemental provider payments in Medi-Cal. The supplemental payments by category are as follows:

Category/Fund	2020-21	2021-22	Category/Fund	2020-21	2021-22
Physician Services			***Pediatric Day Health Care Facilities***		
Total Fund	$1,276,175,000	$1,275,228,000	Total Fund	$17,353,000	$14,246,000
Proposition 56	$400,454,000	$426,761,000	Proposition 56	$7,741,000	$6,656,000
Federal Funds	$875,721,000	$848,467,000	Federal Funds	$9,612,000	$7,590,000
Dental Services			***Pediatric Subacute Facilities***		
Total Fund	$518,839,000	$514,291,000	Total Fund	$9,155,000	$8,943,000
Proposition 56	$180,707,000	$193,052,000	Proposition 56	$3,832,000	$4,085,000
Federal Funds	$338,132,000	$321,239,000	Federal Funds	$5,323,000	$4,858,000

Women's Health			***Community-Based Adult Svcs (CBAS)***		
Total Fund	$154,170,000	$163,957,000	Total Fund	$38,648,000	$30,753,000
Proposition 56	$21,476,000	$22,595,000	Proposition 56	$16,928,000	$14,285,000
Federal Funds	$132,694,000	$141,362,000	Federal Funds	$21,720,000	$16,468,000
Medi-Cal Family Planning			***Home Health***		
Total Fund	$436,844,000	$431,071,000	Total Fund	$167,320,000	$92,754,000
Proposition 56	$43,684,000	$43,107,000	Proposition 56	$77,152,000	$43,338,000
Federal Funds	$393,160,000	$387,964,000	Federal Funds	$90,168,000	$49,416,000
Interm. Care Facilities-Developmental Disabilities			***Developmental Screenings***		
Total Fund	$25,988,000	$25,925,000	Total Fund	$53,308,000	$61,960,000
Proposition 56	$11,076,000	$11,782,000	Proposition 56	$20,955,000	$25,878,000
Federal Funds	$14,912,000	$14,143,000	Federal Funds	$32,353,000	$36,082,000
AIDS Waiver			***Trauma (ACES) Screenings***		
Total Fund	$6,800,000	$6,800,000	Total Fund	$42,090,000	$47,682,000
Proposition 56	$2,978,000	$3,189,000	Proposition 56	$14,910,000	$18,217,000
Federal Funds	$3,822,000	$3,611,000	Federal Funds	$27,180,000	$29,465,000
Non-Emergency Medical Transportation			***Provider ACES Training***		
Total Fund	$7,925,000	$7,925,000	Total Fund	$61,924,000	$41,712,000
Proposition 56	$3,664,000	$3,892,000	Proposition 56	$30,962,000	$20,856,000
Federal Funds	$4,261,000	$4,033,000	Federal Funds	$30,962,000	$20,856,000
Behavioral Healthcare Incentive Program			***Hosp-Based Pediatric Providers (One-time)***		
Total Fund	$57,000,000	$76,000,000	Total Fund	$4,000,000	$0
Proposition 56	$24,966,000	$35,644,000	Proposition 56	$1,752,000	$0
Federal Funds	$32,034,000	$40,356,000	Federal Funds	$2,248,000	$0
Value-Based Payment (VBP) Program			***TOTAL***		
Total Fund	$364,513,000	$364,207,000	Total Fund	$3,242,052,000	$3,163,454,000
Proposition 56	$112,547,000	$119,866,000	Proposition 56*	$975,784,000	$993,203,000
Federal Funds	$251,966,000	$244,341,000	Federal Funds	$2,266,268,000	$2,170,251,000

* Due to estimated reductions in the availability of Proposition 56 revenue, approximately 28 percent of 2021-22 supplemental payments are supported by the state's General Fund.

Mandatory and Optional Benefits in Medi-Cal Federal Medicaid law requires certain benefits to be included in a state's Medicaid plan for providing services to its beneficiaries. In addition to the required benefits, states are authorized to include certain optional benefits for Medicaid beneficiaries. Both mandatory and optional benefits are eligible for federal matching funds. According to the federal Centers for Medicare and Medicaid Services, the mandatory and optional benefits in federal Medicaid laws and regulations are as follows:

Mandatory Benefits	Optional Benefits
Inpatient hospital services	Prescription Drugs
Outpatient hospital services	Clinic services
EPSDT	Physical therapy

Nursing Facility Services	Occupational therapy
Home health services	Speech, hearing and language disorder services
Physician services	Respiratory care services
Rural health clinic services	Other diag./screening/preventive/rehab. services
FQHC services	Podiatry services
Laboratory and X-ray services	Optometry services
Family planning services	Dental Services
Nurse Midwife services	Dentures
Certified Pediatric/Family NP services	Prosthetics
Freestanding Birth Center services	Eyeglasses
Transportation to medical care	Chiropractic services
Tobacco cessation counseling (pregnant women)	Other practitioner services
	Private duty nursing services
	Personal Care
	Hospice
	Case management
	Services for Individuals 65 or Older in an IMD
	Services in an ICF-DD
	State Plan HCBS - 1915(i)
	Self-Directed Pers. Assistance Services- 1915(j)
	Community First Choice Option- 1915(k)
	TB Related Services
	Inpatient psychiatric services-individuals under 21
	Other services approved by the Secretary
	Health Homes (for Chronic Conditions)- 1945

2009 Budget Actions Eliminated Many Medi-Cal Optional Benefits Until 2020. In 2009, facing a significant General Fund deficit, the budget included several reductions in reimbursement and benefits in the Medi-Cal program. AB 5 X3 (Evans), Chapter 20, Statutes of 2009, Third Extraordinary Session, eliminated several optional Medi-Cal benefits, including adult dental services, acupuncture, audiology, speech therapy, chiropractic services, optician and optical lab services, podiatric services, psychology services, and incontinence creams and washes. These benefits were not eliminated for beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program, beneficiaries in a skilled nursing facility or intermediate care facility, or pregnant beneficiaries. Over the course of several years, budget and legislative actions have restored nearly all of the eliminated benefits as of January 1, 2020, including full adult dental benefits, optical benefits, acupuncture, audiology, incontinence creams/washes, podiatry, and speech therapy.

Extension of Medi-Cal for Provisional Postpartum Care. SB 104 (Committee on Budget and Fiscal Review), Chapter 67, Statutes of 2019, extended Medi-Cal eligibility for pregnancy-only programs from

60 days to one year after delivery if the beneficiary is diagnosed with a maternal mental health disorder. The implementation of the provisional postpartum care extension occurred August 2020. The budget includes General Fund expenditure authority of $27.1 million in 2021-22 for the eligibility expansion.

Expansion of Screening, Brief Intervention, Referral to Treatment (SBIRT) to Opioids and Other Drugs. SB 78 (Committee on Budget and Fiscal Review), Chapter 38, Statutes of 2019, directed DHCS to seek federal approval to expand the Medi-Cal benefit for screening, brief intervention, and referral to treatment (SBIRT) to include screening for overuse of opioids and other illicit drugs such as heroin and methamphetamine. Effective June 9, 2020, the United States Preventive Services Task Force (USPSTF) assigned a "B" rating to SBIRT screening for opioids and other illicit drugs for adults ages 18 and older. The California Medicaid State Plan requires mandatory coverage of any benefit recommended by the USPSTF. As a result, the budget includes expenditure authority of $1.6 million ($563,000 General Fund and $1 million federal funds) in 2020-21 and $1.7 million ($622,000 General Fund and $1.1 million federal funds) in 2021-22 for the expansion of SBIRT.

Suspension of Proposition 56 Supplemental Payments, Optional Benefits, Post-Partum Care Extension and SBIRT. The 2019 Budget Act included language to suspend expenditures for certain health and human services programs on December 31, 2021. If the Director of Finance determines that projected annual General Fund revenues exceed projected annual General Fund expenditures sufficient to fund all suspended programs, the suspensions would not take effect. These suspensions were intended to address an expected General Fund shortfall in subsequent fiscal years due to a recessionary forecast. The health related programs subject to suspension included: 1) Proposition 56 supplemental provider payments, 2) Medi-Cal optional benefits, 3) provisional post-partum care Medi-Cal eligibility expansion, 4) SBIRT expansion to opioids and other drugs, 5) comprehensive HIV prevention grants, 6) sexually transmitted disease (STD) prevention grants, and 7) hepatitis C prevention grants.

The 2020 Budget Act maintained the structure of the suspensions, but accelerated suspensions of Proposition 56 supplemental provider payments to July 1, 2021 (except family planning, women's health, and the physician and dentist loan repayment program), and repealed the suspensions for the HIV, STD, and hepatitis C prevention grant programs.

Administration Proposes to Delay Some Suspensions, Repeal Others. DHCS proposes provisional budget bill language and trailer bill language to delay or repeal program and benefit suspensions. Specifically, the proposed language would make the following changes to the suspensions framework:

1) *Proposition 56 Supplemental Provider Payments* – DHCS proposes provisional budget bill language and trailer bill language that would delay the suspension of most Proposition 56 supplemental provider payments until July 1, 2022, or one year after the current suspension date. The language would suspend supplemental payments for intermediate care facilities-developmental disabilities (ICF-DDs), freestanding pediatric subacute facilities, and community-based adult services on December 31, 2022, or 18 months after the current suspension dates. The language would also repeal the suspension for supplemental payments for the AIDS waiver, home health, and pediatric day health care facilities, as DHCS does not expect federal approval for these suspensions.
2) *Optional Benefits* - DHCS proposes trailer bill language to delay the suspension of Medi-Cal optional benefits until January 1, 2023, or one year after the current suspension date. These

benefits would include podiatric services, audiology services, speech therapy, optician and optical services, and incontinence creams and washes.

