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.

Thursday, February 24, 2022
Upon Adjournment of Session
State Capitol - Room 4203

Consultant: Scott Ogus

PUBLIC COMMENT

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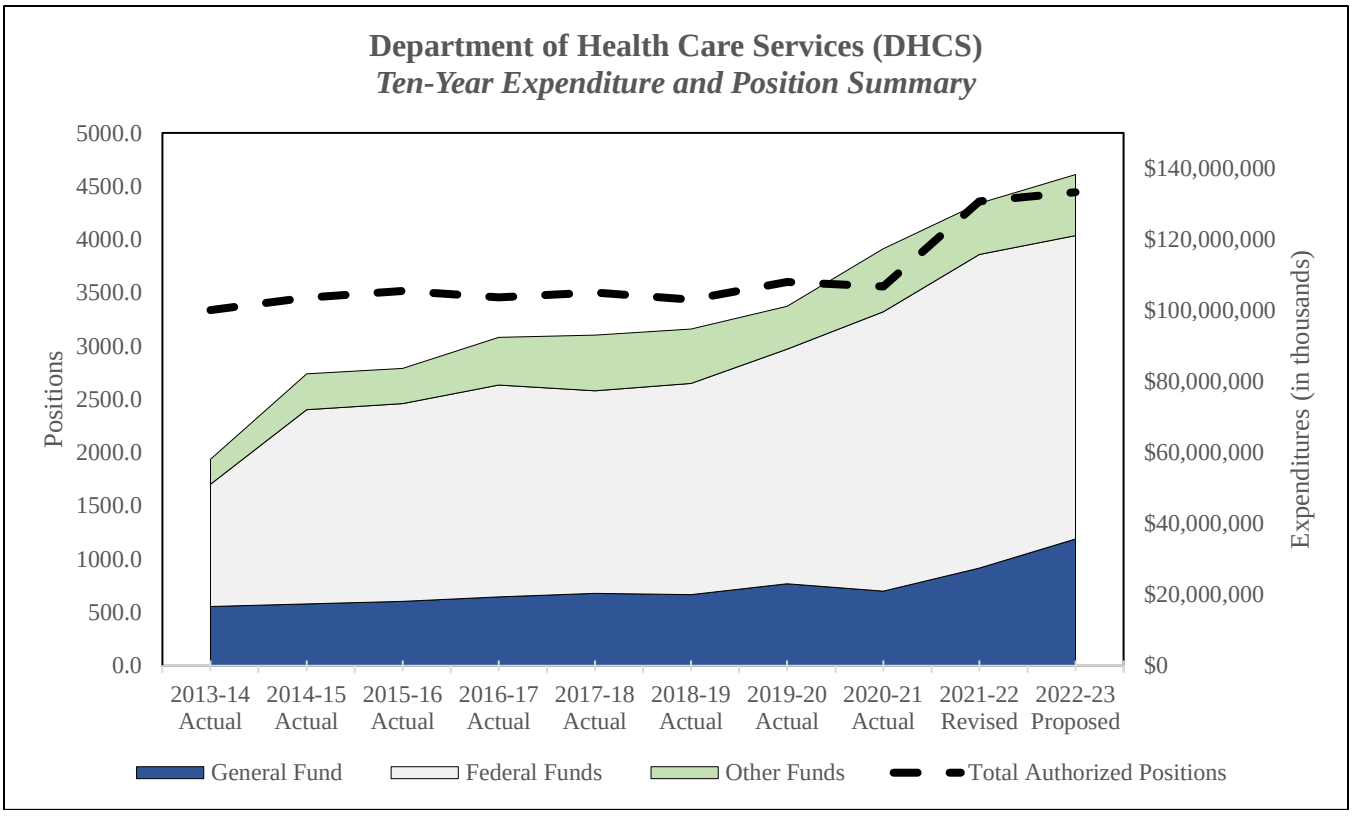
4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview



Department of Health Care Services - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	***2020-21 Actual***	***2021-22 Budget Act***	***2021-22 Revised***	***2022-23 Proposed***
General Fund	$21,046,822	$29,042,240	$27,489,675	$35,658,434
Federal Funds	$78,598,731	$82,596,990	$88,300,399	$85,440,508
Other Funds	$17,798,644	$14,708,372	$14,443,338	$17,174,915
Total Department Funding:	**$117,444,197**	**$126,347,602**	**$130,233,412**	**$138,273,857**
Total Authorized Positions:	**3557.7**	**3752.5**	**4357.2**	**4443.5**
Other Funds Detail:				
Breast Cancer Control Account (0007)	*$10,659*	*$10,848*	*$10,944*	*$10,946*
Child Lead Poisoning Prev Fund (0080)	*$0*	*$1,058*	*$1,003*	*$1,003*
DUI Program Licensing Trust Fund (0139)	*$983*	*$1,383*	*$1,411*	*$1,412*
Prop 99 - Hospital Services Acct (0232)	*$87,513*	*$77,295*	*$97,987*	*$89,639*
Prop 99 - Physician Services Acct (0233)	*$25,067*	*$22,072*	*$27,831*	*$25,769*
Prop 99 - Unallocated Acct (0236)	*$56,216*	*$47,770*	*$64,455*	*$54,771*

NTP Licensing Fund (0243)	*$1,599*	*$1,913*	*$1,789*	*$1,792*
Perinatal Insurance Fund (0309)	*$149*	*$17,177*	*$12,652*	*$23,303*
Audit Repayment Trust Fund (0816)	*$0*	*$67*	*$41*	*$41*
Medi-Cal Inpatient Pmt Adj Fund (0834)	*$46,016*	*$112,886*	*$84,433*	*$109,801*
Special Deposit Fund (0942)	*$74,493*	*$82,796*	*$70,360*	*$76,972*
Reimbursements (0995)	*$1,680,268*	*$1,347,799*	*$1,368,323*	*$2,094,970*
County Health Init Matching Fund (3055)	*$0*	*$176*	*$174*	*$174*
Children's Medical Svcs Rebate Fund (3079)	*$67,722*	*$24,600*	*$15,052*	*$20,335*
Mental Health Services Fund (3085)	*$2,791,921*	*$2,309,484*	*$3,364,389*	*$3,501,843*
Nondesig Public Hosp Suppl Fund (3096)	*($697)*	*$0*	*$3,658*	*$0*
Private Hospital Supplemental Fund (3097)	*$116,256*	*$26,916*	*$21,510*	*$26,423*
Mental Health Fac Licensing Fund (3099)	*$48*	*$386*	*$373*	*$373*
Residential/Outpatient Prog Lic Fund (3113)	*$7,988*	*$8,655*	*$9,027*	*$9,420*
Children's HHS Special Fund (3156)	*$100,000*	*$0*	*$0*	*$0*
Hospital Qual Assurance Rev Fund (3158)	*$4,561,942*	*$3,863,457*	*$3,748,455*	*$3,820,096*
SNF Quality/Accountability Fund (3167)	*($14,566)*	*($1,472)*	*($1,516)*	*$14,750*
Emerg Med Air Transportation Fund (3168)	*$5,608*	*$3,446*	*$4,351*	*$3,811*
Pub Hosp Invest/Impl/Incent Fund (3172)	*$499,838*	*$0*	*$0*	*$0*
LTC Quality Assurance Fund (3213)	*$584,113*	*$532,752*	*$447,165*	*$592,657*
Healthcare Treatment Fund (3305)	*$1,041,819*	*$719,418*	*$929,024*	*$785,310*
Health Care Svc Plan Penalties Fund (3311)	*$25,967*	*$5,798*	*$12,487*	*$12,382*
Medi-Cal Emerg Med Transp Fund (3323)	*$97,114*	*$69,848*	*$57,811*	*$54,972*
Medi-Cal Drug Rebate Fund (3331)	*$1,240,421*	*$1,456,697*	*$1,474,916*	*$1,852,874*
Health Care Services Special Fund (3334)	*$2,769,657*	*$2,517,458*	*$2,517,457*	*$2,065,534*
YEPEITA - Cannabis Tax Fund (3350)	*$202,688*	*$265,906*	*$401,766*	*$356,921*
PACE Oversight Fund (3362)	*$87*	*$771*	*$748*	*$748*
Loan Repayment Account (3375)	*$0*	*$29,092*	*$28,477*	*$41,400*
Opioid Settlement Fund (3397)	*$0*	*$0*	*$0*	*$5,000*
Whole Person Care Special Fund (8107)	*$419,025*	*$273,790*	*$309,811*	*$0*
Global Payment Program Fund (8108)	*$746,024*	*$671,268*	*$1,481,349*	*$1,280,725*
DPH GME Special Fund (8113)	*$552,706*	*$206,862*	*$223,694*	*$234,304*
HCBS ARP Fund (8507)	*$0*	*$0*	*($2,348,069)*	*$4,444*