3) *Provisional Post-Partum Care Eligibility Extension* – DHCS proposes trailer bill language to delay the suspension of the provisional post-partum care extension of Medi-Cal eligibility until December 31, 2022, or one year after the current suspension date.
4) *SBIRT for Opioids and Other Drugs* – DHCS proposes trailer bill language to repeal the suspension of the SBIRT benefit for opioids and other drugs, as recommendations by the USPSTF require mandatory coverage of this benefit.

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

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

1. Please provide a brief overview of these proposals.

Issue 7: AB 1705 Ground Emergency Medical Transportation Public Provider IGT Program

Budget Change Proposal – Governor's Budget. DHCS requests five positions and expenditure authority of $715,000 ($358,000 federal funds and $357,000 reimbursements) in 2021-22, and $670,000 ($335,000 federal funds and $335,000 reimbursements) annually thereafter. If approved, these positions and resources would allow DHCS to implement a new Ground Emergency Medical Transportation (GEMT) Public Provider Intergovernmental Transfer (IGT) program, pursuant to AB 1705 (Bonta), Chapter 544, Statutes of 2019.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0890 – Federal Trust Fund	$358,000	$335,000
0995 – Reimbursements	$357,000	$335,000
Total Funding Request:	**$715,000**	**$670,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and Resources ongoing after 2022-23.

Background. SB 523 (Hernandez), Chapter 773, Statutes of 2017, established the Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) program, which assesses a fee on each emergency medical transport to support enhanced reimbursement to GEMT providers. For GEMT providers in the Medi-Cal fee-for-service delivery system, fee revenue serves as the non-federal share of a reimbursement rate add-on for transports. For GEMT providers in the Medi-Cal managed care delivery system, fee revenue serves as the non-federal share of increased capitation payments to Medi-Cal managed care plans to provide supplemental payments to noncontract providers of GEMT services. Under SB 523, the QAF program supports enhanced reimbursement for both public and private GEMT providers.

AB 1705 (Bonta), Chapter 544, Statutes of 2019, suspends the GEMT QAF program for public providers, and instead establishes a GEMT Public Provider Intergovernmental Transfer (IGT) program. Under this program, public providers would participate in a voluntary transfer of funding to DHCS, which would support the non-federal share of enhanced reimbursement to eligible GEMT providers. Similar to the GEMT QAF program, the GEMT Public Provider IGT program would provide a rate add-on in the fee-for-service delivery system, and would increase managed care capitation payments to provide supplemental payments to providers in the managed care delivery system. Managed care plans would be required to reimburse a noncontract GEMT provider an amount equal to what the provider would have received under the fee-for-service delivery system.

Under the GEMT Public Provider IGT program, DHCS would assess a 10 percent fee on each voluntary IGT to support program operations, as well as the non-federal share of health care services expenditures in the Medi-Cal program. The 10 percent assessment is a feature of other IGT programs administered by DHCS, and supports administration of the program without an impact on the state's General Fund. According to DHCS, the IGT program would likely provide a higher reimbursement rate to providers than these providers currently receive under the QAF program. DHCS reports the GEMT public provider community has communicated strong support for the implementation of this program.

Staffing and Resource Request. DHCS requests five positions and expenditure authority of $715,000 ($358,000 federal funds and $357,000 reimbursements) in 2021-22, and $670,000 ($335,000 federal funds and $335,000 reimbursements) annually thereafter to implement the GEMT Public Provider IGT program. According to DHCS, the new program would create new workload in the department's Capitated Rates Development Division (CRDD), which would require **one Staff Services Manager I** position and **four Associate Governmental Program Analysts**. These positions would work with the department's contracted actuary to develop managed care capitation rate adjustments for the program; manage the IGT agreements and revenue collections; serve as subject matter experts for the new program; oversee and develop appropriate tools and mechanisms to process GEMT public provider IGT information; research, develop, and recommend policies and standards; and communicate policies, processes, timelines, and other requirements to the GEMT public provider community.

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

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

1. Please provide a brief overview of this proposal.

Issue 8: Medi-Cal Telehealth Proposal and Remote Patient Monitoring

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

Program Funding Request Summary – Local Assistance Funding (Remote Patient Monitoring)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$-	$33,987,890
0890 – Federal Trust Fund	$-	$60,797,530
Total Funding Request:	**$-**	**$94,785,400**

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

Temporary Flexibilities During Pandemic Emergency. DHCS implemented the following temporary policy changes during the pandemic emergency, related to telehealth:

- Expanded ability for providers to render all applicable services that can be appropriately provided via telehealth modalities, including home- and community-based services, Local Education Agency, and Targeted Case Management services.
- Allowed most telehealth modalities to be provided for new and established patients.
- Allowed many covered services to be provided via telephone/audio-only for the first time.
- Allowed payment parity between services provided in-person face-to-face, by synchronous telehealth, and by telephonic/audio only when the services met the requirements of the billing code by various provider types, including federally qualified health centers (FQHCs) and rural health centers (RHCs).
- Waived site limitations for providers and patients of FQHCs and RHCs
- Allowed expanded access to telehealth through non-public technology platforms, based on a federal exemption to Health Insurance Portability and Accountability Act (HIPAA) requirements.

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

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

- Allow an FQHC or RHC to establish new patients, within its federally designated service area, through synchronous telehealth only.
- Permanently remove the site limitations on the provision of services by FQHCs and RHCs.
- Expand synchronous and asynchronous telehealth services to home- and community-based services waivers, the Targeted Case Management (TCM) Program, and the Local Education Agency Billing Option Program (LEA-BOP).
- Add synchronous telehealth and telephonic/audio-only services to State Plan Drug Medi-Cal.
- Require payment parity between in-person face-to-face visits and synchronous telehealth modalities only.
- Expand use of clinically appropriate telephonic/audio-only, other virtual communication, and remote patient monitoring for established patients, subject to a separate fee schedule and not billable by FQHCs or RHCs.
- Provides that the TCM Program and LEA BOP will follow traditional certified public expenditure reimbursement methodologies when rendering services via telehealth.

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

- Telephonic/audio-only modalities as a billable visit for FQHCs or RHCs reimbursed at the per-visit rate
- Telephonic/audio-only modalities to establish a new patient
- Payment parity for telephonic/audio-only modalities and virtual communications
- Various flexibilities for Tribal 638 clinics.

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

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

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

1. Please provide a brief overview of the proposed extension of telehealth flexibilities and the rationale for why certain flexibilities were extended and others were not.

2. Please describe the details of the new remote patient monitoring benefit. How would providers be reimbursed for this benefit?

Issue 9: New/Restored Benefits: CGM and OTC Acetaminophen, and Cough/Cold Products

Local Assistance and Trailer Bill Language– Governor's Budget. DHCS requests expenditure authority of $10.9 million ($3.8 million General Fund and $7.1 million federal funds) to add continuous glucose monitoring (CGM) systems as a Medi-Cal benefit for beneficiaries with Type 1 diabetes. In addition, DHCS proposes trailer bill language to restore over-the-counter acetaminophen and cough and cold products as Medi-Cal benefits. DHCS expects a reduction in annual Medi-Cal expenditures of $21 million ($7.8 million General Fund and $13.2 million federal funds) due to the replacement of more costly opioids, prescription pain relievers, and other prescription cough treatments with these less costly over-the-counter options.

Program Funding Request Summary – Local Assistance Funding (CGM)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$-	$3,797,000
0890 – Federal Trust Fund	$-	$7,144,000
Total Funding Request:	**$-**	**$10,941,000**

Program Funding Request Summary – Local Assistance Funding (Acetaminophen)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	($7,761,000)	($7,777,000)
0890 – Federal Trust Fund	($13,197,000)	($13,223,000)
Total Funding Request:	**($20,958,000)**	**($21,000,000)**

Proposed New Medi-Cal Benefit - Continuous Glucose Monitoring Systems. Continuous glucose monitoring (CGM) systems use small sensors located just under a patient's skin to provide near real-time glucose data, which facilitates monitoring of time spent in the desirable target glucose range, warns users if glucose is trending toward hypoglycemia or hyperglycemia, and leads to improved glycemic control and outcomes compared to traditional self-monitoring of blood glucose for adult patients with Type 1 diabetes. In particular, use of CGM systems demonstrates sustained improvement in glycemic indicators and a reduction in adverse events such as severe hypoglycemia and episodes of ketoacidosis.[11,12] Currently, the California Children's Services (CCS) program and the Genetically Handicapped Persons Program (GHPP) provide coverage of medically necessary CGM devices for program participants.

DHCS requests expenditure authority of $10.9 million ($3.8 million General Fund and $7.1 million federal funds) to add CGM systems as a Medi-Cal benefit for beneficiaries 21 and older with Type 1 diabetes that demonstrate medical necessity. The implementation of the benefit would begin January 1, 2022. The benefit would include two physician visits for sensor placement and calibration, patient training, and a follow-up; an external CGM receiver for three years; and monthly supplies of sensors and transmitters. The CGM systems would be reimbursed as durable medical equipment. DHCS plans to enter into rebate agreements with CGM system manufacturers to offset General Fund costs for the new benefit. In addition,

[11] Danne, T., et al. "*International Consensus on Use of Continuous Glucose Monitoring*". Diabetes Care. 2017.