Department of Health Care Services – *Changes to State Operations and Local Assistance*				
Fiscal Year:	**2020-21**	**2021-22 (CY)**	**2022-23 (BY)**	**CY to BY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$240,224,000	$318,127,000	$389,381,000	$71,254,000
Federal Funds[1]	$396,953,000	$584,180,000	$549,355,000	($34,825,000)
Spec. Funds/Reimb	$212,792,000	$426,466,000	$352,613,000	($73,853,000)
Total Expenditures	**$849,969,000**	**$1,328,773,000**	**$1,291,349,000**	**($37,424,000)**
Total Positions	**3557.7**	**4357.2**	**4443.5**	**86.3**
LOCAL ASSISTANCE (*MEDI-CAL AND OTHER PROGRAMS)*				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$20,806,598,000	$27,171,548,000	$35,269,053,000	$8,097,505,000
Federal Funds[1]	$78,201,778,000	$87,716,219,000	$84,891,153,000	($2,825,066,000)
Spec. Funds/Reimb	$17,585,852,000	$14,016,872,000	$16,822,302,000	$2,805,430,000+
Total Expenditures	**$116,594,228,000**	**$128,904,639,000**	**$136,982,508,000**	**$8,077,869,000**
[1]*Federal Funds include Funds 0890, 7502, 7503, and 8506.*				

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

- ***Medi-Cal.*** DHCS serves as the single state agency for Medi-Cal, California's Medicaid program. Medi-Cal is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 14.3 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.

Oversight of Prior Budget Investment – Hearing Aid Coverage for Children Program. The 2020 Budget Act included one position and General Fund expenditure authority of $400,000 in 2020-21, $15.1 million in 2021-22, and $14.5 million annually thereafter to provide hearing aids and associated services to uninsured children up to 600 percent of the federal poverty level, beginning July 1, 2021. DHCS implemented the Hearing Aid Coverage for Children Program (HACCP), which covers children ages zero to 17 who do not have coverage for hearing aids and related services.

According to advocates, only 44 children have been enrolled in HACCP and seven have received hearing aids. These advocates report many parents are unable to find a pediatric provider in their county that has opted in to serve HACCP children. The limited scope of care and low reimbursement rates have reduced provider participation in the 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.

2. Please provide an update on implementation of the HACCP, including how many children are enrolled, how many hearing aids have been dispensed, and any barriers to access to care identified during implementation.

3. Has the department engaged with stakeholders to ensure the HACCP is appropriately and adequately serving its intended population?

Issue 2: November 2021 Medi-Cal Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2021 Medi-Cal Local Assistance Estimate includes $123.8 billion ($26.8 billion General Fund, $86.5 billion federal funds, and $10.5 billion special funds and reimbursements) for expenditures in 2021-22, and $132.7 billion ($34.9 billion General Fund, $84.6 billion federal funds, and $13.2 billion special funds and reimbursements) for expenditures in 2022-23.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2021-22 (CY)**	**2022-23 (BY)**	**CY to BY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$25,698,266,000	$33,570,362,000	$7,872,096,000
Federal Funds	$81,664,810,000	$79,953,777,000	($1,711,033,000)
Special Funds/Reimbursements	$10,505,796,000	$13,195,261,000	$2,689,465,000
Total Expenditures	**$117,868,872,000**	**$126,719,400,000**	**$8,850,528,000**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$990,974,000	$1,177,167,000	$186,193,000
Federal Funds	$4,523,199,000	$4,300,171,000	($223,028,000)
Special Funds and Reimbursements	$18,110,000	$13,943,000	($4,167,000)
Total Expenditures	**$5,532,283,000**	**$5,491,281,000**	**($41,002,000)**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$157,648,000	$138,467,000	($19,181,000)
Federal Funds	$285,680,000	$310,467,000	$24,787,000
Special Funds and Reimbursements	$0	$0	$0
Total Expenditures	**$443,328,000**	**$448,934,000**	**$5,606,000**
TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$26,846,888,000	$34,885,996,000	$8,039,108,000
Federal Funds	$86,473,689,000	$84,564,415,000	($1,909,274,000)
Special Funds and Reimbursements	$10,523,906,000	$13,209,204,000	$2,685,298,000
Total Expenditures	**$123,844,483,000**	**$132,659,615,000**	**$8,815,132,000**