[12] Soupal, J., et al. "*Glycemic Outcomes in Adults With T1D Are Impacted More by Continuous Glucose Monitoring Than by Insulin Delivery Method: 3 Years of Follow-Up From the COMISAIR Study*". Diabetes Care. 2020.

DHCS estimates beneficiaries' transition from self-monitoring of blood glucose to CGM systems would result in offsetting savings to the Medi-Cal program due to a reduction in use of traditional blood glucose monitoring supplies.

Proposed Restored Benefit – Over-the-Counter Acetaminophen and Cough/Cold Products. Federal Medicaid law provides states the option to provide coverage for over-the-counter acetaminophen and cough and cold products. Prior to 2010, Medi-Cal covered these products as an inexpensive alternative to prescription pain relievers and other drugs. SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, eliminated Medi-Cal coverage for over-the-counter (OTC) acetaminophen products as part of a package of General Fund reductions to address recessionary budget shortfalls. The 2010 Budget Act assumed an annual General Fund savings of $3.1 million from eliminating the OTC acetaminophen benefit. AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, eliminated OTC cough and cold products, also to address recessionary budget shortfalls. The 2011 Budget Act assumed annual General Fund savings of $2.2 million from elimination of the OTC cough and cold product benefit.

During the COVID-19 pandemic, Medi-Cal temporarily reinstated coverage of OTC acetaminophen and cough and cold products for beneficiaries. The primary symptoms of COVID-19 include pain, aches, fever, cough, and congestion. As the preferred treatment for these symptoms are OTC fever reducers, analgesics and cough and cold products, DHCS reinstated coverage for these products.

DHCS proposes trailer bill language to permanently reinstate coverage of OTC acetaminophen and cough and cold products. According to DHCS, this policy change would result in savings for the Medi-Cal program, as these products are less costly than prescription opioids, analgesics, and cough treatments currently covered for beneficiaries. The budget assumes General Fund savings of $21 million ($7.8 million General Fund and $13.2 million federal funds) annually from implementation of this proposal. The department's current estimate that restoration of these benefits would result in savings to the Medi-Cal program suggests that the General Fund savings estimates included in the 2010 and 2011 Budget Acts for elimination of these benefits were likely erroneous.

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

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

1. Please provide a brief overview of these proposals.

Issue 10: California Community Transitions (SB 214)

Budget Change Proposal – Governor's Budget. DHCS requests General Fund expenditure authority of $432,000 in 2021-22 and $405,000 in 2022-23 and 2023-24. If approved, these resources would allow DHCS to implement and operate a temporary, state-funded California Community Transitions (CCT) program, pursuant to the requirements of SB 214 (Dodd), Chapter 300, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$432,000	$405,000
Total Funding Request:	**$432,000**	**$405,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24: $405,000.

Background. The Deficit Reduction Act of 2005 established the Money Follows the Person (MFP) rebalancing demonstration, which was designed to increase the use of home- and community-based, rather than institutional, long-term care services and eliminate barriers to enable beneficiaries to receive support for appropriate and necessary long-term services in the setting of their choice. In California, the MFP demonstration is known as California Community Transitions (CCT), which works with CCT Lead Organizations (CCTLOs) to identify eligible Medi-Cal beneficiaries who have continuously resided in state-licensed health care facilities for 90 consecutive days or longer. CCTLOs employ or contract with transition coordinators who work directly with eligible individuals, support networks, and providers to facilitate and monitor beneficiaries' transitions from facilities to the community settings of their choice. CCTLO staff meet with individuals to develop a transition plan and identify the individual's needs to safely live in the community, including skilled-nursing or in-home attendant care, medical equipment, transportation, and case management. After transition, a transition coordinator works with the individual for up to one year to address post-transition needs.

Transitions During COVID-19 Pandemic. During the pandemic, individuals over 65 years of age have been more likely to experience a more severe case of COVID-19 with 12,579 deaths occurring among skilled nursing facility residents, 27 percent of the state's total. As a result, several state efforts have been focused on reducing COVID-19 impacts on congregate care facilities, including skilled nursing facilities. Identifying eligible individuals that could transition from these facilities into a home- and community-based setting, including in the CCT program, helps decompress facilities and avoid exposure of vulnerable seniors and persons with disabilities to COVID-19. However, as a condition of federal MFP demonstration funding, individuals are only eligible for CCT services if they have continuously resided in a facility for 90 days. This requirement would not allow individuals to receive transition services immediately when determining suitability for a home- and community-based placement, but rather would require a stay of 90 days or longer in facilities that have been a locus of morbidity and mortality for COVID-19.

SB 214 Establishes a State-Only CCT Program to Eliminate 90 Day Stay Requirement. To alleviate the impact of COVID-19 on facilities, residents, and staff, SB 214 establishes a state-only program to provide CCT services to individuals residing in facilities for less than 90 days. DHCS expects the program would transition 300 eligible individuals in 2021 and 420 in 2022 from facilities to home- and community-

based settings of their choice. According to DHCS, these transitions would also result in long-term savings to the Medi-Cal program by providing lower-cost home- and community-based care to eligible individuals, rather than more costly long-term care in a facility. The state-only CCT program would sunset on January 1, 2023.

Staffing and Resource Request. DHCS requests General Fund expenditure authority of $432,000 in 2021-22 and $405,000 in 2022-23 and 2023-24 to implement and operate the temporary state-funded CCT program required by SB 214. This expenditure authority would support the **equivalent of one Associate Governmental Program Analyst, one Health Program Specialist I** position, and **one Research Data Analyst II** position. These positions would coordinate implementation and operation of the program with CCTLOs, DHCS administrative staff, and clinical staff. This workload would include processing applications and treatment authorization requests, providing enrollment packets, implementation of a separate tracking process for state-only participants, and overseeing program performance.

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

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

1. Please provide a brief overview of this proposal.

2. Given the expected long-term savings to the Medi-Cal program, would DHCS continue this program after its sunset on January 1, 2023?

Issue 11: Long-Term Health Care Facility Penalties for Improper Discharges

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to assess monetary penalties against a long-term health care facility for noncompliance with a hearing decision issued by DHCS that orders the readmission of a resident after a finding that the facility improperly transferred, discharged, or failed to readmit a resident.

Background. Federal law requires states to provide a long-term health care facility resident with a fair hearing if the resident has been refused readmission to the facility from a hospital. The hearing process, meant to protect against improper resident discharge, known as "patient dumping", is administered by the DHCS Office of Administrative Hearings and Appeals (OAHA), which conducts the hearing and issues decisions and orders related to improper discharges, transfers, or refusals to readmit. According to DHCS, once OAHA issues a decision and order, it no longer has jurisdiction or authority for enforcement, but refers the issue to the Department of Public Health (DPH). DPH handles these referrals as complaints, investigates the improper discharge, and may issue a citation to the facility.

DHCS indicates the hearing process for improper discharges, followed by an investigation by DPH, can lead to delays in returning residents to their facility of origin in a timely manner. In addition, DHCS reports its OAHA findings occasionally do not align with DPH findings in its investigative process. Because DHCS has no enforcement authority, it must defer to DPH to ensure a resident is readmitted to their facility of origin, and to impose penalties on noncompliant facilities.

DHCS proposes trailer bill language that would authorize the department to assess penalties of up to $1,000 for each calendar day the facility fails to comply with a hearing decision, beginning on the sixth calendar day after the date of service of the decision. Penalties would not exceed a total of $100,000 for each hearing decision noncompliance episode. The language would authorize DHCS to waive a portion of penalties upon a facility's successful demonstration of hardship. Penalty revenue would be deposited in the state's General Fund.

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

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

1. Please provide a brief overview of this proposal.

Issue 12: Medi-Cal Enterprise System Modernization

Budget Change Proposal – Governor's Budget. DHCS requests expenditure authority of $22.3 million ($4 million General Fund and $18.3 million federal funds) in 2021-22 and $1.3 million ($128,000 General Fund and $1.1 million federal funds) in 2022-23 to continue support of critical information technology modernization efforts.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$4,016,000	$128,000
0890 – Federal Trust Fund	$18,263,000	$1,147,000
Total Funding Request:	**$22,279,000**	**$1,275,000**
Total Requested Positions:	**0.0**	**0.0**

Background. Over the past several years, DHCS has undertaken several information technology (IT) projects to upgrade systems for payment processing, eligibility, and other functions. These projects have been managed either directly by DHCS or in partnership with the California Health and Human Services Agency and other state partners. Beginning with the 2020 Budget Act, DHCS has changed its approach from focusing on individual IT systems to focusing on a comprehensive Medi-Cal Enterprise System (MES), which coordinates these efforts. The MES would combine the following previously separate modernization efforts: 1) the California Medicaid Management Information System (CA-MMIS) Modernization project; 2) the Medi-Cal Eligibility System (MEDS) Modernization project; and 3) the Comprehensive Behavioral Health Data System Modernization (CBHDSM) project. According to DHCS, the department has already begun the process of consolidating these efforts and requires additional resources to continue to build and manage its portfolio of IT projects.