Caseload. In 2021-22, the budget assumes annual Medi-Cal caseload of 14.6 million, an increase of 0.8 percent compared to assumptions in the 2021 Budget Act. The department estimates 85.4 percent of Medi-Cal beneficiaries, or 12.5 million, will receive services through the managed care delivery system while 14.7 percent, or 2.1 million, will receive services through the fee-for-service delivery system.

In 2022-23, the budget assumes annual Medi-Cal caseload of 14.2 million, a decrease of 2.9 percent compared to the revised caseload estimate for 2021-22. The department estimates 85.2 percent of Medi-Cal beneficiaries, or 12.1 million, will receive services through the managed care delivery system while 14.8 percent, or 2.1 million, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The November 2021 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

2021-22 General Fund Savings - The budget includes decreased General Fund expenditures in the Medi-Cal program of $1.3 billion in 2021-22 compared to the 2021 Budget Act. These savings are primarily attributable to the following factors:

- COVID-19 Impacts – $1 billion General Fund savings from reduced impacts on the Medi-Cal program from the COVID-19 pandemic than previously estimated. These impacts include continuation of increased federal matching funds ($1.4 billion General Fund savings), lower than expected caseload ($415 million General Fund savings), lower than expected expenditures on school testing as schools have relied on direct federal funding instead of Medi-Cal ($265 million General Fund savings), updated estimates of vaccine administration ($26 million General Fund costs), higher estimates of fee-for-service utilization costs than previously estimated ($51 million General Fund costs), and costs for the COVID-19 Vaccination Incentive Program ($175 million General Fund costs).
- Cost Shifts into Future Fiscal Years – Various cost shifts from 2021-22 into future years resulting in General Fund savings of $553 million. These cost shifts include: shifting of costs for the Behavioral Health Continuum Infrastructure Program to future years ($443 million General Fund savings), shifting of costs for student behavioral health services to future years ($32 million General Fund savings), shifting of costs for the CalAIM justice-involved initiatives to future years ($47 million General Fund savings), shifting of costs for the CalAIM population health management service to future years ($22.5 million General Fund savings), shifting of costs for CalHOPE Student Support to future years ($34 million General Fund savings), and shifting of costs for outreach and enrollment for dual beneficiaries to future years ($10 million General Fund savings).
- Hospital Quality Assurance Fee – $189 million General Fund savings for children's health coverage resulting from additional collections of hospital quality assurance fee revenue from prior years.
- Reduced One-Time Impact from CalAIM Transitions – $170 million General Fund savings from changes in timing for populations transitioning between delivery systems in Medi-Cal as part of the CalAIM initiative.

These savings are offset by the following increased General Fund costs in 2021-22:

- Increases in State-Only Claiming Costs – $548 million General Fund costs related to increases in repayment to the federal government for inappropriate claiming of federal matching funds for state-only program costs.

Additional Drug Rebates. $478 million General Fund savings from an increase in estimated manufacturer rebates to the Medi-Cal program for prescription drugs.

Reduced Federal Deferrals. $415 million General Fund savings from reduced deferrals of matching funds from the federal Centers for Medicare and Medicaid Services.

Full-Year Savings from Medi-Cal Rx. $327 million General Fund savings from full-year implementation of Medi-Cal Rx, which standardizes the pharmacy benefit in the Medi-Cal program by transitioning to the fee-for-service delivery system.

Human Papillomavirus Vaccination Coverage in FPACT. $5 million General Fund costs to support human papillomavirus (HPV) vaccination as a covered benefit for individuals age 19 through 45 in the Family Prevention, Access, Care, and Treatment (FPACT) Program.