Resource Request. DHCS requests expenditure authority of $22.3 million ($4 million General Fund and $18.3 million federal funds) in 2021-22 and $1.3 million ($128,000 General Fund and $1.1 million federal funds) in 2022-23 to continue support of critical IT modernization efforts under the Medi-Cal Enterprise System. Specifically, DHCS requests the following contract resources for the following projects and components:

California Automated Recovery Management (CalARM) **–** DHCS requests expenditure authority of $3 million ($297,000 General Fund and $2.7 million federal funds) to contract with a Software-as-a-Service vendor in 2021-22 for design and implementation activities for the California Automated Recovery Management (CalARM) module, which provides support for third-party liability and recovery activities, and was previously part of the CA-MMIS modernization project. This contract would be part of the CalARM project's Project Approval Lifecycle Stage 4 submission.

Comprehensive Behavioral Health Data Systems Modernization (CBHDSM) – DHCS requests expenditure authority of $1.3 million ($128,000 General Fund and $1.1 million federal funds) in 2021-22 and 2022-23 for a contract to support completion of the Project Approval Lifecycle Stage 2 Alternatives Analysis, Stage 3 Preliminary Assessment, and the federal Implementation Advanced Planning Document (IAPD) for the Comprehensive Behavioral Health Data System Modernization (CBHDSM). This project

would modernize required data collection from county behavioral health programs as part of the department's oversight of these programs.

Federal Draw and Reporting (FDR) System – DHCS requests expenditure authority of $9.8 million ($2.5 million General Fund and $7.4 million federal funds) for an engineering services contract to build on existing functionality delivered in 2020-21 for the Federal Draw and Reporting (FDR) System, which replaces functionality currently provided by the CMS-64 system and other manual processes for reporting Medi-Cal expenditure information to the federal Centers for Medicare and Medicaid Services for the purpose of federal matching funds.

Modernization Strategy Planning and Support – DHCS requests expenditure authority of $8.2 million ($1.1 million General Fund and $7.1 million federal funds) in 2021-22 to implement its consolidation of IT projects under the Medi-Cal Enterprise System (MES). According to DHCS, MES Modernization would implement an agile organization, capable of delivering modern technology solutions that have design, technology, and development procedure consistency. To support the transformation to a modern, enterprise approach, DHCS specifically requests the following contract services:

- *Digital Support Services (DSS)*
  $2 million ($200,000 General Fund and $1.8 million federal funds)
  This contract would provide the MES Modernization effort the capability to bring resources with specialized skills to meet the project and business objectives across the comprehensive set of IT projects.
- *Modern Development Environment*
  $1 million ($100,000 General Fund and $900,000 federal funds)
  This contract would provide engineering support for the development and operations, and licensing costs for platform and tools.
- *Architecture Planning and Governance Support*
  $3.4 million ($340,000 General Fund and $3.1 million federal funds)
  This contract would enable development of the MES Modernization strategy including development of an MES Modernization approach, MES Modernization roadmap, MES Modernization product and module portfolio, MES Modernization governance structure, initial understanding of cost and timeframes, and related MES Modernization management functions.
- *Organizational Change Management*
  $735,000 ($74,000 General Fund and $662,000 federal funds)
  This contract would plan, execute, and support the transformation DHCS program and IT staff, knowledge, skills, and abilities, including the transition of culture, process, and organizational approach.
- *Independent Validation and Verification (IV&V)*
  $375,000 ($38,000 General Fund and $338,000 federal funds)
  This contract would provide oversight for all MES Modernization work efforts, to assess these efforts as a whole, rather than as individual modules.

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

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

1. Please provide a brief overview of this proposal.

Issue 13: Coordination of Benefits and Post-Payment Recovery

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to clarify requirements for third-party commercial health insurance carriers to share data with the department of post-payment recovery and coordination of benefits.

Background. Federal and state law requires Medi-Cal to be the payer of last resort for the provision of health care services. If a Medi-Cal beneficiary has other health coverage, DHCS identifies these other coverage entities and maintains that information in the department's eligibility data system. Medi-Cal providers are able to access this information when they provide services to Medi-Cal beneficiaries and are required to seek reimbursement from a beneficiary's other health coverage before they may bill Medi-Cal for any remaining balance. DHCS refers to this process as "cost avoidance". If DHCS identifies other health coverage for a Medi-Cal beneficiary after the delivery of a health care service, Medi-Cal reimburses the provider for the service and recoups allowable costs from the other health coverage entity. DHCS refers to this process as "pay and chase".

For both "cost avoidance" and "pay and chase", DHCS obtains commercial health insurance eligibility files through electronic data exchanges. Other health coverage carriers are required by existing law to provide this information to DHCS through cooperative agreements. DHCS must negotiate these agreements with each individual carrier and has limited ability to request a comprehensive data set from each carrier. DHCS reports verification of this information is also a labor-intensive process.

DHCS proposes trailer bill language that would do the following:

1) Update and clarify the list of other health coverage carriers required to enter into cooperative agreements with DHCS to include all health care entities licensed by the California Department of Insurance, third party administrators, and union trusts.
2) Remove requirements that carriers be paid at the same rate paid to the Department of Motor Vehicles for providing information.
3) Establish the specific beneficiary data required to be submitted to DHCS from third-party entities.
4) Establish other data required when available about other persons' covered under the member's policy.
5) Require entities to provide DHCS with access to real-time electronic eligibility verification, at no cost to DHCS and in a form and manner specified by DHCS as is necessary to conduct its coordination of benefits responsibilities.

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

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

1. Please provide a brief overview of this proposal.

Issue 14: Limited-Term Positions – Extension or Conversion to Permanent

Budget Change Proposals – Governor's Budget. DHCS requests expenditure authority of $8.7 million ($3.1 million General Fund and $5.6 million federal funds) in 2021-22, $1.5 million ($222,000 General Fund and $1.3 million federal funds) in 2022-23, $1.3 million ($132,000 General Fund and $1.1 million federal funds) in 2023-24 and 2024-25, and General Fund expenditure authority of $132,000 in 2025-26. If approved, these resources would allow DHCS to extend previously approved limited-term resources equivalent to 38 positions for workload in various programs.

DHCS also requests 62.5 positions and expenditure authority of $9.5 million ($3.2 million General Fund, $5.6 million federal funds, and $676,000 Hospital Quality Assurance Revenue Fund) annually. If approved, these positions and resources would allow DHCS to address ongoing workload in various programs.

Program Funding Request Summary – Extension of Limited-Term Positions		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$3,081,000	$222,000
0890 – Federal Trust Fund	$5,621,000	$1,322,000
Total Funding Request:	**$8,702,000**	**$1,544,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24 and 2024-25: $1,262,000; 2025-26: $132,000.

Program Funding Request Summary – Conversion of Limited-Term Positions to Permanent		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$3,176,000	$3,176,000
0890 – Federal Trust Fund	$5,603,000	$5,603,000
0890 – Federal Trust Fund	$676,000	$676,000
Total Funding Request:	**$9,455,000**	**$9,455,000**
Total Requested Positions:	**62.5**	**62.5**

* Positions and resources ongoing after 2022-23.

Background. Over the past several years, DHCS has received limited-term resources to support workload in the following programs:

- California Community Transitions (CCT) Demonstration Project
- Federal Managed Care Regulations
- 1115 Waiver Extension – Medi-Cal 2020
- Medi-Cal Health Enrollment Navigators
- Robert F. Kennedy Workers Medical Plan
- Legal Support for Ongoing Waiver Activities
- Health Care Reform Financial Reporting
- Private Hospital Directed Payment Program
- Medi-Cal Eligibility Systems Staffing

These resources were established as limited-term to provide support for new workload that was either seen as time-limited in scope, or to allow sufficient time to assess whether the workload was ongoing and required permanent positions and resources. DHCS is requesting resources for additional limited-term extension of resources for workload for which such a temporary extension is appropriate, and to convert limited-term resources to permanent for ongoing workload.

Extension of Limited-Term Resources. DHCS requests limited-term extension of previously approved limited-term resources equivalent to 38 positions that expire on June 30, 2021, and expenditure authority of $8.7 million ($3.1 million General Fund and $5.6 million federal funds). Specifically, DHCS is requesting the following resources in the following programs:

California Community Transitions Demonstration Project – The California Community Transitions (CCT) Demonstration Project is supported by a federal Money Follows the Person (MFP) Rebalancing Demonstration grant to assist Medi-Cal beneficiaries in an in-patient facility to return to a home- or community-based setting. Because the MFP grant is approved by Congress on a limited-term basis, resources for this program have also been approved on a limited-term basis. DHCS is requesting four-year extension of resources **equivalent to eight positions** until June 30, 2025.

Federal Managed Care Regulations and 1115 Waiver Extension – In 2015, the federal Centers for Medicare and Medicaid Services (CMS) released a final rule expanding state requirements for oversight and monitoring of managed care plans, mental health plans, prepaid inpatient hospital plans, and dental managed care plans. Also in 2015, CMS approved California's 1115 Waiver renewal titled Medi-Cal 2020. Because the waiver is only approved for five years, these resources were only approved for a limited-term. However, due to the public health emergency, this waiver was extended by an additional year. For both the federal managed care regulations and 1115 Waiver extension resources, DHCS is requesting one-year extension of resources **equivalent to 25 positions** and 15 month extension of resources **equivalent to seven positions.**

Medi-Cal Health Enrollment Navigators – The 2019 Budget Act included resources to support outreach and enrollment support for retaining and using health coverage and gaining access to necessary medical care. Because the resources were available for a limited time, resources to support program workload was also approved for a limited-term. DHCS is requesting one-year extension of resources **equivalent to four positions**, as the grant program is continuing to provide funds to counties and organizations to contact hard-to-reach target populations to engage in outreach activities.