Eliminate Certain AB 97 Provider Rate Reductions. $9 million General Fund costs to eliminate the 10 percent provider rate reduction, originally implemented by AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, for the following providers: nurses, alternative birthing centers, audiologists/hearing aid dispensers, respiratory care providers, durable medical equipment oxygen and respiratory services, chronic dialysis clinics, non-emergency medical transportation, and emergency air medical transportation.

Medi-Cal Dental Evidence-Based Practices. $13 million General Fund costs to expand Medi-Cal coverage of evidence-based dental practices consistent with the American Association of Pediatric Dentists and the American Dental Association, including laboratory-processed crowns for posterior teeth. Implementation of the Mobile Crisis Benefit. $16 million General Fund costs to implement a mobile crisis response services benefit in Medi-Cal, pursuant to funding opportunities available through the federal American Rescue Plan Act.

Elimination of Medi-Cal Premiums. $19 million General Fund costs to eliminate premiums in the Medi-Cal program.

Nursing Facility Financing Reform. $46 million General Fund costs to reauthorize the skilled nursing facility quality assurance fee and reform nursing facility financing to incentivize value and quality.

Expiration of MCO Tax. $77 million General Fund costs from expiration of the enrollment tax on managed care organizations.

Full-Year Costs of Postpartum Care Extension. $134 million General Fund costs from full-year implementation of the expansion of full-scope Medi-Cal to postpartum birthing parents for 12 months.

General Fund Backfill of Declining Proposition 56 Provider Payments. $176 million General Fund costs to backfill declining Proposition 56 tobacco tax revenue that supports supplemental Medi-Cal provider payments to physicians, dentists, and other providers of Medi-Cal services.

Equity and Practice Transformation Payments. $200 million General Fund costs to support practice transformation and COVID-19 recovery payments to Medi-Cal providers focused on advancing equity and improving quality in children's preventive, maternity, and integrated behavioral health care.

Discontinue Checkwrite Hold. $309 million General Fund costs to reverse the 2008 recession-era practice of withholding the last two weeks of fee-for-service checkwrite payments to providers until the next fiscal year.

Managed Care Rate Growth. $340 million General Fund costs related to increases in base managed care capitation rates.

Medicare Cost Growth. $348 million General Fund costs for Medicare payments made on behalf of beneficiaries dually eligible for Medicare and Medi-Cal.

Full-Year Implementation of CalAIM. $547 million General Fund costs for full-year implementation of components of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including enhanced care management, community supports, managed care plan incentives, inmate pre-release applications, population health management service, and the long-term care benefit transition.

State-Only Claiming. $813 million General Fund costs for increased repayment to the federal government for inappropriate claiming of federal matching funds for state-only program costs.

Behavioral Health Bridge Housing. $1 billion General Fund costs for Behavioral Health Bridge Housing, which would provide additional beds for county mental health departments and other housing types to address needs of people experiencing homelessness with serious and persistent behavioral health conditions.

COVID-19 Impacts. $2.3 billion General Fund costs for impacts related to the COVID-19 pandemic, including reduced federal matching, reduced estimated caseload impacts, reduced costs for testing in schools due to direct federal aid, costs related to vaccine administration, and savings from reduction of one-time payments and other initiatives.

Children and Youth Behavioral Health Initiative. $2.4 billion General Fund costs for implementation of components of the Children and Youth Behavioral Health Initiative approved in the 2021 Budget Act, including dyadic services in Medi-Cal ($41 million General Fund costs), evidence-based behavioral health practices ($429 million General Fund costs), additional funding for school behavioral health partnerships and capacity ($450 million General Fund costs), implementation of a behavioral health services and supports platform ($120 million General Fund costs), and additional funding for the Behavioral Health Continuum Infrastructure program ($1.2 billion General Fund costs, $480.5 million attributable to the initiative).

Other Impacts. $129 million General Fund costs for various other Medi-Cal impacts.

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 2021-22 and 2022-23 fiscal years.