Robert F. Kennedy (RFK) Farm Workers Medical Plan – The RFK Medical Plan is a non-governmental, self-funded, self-insured health plan subject to collective bargaining agreements between the United Farm Workers and multiple agricultural employers. The 2017 Budget Act provided support to the RFK Medical Plan to ensure its financial viability through 2026. Because the funding was limited-term, the resources were only approved for a limited-term, as well. DHCS is requesting five year extension of resources **equivalent to one positions** to continue supporting the program until funding expires in 2026.

Conversion of Limited-Term Resources to Permanent. DHCS requests 62.5 positions and expenditure authority of $9.5 million ($3.2 million General Fund, $5.6 million federal funds, and $676,000 Hospital Quality Assurance Revenue Fund) annually to allow DHCS to address ongoing workload in various

programs. Specifically, DHCS is requesting the following positions and resources in the following programs:

Federal Managed Care Regulations - In 2015, the federal Centers for Medicare and Medicaid Services (CMS) released a final rule expanding state requirements for oversight and monitoring of managed care plans, mental health plans, prepaid inpatient hospital plans, and dental managed care plans. Much of this workload is permanent, as it is unlikely CMS is going to relax these standards. DHCS is requesting authority for **30 positions** to convert these limited-term resources to permanent staff.

Legal Support for Ongoing Waiver Activities – The 1115 Waiver requires legal support and expertise for legislative, regulatory, contractual, and litigation support work. As the 1115 Waivers have been time-limited, the resources have been approved for limited-term. However, the workload is ongoing for the conclusion of this waiver and any successor programs. DHCS is requesting authority for **two positions** to convert these limited-term resources to permanent staff.

Health Care Reform Financial Reporting – The 2015 Budget Act provided limited-term resources equivalent to 18 positions to address increases in mandated reporting requirements related to the federal Affordable Care Act. This workload includes federal reporting of quarterly expense reports based on state plan amendments, waivers, and base provider payments. This workload is ongoing. DHCS is requesting authority for **18 positions** to convert these limited-term resources to permanent staff.

Private Hospital Directed Payment Program – The Private Hospital Directed Payment program implements a uniform dollar increase in reimbursement to private hospitals that provide designated inpatient and outpatient services under contract with managed care plans. DHCS must annually submit adjustments to managed care rates to comply with CMS requirements for this directed payment program. The 2018 Budget Act included three year limited-term resources equivalent to 9.5 positions to support the program. DHCS is requesting authority for **7.5 positions** to convert some of these limited-term resources to permanent.

Medi-Cal Eligibility Systems Staffing – The 2016 Budget Act provided three-year limited-term resources to support enhancements to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), Medi-Cal Eligibility Data System (MEDS), and Statewide Automated Welfare Systems (SAWS). DHCS is requesting authority for **seven positions** to convert these limited-term resources to permanent staff.

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

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

1. Please provide a brief overview of these proposals.

Issue 15: Community Mental Health - Overview

Community Mental Health – *Three Year Funding Summary*			
Fund Source	**2019-20**	**2020-21**	**2021-22**
1991 Realignment (base and growth):			
Mental Health Subaccount	$0	$86,826,000	$72,833,000
2011 Realignment (base and growth):			
Mental Health Subaccount	$1,120,551,000	$1,129,949,000	$1,120,551,000
Behavioral Health Subaccount	$1,465,202,000	$1,582,340,000	$1,545,456,000
Realignment Total	**$2,585,753,000**	**$2,799,115,000**	**$2,738,840,000**
Medi-Cal SMHS Federal Funds	**$2,925,191,000**	**$3,002,281,000**	**$3,444,951,000**
Medi-Cal SMHS General Fund	**$273,104,000**	**$412,764,000**	**$362,675,000**
MHSA Local Expenditures	**$2,141,435,000**	**$2,128,328,000**	**$2,290,554,000**
Total Funds	**$7,925,483,000**	**$8,342,488,000**	**$8,837,020,000**

Background. California's system of community mental health treatment was first established in 1957 after passage of the Short-Doyle Act. Prior to Short-Doyle, the state was primarily responsible for the care and treatment of Californians with mental illness or developmental disabilities in fourteen regional psychiatric hospitals throughout the state. Short-Doyle was enacted to allow individuals with mental illness to be treated in a community-based setting nearer to friends and family to support more successful treatment outcomes, and resulted in a significant shift of the locus of treatment out of the state's psychiatric hospitals and into the community. Covered Short-Doyle benefits included treatment and rehabilitation services in primarily outpatient settings, as well as community education and training for professionals and staff in public entities to address mental health problems early.

Mental Health Services in Medi-Cal. Medi-Cal, California's state Medicaid program, was established in 1966 and covered specific mental health-related benefits including psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists. In 1971, many of the benefits provided by local Short-Doyle community mental health programs were also included in the scope of benefits provided to Medi-Cal beneficiaries. During this period, beneficiaries could access mental health services through Short-Doyle Medi-Cal (SD/MC) or through direct fee-for-service Medi-Cal providers (FFS/MC).

State-Local Realignment Funding for Community Mental Health. In 1991, in response to a state General Fund deficit, many state programs and funding streams were realigned to local governments including community mental health programs. The Bronzan-McCorquodale Act (1991 Realignment) provided that county mental health departments would be responsible for community mental health

services for Medi-Cal beneficiaries, for payments to state hospitals for treatment of individuals civilly committed under the Lanterman-Petris-Short Act (LPS), and for Institutions for Mental Disease (IMDs) that provide short-term nursing level care to individuals with serious mental illness. Funding for these programs is provided by redirection of sales tax and vehicle license fee revenues to counties.

In 2011, additional mental health responsibilities were realigned to counties in a package primarily focused on major public safety programs (2011 Realignment). Additional sales tax and vehicle license fee revenue was allocated to counties to fund these programs, which included responsibility for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children in Medi-Cal. Funding for the 1991 Mental Health Subaccount, up to $1.12 billion, was redirected to fund maintenance of effort requirements for the California Work Opportunities and Responsibility for Kids (CalWORKs) program. This redirection of funding was replaced by $1.12 billion of 2011 Realignment revenue deposited in the 2011 Realignment Mental Health Subaccount for community mental health programs. Consequently, realignment funding for community mental health services is derived primarily from 2011 Realignment funding allocations.

Affordable Care Act Expansion of Mental Health Benefits. The federal Affordable Care Act expanded certain mental health benefits available to Medi-Cal beneficiaries. SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013, First Extraordinary Session, implemented these new benefit requirements. These benefits are provided to individuals with mild to moderate levels of impairment by Medi-Cal managed care plans, rather than community mental health plans.

Medi-Cal Mental Health. There are three systems that currently provide mental health services to Medi-Cal beneficiaries:

4. **County Mental Health Plans (MHPs) -** California provides Medi-Cal specialty mental health services (SMHS) under a federal 1915(b) waiver that includes outpatient SMHS, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's SMHS is provided under the federal requirements of the EPSDT benefit for persons under age 21. County mental health plans are responsible for the provision of SMHS and Medi-Cal enrollees must obtain SMHS through the county. SMHS is a Medi-Cal entitlement for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria.

5. **Managed care plans –** SB 1 X1 expanded the scope of Medi-Cal mental health benefits, pursuant to the federal Affordable Care Act, and required these services to be provided by Medi-Cal managed care plans excluding those benefits provided by county mental health plans under the SMHS waiver. Generally these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by managed care plans include:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

6. **Fee-For-Service Provider System -** Effective January 1, 2014 the mental health services listed below are also available through the fee-for-service provider system:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

Mental Health Services Act (Proposition 63, Statutes of 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. These tax receipts are reconciled and deposited into the MHSA Fund on a "cash basis" (cash transfers) to reflect funds actually received in the fiscal year. The MHSA provides for a continuous appropriation of funds for local assistance.

The purpose of the MHSA is to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Most MHSA funding is to be expended by county mental health departments for mental health services consistent with local Three-Year Plans with Annual Updates approved by DHCS and the required five components, as required by MHSA. The following is a brief description of the five components:

1. **Community Services and Supports for Adult and Children's Systems of Care.** This component funds the existing adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments establish, through a stakeholder process, a listing of programs for which these funds will be used. Of total annual revenues, 80 percent is allocated to this component.

2. **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. Of total annual revenues, 20 percent is allocated to this component.

3. **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration. This is funded from five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.

4. **Workforce Education and Training.** This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component,

for a total of $460.8 million provided to counties and the Office of Statewide Health Planning and Development (OSHPD).

5. **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

Counties are required to submit annual revenue and expenditure reports to DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC). DHCS monitors county's use of MHSA funds to ensure the county meets the MHSA and Mental Health Services Fund requirements.

Subcommittee Staff Comments and Recommendation—Hold Open. Subcommittee staff recommends holding this item open as updated estimates of caseload and expenditures will be provided at the May Revision.