Issue 3: November 2021 Family Health Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2021 Family Health Local Assistance Estimate includes $248.7 million ($201.6 million General Fund, $5.1 million federal funds, and $42 million special funds and reimbursements) for expenditures in 2021-22, and $265.7 million ($213.3 million General Fund, $5.1 million federal funds, and $47.3 million special funds and reimbursements) for expenditures in 2022-23.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2021-22 (CY)**	**2022-23 (BY)**	**CY to BY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$68,918,000	$75,578,000	$6,660,000
Federal Funds	$0	$0	$0
Special Funds/Reimbursements	$3,992,000	$3,992,000	$0
County Funds [non-add]	[$71,839,000]	[$78,576,000]	[$6,737,000]
Total CCS Expenditures	**$72,910,000**	**$79,570,000**	**$6,660,000**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$120,728,000	$120,956,000	$228,000
Special Funds and Reimbursements	$15,505,000	$20,788,000	$5,283,000
Total GHPP Expenditures	**$136,233,000**	**$141,744,000**	**$5,511,000**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$11,944,000	$16,717,000	$4,773,000
Federal Funds	$5,128,000	$5,128,000	$0
Special Funds and Reimbursements	$22,504,000	$22,504,000	$0
Total EWC Expenditures	**$39,576,000**	**$44,349,000**	**$4,773,000**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$201,590,000	$213,251,000	$11,661,000
Federal Funds	$5,128,000	$5,128,000	$0
Special Funds and Reimbursements	$42,001,000	$47,284,000	$5,283,000
County Funds [non-add]	[$71,839,000]	[$86,088,000]	[$1,964,000]
Total Family Health Expenditures	**$248,719,000**	**$265,663,000**	**$16,944,000**

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

The programs included in the Family Health Estimate are:

- **California Children's Services (CCS)**: The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 200,506 in 2021-22, an increase of 31,526 or 18.7 percent, compared to the 2021 Budget Act. The budget estimates Medi-Cal CCS caseload of 186,169 in 2022-23, a decrease of 14,337 or 7.2 percent, compared to the revised 2021-22 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 9,311 in 2021-22, a decrease of 5,290 or 36.2 percent, compared to the 2021 Budget Act. The budget estimates state-only CCS caseload of 11,687 in 2022-23, an increase of 2,376 or 25.5 percent compared to the revised 2021-22 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 717 in 2021-22, an increase of six or 0.8 percent, compared to the 2021 Budget Act. The budget estimates Medi-Cal GHPP caseload of 712 in 2022-23, a decrease of five or 0.7 percent, compared to the revised 2021-22 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 647 in 2021-22, a decrease of 23 or 3.4 percent, compared to the 2021 Budget Act. The budget estimates state-only GHPP caseload of 649 in 2022-23, an increase of two or 0.3 percent, compared to the revised 2021-22 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 24,103 in 2021-22, a decrease of 499 or two percent, compared to the 2021 Budget Act. The budget estimates EWC caseload of 27,405 in 2022-23, an increase of 3,302 or 13.7 percent compared to the revised 2021-22 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 2021-22 and 2022-23 fiscal years.

Issue 4: California Advancing and Innovating in Medi-Cal (CalAIM) Implementation

Local Assistance and Trailer Bill Language – Governor's Budget. DHCS requests expenditure authority of $1.2 billion ($495.9 million General Fund and $693.6 million federal funds) in 2021-22 and $2.8 billion ($1.1 billion General Fund and $1.7 billion federal funds) 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. This expenditure request includes implementation of the following components of CalAIM:

- Enhanced Care Management (ECM)
- Community Supports (previously In-Lieu of Services)
- Managed Care Plan Incentives
- Medi-Cal Providing Access and Transforming Health (PATH)
- Dental Initiatives
- Population Health Management
- Various Transitions of Populations Between Fee-for-Service and Managed Care
- Behavioral Health Quality Improvement Program
- Designated State Health Programs

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**

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. The 2021 Budget Act included 69 positions and expenditure authority of $1.6 billion ($675.7 million General Fund and $954.7 million federal funds), and the Legislature approved trailer bill language to authorize implementation of CalAIM.

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 CalAIM incorporates many of these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for Medi-Cal managed care plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a

mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD), and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity.

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

CalAIM Implemented Through New Federal Waiver Authority. CalAIM will transition many of Medi-Cal's 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. The federal Centers for Medicare and Medicaid Services (CMS) approved California's 1115 Waiver and 1915(b) Waiver applications implementing CalAIM reforms on December 29, 2021. Both Waivers are approved until December 31, 2026. While the managed care authorities provided by the two Waivers are similar, there are key differences. For example, while 1115 Waivers require budget neutrality (federal expenditures must not be greater under the Waiver than they would have been without the Waiver), 1915(b) Waivers only require the demonstration of cost effectiveness and efficiency (actual expenditures cannot exceed projected expenditures)[1].