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

1. Please provide a brief overview of community mental health programs overseen by DHCS.

Issue 16: Behavioral Health Continuum of Care Infrastructure

Local Assistance – Governor's Budget. DHCS requests General Fund expenditure authority of $750 million in 2021-22. If approved, these resources would allow DHCS to implement a competitive grant program for counties for the acquisition and rehabilitation of real estate assets to expand the community behavioral health continuum.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$750,000,000	$-
Total Funding Request:	**$750,000,000**	**$-**

Background. According to DHCS, California faces a significant behavioral health infrastructure deficit. Inpatient psychiatric bed capacity is 21 beds per 100,000 people, while experts estimate 50 beds per 100,000 would be required to meet the Californians' behavioral health needs. According to 2014 data, California had among the lowest inpatient psychiatric bed capacity in the country. In addition, California only licenses about 2,300 subacute mental health treatment beds and the number of substance use disorder treatment facilities has decreased by 13 percent over the last three years. DHCS reports the following factors lead to this infrastructure deficit:

1) High real estate costs, leading to challenges building new facilities
2) "Not in my backyard" attitudes and zoning restrictions, leading to challenges finding suitable locations to expand treatment facilities and low-income housing
3) Difficulty accessing low-income housing, resulting in growing homelessness, leading to increasing numbers of people with severe mental illness requiring residential care
4) Restrictive federal interpretations regarding matching funds for services provided in Institutions for Mental Disease
5) Cost-based reimbursement of county behavioral health departments, preventing county reserves that could allow for investments in behavioral health infrastructure

According to DHCS' analysis of the gaps in bed capacity:

1) 40 counties, or 69 percent, have no crisis stabilization units
2) 38 counties, or 66 percent, have no mental health rehabilitation centers
3) 37 counties, or 64 percent, have no psychiatric health facilities
4) 31 counties, or 53 percent, have no licensed inpatient psychiatric beds
5) 15 counties, or 26 percent, have no substance use disorder residential treatment beds
6) 8 counties, or 14 percent, have no permanent supportive housing beds

Investment in Mental Health Wellness Act. SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, provided $142.5 million in one-time General Fund, $4 million in ongoing Mental Health Services Act (MHSA) funding, and $2.8 million in federal matching funds (reimbursements) to provide grants for community-based mental health crisis support. Known as the Investment in Mental Health Wellness Act of 2013, SB 82 authorized the California Health Facilities Financing Authority (CHFFA) to disburse funds to California counties or their nonprofit or public agency designees to develop

mental health crisis support programs. The one-time General Fund grants support capital projects to increase capacity for crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and peer respite. The MHSA and federal funds grants support personnel costs associated with operation of mobile crisis support teams. The grants support capital improvement, expansion and limited start-up costs.

CHFFA conducted six funding rounds for competitive grant awards, approving a total of 56 grants for 79 projects (69 capital and 10 personnel) in 41 counties. Approximately $136.5 million of capital funding (General Fund) and $4 million of MHSA funding for mobile crisis support team personnel has been encumbered. As of October 2020, $96.9 million of total funding has been disbursed, representing a total of 464 beds, including the following:

- 110 mobile crisis vehicles (or equivalent IT equipment)
- 57.25 mobile crisis personnel
- 736 crisis stabilization and crisis residential treatment beds
- 6 peer respite beds

Local Assistance Resource Request. DHCS requests General Fund expenditure authority of $750 million in 2021-22 to implement a competitive grant program for counties for the acquisition and rehabilitation of real estate assets to expand the community behavioral health continuum. Specifically, these resources would support the addition of at least 5,000 beds, units, or rooms, including the following:

- **Treatment facilities** including Crisis Intervention and Stabilization, Crisis Residential, Residential Treatment, Day Rehabilitation, Day Treatment Intensive or Partial Hospitalization with Housing Supports
- **Housing facilities** including Adult and Senior Care Facilities, Room and Board with Intensive Outpatient Services, and Peer Respite and Shared housing. These facilities would include intensive wrap-around supports, such as enhanced care management, in-lieu-of services, and county behavioral health services.

The grant program would allow facilities to be directly operated by counties, or operated through a contract with qualified nonprofit providers. Counties would be required to provide a 25 percent match of local funds, which may include property, land, or philanthropic donations.

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

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

1. Please provide a brief overview of this proposal.

2. Why did the Administration choose not to augment the Investment in Mental Health Wellness Act program, which has operated a similar grant program for the past several years at CHFFA? Has DHCS coordinated with CHFFA on this proposal to identify best practices or lessons learned?

Issue 17: Increased Access to Student Behavioral Health Services

Budget Change Proposal and Local Assistance – Governor's Budget. DHCS requests expenditure authority of $389 million ($194.5 million General Fund and $194.5 million federal funds) in 2021-22. If approved, these resources would allow DHCS to implement an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services.

DHCS also requests expenditure authority of $11 million ($5.5 million General Fund and $5.5 million federal funds) in 2021-22. If approved, these resources would support implementation workload for the student behavioral health incentive program, including capitated rate development, local government financing, and managed care operations and monitoring.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$194,493,000	$-
0890 – Federal Trust Fund	$194,493,000	$-
Total Funding Request:	**$388,986,000**	**$-**

Program Funding Request Summary – Budget Change Proposal		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$5,507,000	$-
0890 – Federal Trust Fund	$5,507,000	$
Total Funding Request:	**$11,014,000**	**$**
Total Requested Positions:	**0.0**	**0.0**

Background. According to DHCS, schools are a critical point of access for preventive and early intervention behavioral health services, as children are in school for many hours a day, for approximately half the days of the year. Early identification and treatment through school-affiliated behavioral health services can reduce emergency room visits, crisis situations, inpatient stays, and placement in high-cost special education settings or out of home placement. Schools often lack on-campus behavioral health resources, making it difficult to recognize and respond appropriately to children's mental health needs.

Mental Health Student Services Act. The 2019 Budget Act included expenditure authority from the Mental Health Services Fund of $50 million in 2019-20 and $10 million annually thereafter for the Mental Health Student Services Act (MHSSA), a competitive grant program to establish mental health partnerships between county mental health or behavioral health departments and school districts, charter schools, and county offices of education. These partnerships support: (1) services provided on school campuses; (2) suicide prevention; (3) drop-out prevention; (4) outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ), and youth who have been expelled or suspended from school; (5) placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services; and (6) other prevention, early intervention, and direct services, including, but not limited to, hiring

qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth.

Prior to the MHSSA, SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, known as the Investment in Mental Health Wellness Act, included expenditure authority from the Mental Health Services Fund of $32 million annually for MHSOAC to support counties to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. In 2018-19 the expenditure authority was reduced to $20 million annually. According to MHSOAC, since 2017-18, 50 percent of the funding has been allocated to programs dedicated to children and youth aged 21 and under, and approximately $20 million was allocated for four School-County Collaboration Triage grants to: 1) provide school-based crisis intervention services for children experiencing or at risk of experiencing a mental health crisis and their families or caregivers; and 2) supporting the development of partnerships between behavioral health departments and educational entities. Humboldt County, Placer County, Tulare County Office of Education, and a joint powers authority in San Bernardino County were awarded $5.3 million annually over four years in this program. MHSOAC also awarded grants for school-based triage programs in Berkeley, Humboldt, Riverside, Sacramento, and San Luis Obispo.

Building on the partnership model in the triage grant program, MHSSA supports partnerships between county behavioral health programs and educational entities. Combining the $50 million allocation in 2019-20 with the annual $10 million allocations for the subsequent three fiscal years, MHSOAC allocated a total of $75 million over four years for funding of the MHSSA Partnership Grant Program. The funding was made available in two categories: 1) $45 million for counties with existing school mental health partnerships, and 2) $30 million for counties developing new or emerging partnerships. Within each category, funding was made available based on the population size of a county with a total of six grants at $2.5 million each made available to small counties (less than or equal to 200,000 population), six grants at $4 million each made available to medium counties (between 200,000 and 750,000 population), and six grants at $6 million each made available to large counties (greater than 750,000 population).

The January budget includes expenditure authority from the Mental Health Services Fund of $25 million in 2021-22 for additional MHSSA grants. According to MHSOAC, proposals requesting approximately $80.5 million of grant funding were not approved during the most recent funding round.

Local Assistance Resource Request. DHCS requests expenditure authority of $389 million ($194.5 million General Fund and $194.5 million federal funds) in 2021-22 to implement an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services. The incentive payments would support the following interventions:

- Local planning efforts to review existing plans and documents that articulate student needs; compile data; map existing behavioral health resources; identify gaps, disparities, and inequities; convene stakeholders; and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for students. These planning efforts would include Medi-Cal managed care plans, county behavioral health departments, schools, and other key local stakeholders.

- Execution of contracts between schools, Medi-Cal managed care plans, and county behavioral health departments to provide preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers. Incentives would be provided for reaching threshold levels of school participation and for three-way contracts between the schools, behavioral health departments and Medi-Cal managed care plans.
- Development of behavioral health wellness programs, including Mental Health First Aid or Social and Emotional Learning.
- Expand the workforce using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-aged children.
- Increase behavioral health telehealth services in schools, including access to equipment and space
- Implement adverse childhood experience (ACE) screenings and referral processes in schools
- Implement a school suicide prevention strategy
- Implement culturally appropriate and community-defined interventions and systems for behavioral health services in schools to close health equity gaps.
- Increase prenatal and postpartum access to behavioral health for teen parents
- Improve public reporting of performance and outcomes for behavioral health access and quality
- Increase access to substance use disorder prevention, early intervention and treatment
- Provide care teams to conduct outreach, engagement, and home visits, as well as linkage to social services to address non-clinical needs

State Operations Resource Request. DHCS requests expenditure authority of $11 million ($5.5 million General Fund and $5.5 million federal funds) in 2021-22 to support implementation workload for the student behavioral health incentive program, including capitated rate development, local government financing, and managed care operations and monitoring. Specifically, DHCS requests the following resources:

Capitated Rates Development Division (CRDD) – CRDD would require resources **equivalent to two Research Data Analyst II** positions and **one Health Program Specialist II** position to develop, implement, and communicate financial policies for the new incentive program to Medi-Cal managed care plans. These activities would include providing contract updates, issuing All Plan Letters, or other program communications.

Local Government Financing Division (LGFD) – LGFD would require resources **equivalent to one Research Data Analyst II** position and **two Associate Governmental Program Analysts** to manage the technical contract and act as the coordinating hub on behalf of local educational agencies (LEAs).

LGFD would also require $5.3 million ($2.6 million General Fund and $2.6 million federal funds) for a technical assistance contract to develop, implement, and manage a methodology to successfully build partnerships with the 1,037 LEAs, the 58 county mental health departments, and the 24 Medi-Cal managed care plans.

Managed Care Operations Division (MCOD) – MCOD would require resources **equivalent to two Health Program Specialist I** positions and **one Associate Governmental Program Analyst** to lead necessary contract updates for Medi-Cal managed care plans, supporting requirements to increase preventive and early intervention behavioral health services provided by managed care plans in schools.

Managed Care Quality and Monitoring Division (MCQMD) – MCQMD would require resources **equivalent to two Health Program Specialist I** positions and **one Associate Governmental Program Analyst** to lead managed care policy development, issue formal managed care plan guidance, participate in the development of the incentive program, and engage with stakeholders.

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

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

1. Please provide a brief overview of the incentive program for school behavioral health services.

2. How does this proposal interact with the other school mental health proposals at the MHSOAC and through Proposition 98, proposed in the January budget?

3. Please provide a brief overview of the state operations request for this program.

Issue 18: Mental Health Services Act Flexibilities

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to extend county flexibility for expenditures of Mental Health Services Act funding for behavioral health services by one year, until July 1, 2022. These flexibilities were originally authorized until July 1, 2021, pursuant to AB 81 (Committee on Budget), Chapter 13, Statutes of 2020.

Background. In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directed the majority of revenues to county mental health programs and services in the following five categories:

1. Community Services and Supports (CSS) – 80 percent of county MHSA funding treats severely mentally ill Californians through a variety of programs and services, including full service partnerships and outreach and engagement activities aimed at reaching unserved populations.
2. Prevention and Early Intervention (PEI) – Up to 20 percent of county MHSA funds may be used for PEI programs, which are designed to identify early mental illness, improve timely access to services for underserved populations, and reduce negative outcomes from untreated mental illness, such as suicide, incarceration, school failure or dropping out, unemployment, homelessness and removal of children from homes.
3. Innovation – Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Since 2008-09, counties have the option of using a portion of their CSS funding in these areas or to build up a prudent reserve:

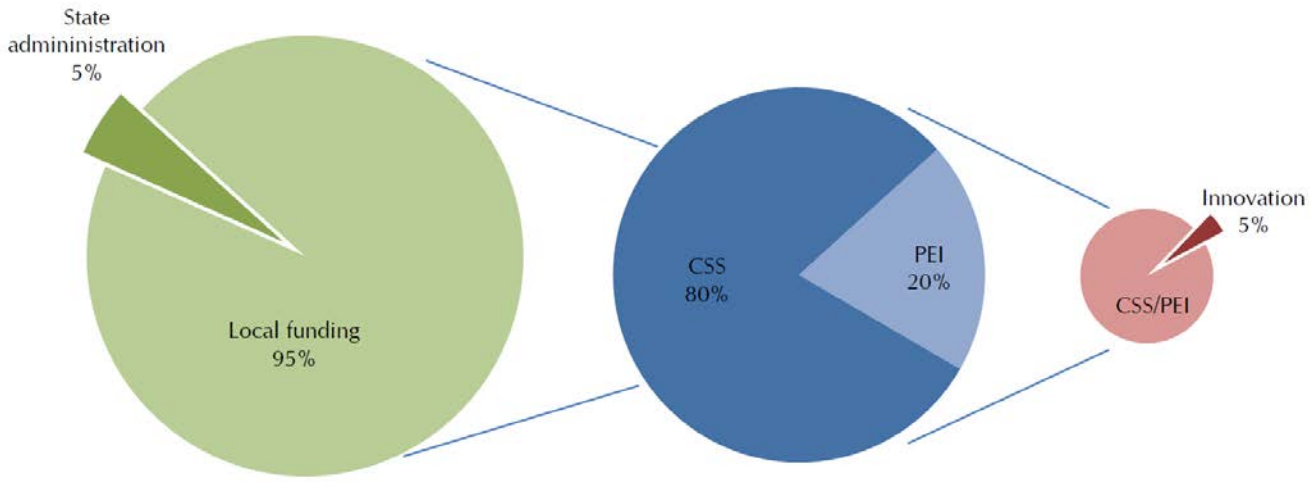
4. Workforce Education and Training – This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.
5. Capital Facilities and Technological Needs – This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

MHSA funds are allocated to counties by the State Controller through a formula that weighs each county's need for mental health services, the size of its population most likely to apply for services, and the prevalence of mental illness in the county. Adjustments are made for the cost of living and other available funding resources. The formula also provides a minimum allocation to rural counties for the CSS and PEI components.

State Administration Funds. MHSA authorizes the use of up to five percent of annual revenues for state administration and specifies that these funds are to be used by state agencies to "implement all duties

pursuant to the [MHSA] programs." This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs.

Apportionment of Mental Health Services Act Funds.



Source: Little Hoover Commission Report #225: *Promises to Keep: A Decade of the Mental Health Services Act* (Jan. 2015)

Reversion Requirements for Unspent County Funds. MHSA requires the reversion of unspent county funds to the state. According to Welfare and Institutions Code section 5892 (h), "any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years". However, DHCS has not reverted unspent county funds since 2008. In recent years, mental health advocates expressed concerns that counties were retaining MHSA funds that could be reverted and reallocated to the provision of additional mental health services. However, counties reported various challenges with accurate reporting of funds subject to reversion, including limitations on reporting forms from DHCS, inadequate identification of funds owed, and unclear policies for reversion.

2017 Budget Act Implemented Transparency Requirements for MHSA Reversion. In an effort to address the concerns from stakeholders and counties regarding the MHSA reversion process, the Legislature adopted several reforms in trailer bill language as part of the 2017 Budget Act. AB 114 (Committee on Budget), Chapter 38, Statutes of 2017, implemented the following changes:

1. Holds counties harmless for reversion prior to 2017-18, with funds reallocated to the counties of origin for the originally allocated purposes (e.g. prevention and early intervention, or innovative programs).
2. By July 1, 2018, requires DHCS and counties to report on the amounts owed prior to 2017-18 and requires counties to submit a plan to spend these funds by July 1, 2020.
3. Extends reversion period from three to five years for small counties (population under 200,000).
4. Requires DHCS to annually post by each October 1, the amount of each county's funds subject to reversion and when the funds will revert.

5. After July 1, 2017, requires reverted funds be reallocated to other counties for the purposes originally allocated (e.g. prevention and early intervention, or innovative programs).
6. Upon approval of an innovation plan by the Mental Health Services Oversight and Accountability Commission, allows funds allocated for innovative programs to re-start the three year period, after which the funds would be subject to reversion (five year period for small counties).

AB 114 provided clarity regarding counties' treatment of funds previously subject to reversion, provided timelines for DHCS to report annually to counties and the public regarding MHSA funds subject to reversion, and ensured MHSA funds allocated to each of the expenditure components required by the act (CSS, PEI, and Innovation) remain allocated to those components after reversion to other counties. In its October 2018 report on funds subject to reversion as of July 1, 2017, DHCS identified a total of $391 million subject to reversion that was deemed reverted and reallocated to the expenditure components to which it was first allocated. Of this amount, $5.1 million was allocated for CSS, $128.2 million for PEI, $187.5 million for Innovation, $27 million for Workforce Education and Training, and $43.2 million for Capital Facilities and Technological Needs.

2020 Budget Act Authority for Pandemic-Related MHSA Expenditure Flexibility. During the pandemic, counties requested flexibility for expenditures of MHSA funds to address the significant unmet behavioral health needs of children and adults due to social isolation, economic dislocations, and other adverse impacts of COVID-19. AB 81 (Committee on Budget), Chapter 13, Statutes of 2020, allowed temporary flexibilities as follows:

- Allows counties to spend down local MHSA prudent reserves without prior approval by DHCS
- Allows counties to spend funds within the Community Services and Supports component regardless of category restrictions, such as required allocations to Full-Service Partnerships
- Allows counties to use existing approved three-year plans or annual updates to expend local MHSA funds through 202-21 if the county certifies it was unable to submit a new three-year plan due to the pandemic
- Extends the reversion deadline for unspent county funds as of July 1, 2019, and July 1, 2020, until July 1, 2021.

DHCS Proposes to Extend MHSA Expenditure Flexibility. DHCS proposes trailer bill language to extend county flexibility for expenditures of Mental Health Services Act funding for behavioral health services, originally authorized by AB 81, by one year, until July 1, 2022. However, this proposal does not include an additional extension of the reversion deadline, which remains July 1, 2021. According to the Administration, as the pandemic continues, counties provide urgently needed mental health services at the same level or above to meet demand, especially outreach and engagement services not covered by other funding sources, and require extension of these flexibilities to support those efforts.

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

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

1. Please provide a brief overview of this proposal.

Issue 19: Behavioral Health 274 Expansion Project

Budget Change Proposal – Governor's Budget. DHCS requests expenditure authority of $1.1 million ($108,000 General Fund and $972,000 federal funds) in 2021-22 and 2022-23 to support contract costs for technical assistance to counties during the expansion of standardized format, content, and data transmission of health provider directories for county behavioral health programs.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$108,000	$108,000
0890 – Federal Trust Fund	$972,000	$972,000
Total Funding Request:	**$1,080,000**	**$1,080,000**
Total Requested Positions:	**0.0**	**0.0**

Background. According to DHCS, the 274 Health Provider Directory (HPD) Expansion Project is a department-wide initiative to standardize the format, content, and transmission of Medi-Cal managed care provider network data. The 274 HPD standard was adopted by DHCS and approved by CMS to ensure managed care provider network data is consistent, uniform, and aligns with national standards. The 274 HPD standard has been implemented for Medi-Cal managed care and dental managed care plans. DHCS is currently implementing the 274 HPD standard for behavioral health plans, including county mental health plans, the Drug Medi-Cal Organized Delivery System (DMC-ODS), and other county Drug Medi-Cal programs.

The 274 HPD will replace the current data systems used by behavioral health program areas, which collects provider data necessary for annual network monitoring and certification. Because the 274 HPD standard is new to these programs, DHCS expects the project will require significant testing, quality assurance, and the development of on-going quality control mechanisms to support data quality and integrity.

Resource Request. DHCS requests expenditure authority of $1.1 million ($108,000 General Fund and $972,000 federal funds) in 2021-22 and 2022-23 to support contract costs for technical assistance to counties during the expansion of standardized format, content, and data transmission of health provider directories for county behavioral health programs. DHCS reports it does not have the staff expertise or resources to implement the 274 HPD expansion. As a result, DHCS would contract for services from a qualified contractor equivalent to a team of one user acceptance and data analysis lead, and four user acceptance and data analysts. These contract staff would work closely with DHCS to conduct user acceptance testing, data analysis, data validation, data issue resolution , and data quality management support functions associated with the implementation of the 274 HPD standard for provider network data. According to DHCS, contract staff implemented the 274 HPD expansion for Medi-Cal managed care and dental managed care plans.

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

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

1. Please provide a brief overview of this proposal.

Issue 20: Mental Health Services Assisted Outpatient Treatment (AB 1976)

Budget Change Proposal – Governor's Budget. DHCS requests General Fund expenditure authority of $288,000 in 2021-22 and $270,000 in 2022-23 and 2023-24. If approved, these resources would allow DHCS to implement and report on additional Assisted Outpatient Treatment (AOT) programs, pursuant to AB 1976 (Eggman), Chapter 140, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$288,000	$270,000
Total Funding Request:	**$288,000**	**$270,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24: $270,000.

Background. AB 1421 (Thomson), Chapter 1017, Statutes of 2002, established the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law. Laura's Law was named after Laura Wilcox, a 19 year old Nevada County college student killed by an individual with severe mental illness who was not complying with prescribed mental health treatment. The law established an option for counties to utilize the courts, probation, and the mental health system to address the needs of individuals unable to participate on their own in mental health treatment programs without supervision. The former Department of Mental Health (now absorbed into DHCS) issued guidance to counties in 2003 specifying the submission requirements for implementation of an AOT program. For many years, Nevada County was the only county that implemented an AOT, known as the Turning Point Providence Center, as Laura's Law did not require counties to implement an AOT program and did not appropriate any additional implementation funding.

SB 585 (Steinberg), Chapter 288, Statutes of 2013, authorized counties to utilize Mental Health Services Act (MHSA) funding from Proposition 63 (2004) revenues to support implementation and operation of AOT programs. According to DHCS, since the passage of SB 585, the following counties have implemented or are planning to implement new AOT programs: Alameda, Contra Costa, El Dorado, Kern, Los Angeles, Marin, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Shasta, Stanislaus, Ventura, and Yolo.

AB 1976 (Eggman), Chapter 140, Statutes of 2020, requires all counties to offer AOT services, beginning July 1, 2021, or to opt out through passage of a resolution adopted by the county's Board of Supervisors. The resolution would be required to identify the reasons for opting out and any facts or circumstances used in making that decision. Participating counties would be allowed to offer AOT services independently, or in partnership with other counties under a memorandum of understanding. DHCS expects 20 additional counties will begin offering AOT services due to the requirements of AB 1976.

DHCS is required to report outcomes for AOT programs to evaluate program efficacy and monitor funding requirements for AOT services. DHCS is required to evaluate whether individuals served by AOT programs maintain housing and contact with treatment, have reduced or avoided hospitalizations, have reduced involvement with local law enforcement, and the extent to which incarceration was reduced or avoided. In addition, to the extent available, DHCS must also report on adherence to prescribed

medication participation in employment or education services, victimization, incidents of violent behavior, substance use, type of treatment, intensity of treatment, frequency of treatment, other indicators of successful engagement, required enforcement mechanisms, improved level of social functioning, improved independent living skills, and satisfaction with program services.

Annual Reporting on AOT Programs. In its most recent annual report to the Legislature and Governor for the period between May 2018 and April 2019, DHCS reported 914 individuals were served in AOT programs. Of these individuals, 75 percent or 686 participants, responded to the initial invitation to voluntary services and did not require a court petition or process. The remaining 228 individuals participated as a result of court orders or settlements. DHCS reported the following aggregate outcomes for court-involved participants:

1) Homelessness decreased by 30 percent
2) Hospitalization decreased by 33 percent
3) Contact with law enforcement decreased by 43 percent
4) Some individuals were able to secure employment or obtain volunteer positions
5) Victimization was reduced by 85 percent
6) Violent behavior decreased by 64 percent
7) Clients presenting with a co-occurring mental health and substance use disorder reduced substance use by 34 percent
8) Most counties reported improvements in clients social functioning and independent living skills
9) Client and family satisfaction surveys indicated satisfaction with AOT services.

Resource Request. DHCS requests General Fund expenditure authority of $288,000 in 2021-22 and $270,000 in 2022-23 and 2023-24 to implement and report on additional Assisted Outpatient Treatment (AOT) programs beginning operation as a result of AB 1976. According to DHCS, one half-time position at the department supports AOT programs in 20 counties. The requested resources would support the **equivalent of one Health Program Specialist I** position and **one Associate Governmental Program Analyst** in the department's Community Services Division. These positions would assist counties with implementation and data reporting requirements, conduct oversight, track county adoption of AOT programs, and compile new county AOT program information into the annual report.

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

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

1. Please provide a brief overview of this proposal.

Issue 21: Substance Use Disorder Recovery Residences (SB 406)

Budget Change Proposal – Governor's Budget. DHCS requests four positions and General Fund expenditure authority of $594,000 in 2021-22 and $558,000 annually thereafter. If approved, these positions and resources would allow DHCS to investigate and take enforcement action against substance use disorder recovery residences providing unallowable, unlicensed health care services, pursuant to the provisions of SB 406 (Pan), Chapter 302, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$594,000	$558,000
Total Funding Request:	**$594,000**	**$558,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and Resources ongoing after 2022-23.

Background. DHCS is responsible for licensing, certifying, and monitoring alcohol and other drug (AOD) treatment facilities. Recovery residences are alcohol and drug-free living environments that promote recovery from alcohol and other drug use, and are commonly used to help individuals transition from the structure of licensed residential treatment facilities to a less restrictive routine living environment. However, because recovery residences are not permitted to provide treatment services, they are not licensed or regulated by DHCS or any other entity.

According to DHCS, licensure for residential substance use disorder treatment is required when one or more of the following treatment services is provided: incidental medical services, detoxification, individual sessions, group sessions, educational sessions, or substance use disorder treatment or recovery planning. DHCS indicates it has received reports of substance use disorder recovery residences operating as unlicensed residential treatment facilities in violation of state law and regulations. The provision of unlicensed substance use disorder treatment can place clients at risk of overdose or death, as there is no oversight or approval of the level of care occurring in the facility. Unlicensed services can also derail sobriety if incorrect information is shared by unlicensed counselors with clients.

SB 406 (Pan) Chapter 302, Statutes of 2020, authorizes DHCS to investigate allegations of unlicensed services provided by a recovery residence facility when it is associated with a facility licensed or certified by the department. If an investigation determines that an unlicensed facility is operating in violation of the law, DHCS would notify the operator of the facility that it is operating without a required license and order the cessation of operations immediately. If the facility does not cease operations, DHCS may assess a civil penalty of up to $2,000 per day until the facility notifies the department it has ceased operations.

Staffing and Resource Request. DHCS requests four positions and General Fund expenditure authority of $594,000 in 2021-22 and $558,000 annually thereafter to investigate and take enforcement action against substance use disorder recovery residences providing unallowable, unlicensed health care services. Specifically, DHCS requests **four Associate Governmental Program Analysts** in its Licensing and Certification Division. These positions would be responsible for investigations of unlicensed recovery residences including: 1) conducting on-site unannounced visits for investigations, 2) extensive research and interviews to identify if unallowable services are being provided in unlicensed facilities, 3)

coordinating with legal staff to assess penalties, 4) respond to inquiries from providers and county programs related to program and licensure requirements and the status of investigations, 5) develop provider and county trainings and outreach on program and licensure requirements, and 6) revise and develop regulations.

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

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

1. Please provide a brief overview of this proposal.