Enhanced Care Management. DHCS requests expenditure authority of $197.8 million ($66.1 million General Fund and $131.7 million federal funds) in 2021-22 and $575.8 million ($192.8 million General Fund and $383 million federal funds) in 2022-23 to support a new enhanced care management benefit. Under the previous waiver authority, Medi-Cal 2020, DHCS implemented Whole Person Care pilot programs to coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. The 25 approved WPC pilots targeted services to individuals with chronic conditions, with behavioral health needs, experiencing or at-risk of homelessness, or who are justice-involved. The pilots provided eight categories of service to these individuals, including: 1) outreach, 2) care coordination, 3) housing support, 4) peer support, 5) benefit support, 6) employment assistance, 7) sobering centers, and 8) medical respite.

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

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

centered. Medi-Cal beneficiaries will be eligible for ECM if they are included in one of the following populations of focus:

Children and Youth Populations of Focus

- Children (up to age 21) experiencing homelessness
- High utilizers
- Children with serious emotional disturbance or identified to be at clinical high risk for psychosis
- California Children's Services (CCS) with additional needs beyond CCS qualifying conditions
- Involved in, or with a history of involvement in, child welfare
- Children transitioning from incarceration

Adult Populations of Focus

- *Individuals and Families Experiencing Homelessness.* Individuals who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes or decreased utilization of high-cost services.
- *High Utilizers.* Adult high utilizers including those with five or more avoidable emergency room, or three or more avoidable, unplanned hospital or short-term skilled nursing facility stays in a six month period.
- *SMI/SUD.* Adults with serious mental illness (SMI) or substance use disorders (SUD), with at least one complex social factor influencing their health (e.g. food, housing, or economic insecurity; history of Adverse Childhood Experiences, former foster youth, justice-involvement), and are at high risk for institutionalization, overdose and/or suicide; use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care; experienced two or more emergency department or hospital visits due to SMI or SUD in the past 12 months; or are pregnant or post-partum.
- *Individuals Transitioning From Incarceration.* Adults transitioning from incarceration within the past 12 months with at least one of the following conditions: chronic mental illness, SUD, chronic disease, intellectual or developmental disability, traumatic brain injury, human immunodeficiency virus (HIV), or pregnancy.
- *Individuals at Risk for Institutionalization.* Adults at risk of institutionalization eligible for long-term care services who, in the absence of services and supports, would otherwise require care for 90 days or more in an inpatient nursing facility.
- *Nursing Facility Residents Seeking Community Transition.* Adults residing in nursing facilities who desire to transition back to the community and are likely to make a successful transition.

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

- *Outreach and Engagement.* Medi-Cal managed care plans are required to develop comprehensive outreach policies and procedures that can include, but are not limited to:
  - Attempting to locate, contact, and engage Medi-Cal beneficiaries who have been identified as good candidates to receive ECM services, promptly after assignment to the plan.

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

ECM will phase in based on which counties implemented Home Health Programs and Whole Person Care pilots, and for certain populations as follows:

- January 1, 2022 – Counties with Home Health Programs (HHP) or Whole Person Care (WPC) pilots must provide ECM services to the following populations of focus:
  - Individuals and Families Experiencing Homelessness
  - High Utilizer Adults
  - Adults with SMI/SUD
- July 1, 2022 – Counties without HHP or WPC pilots must provide ECM services to the following populations of focus:
  - Individuals and Families Experiencing Homelessness
  - High Utilizer Adults
  - Adults with SMI/SUD
- January 1, 2023 – All counties must provide ECM services to the following populations of focus:
  - Individuals Transitioning from Incarceration (Children and Adults)
  - Individuals at Risk for Institutionalization
  - Nursing Facility Residents Seeking Community Transition
- July 1, 2023 – All counties must provide ECM services to all other Children and Youth

Community Supports. DHCS requests expenditure authority of $66.5 million ($21.6 million General Fund and $44.9 million federal funds) in 2021-22 and $162.8 million ($52.8 million General Fund and $110 million federal funds) in 2022-23 to support implementation of community supports services. Previously known as In-Lieu of Services, community supports are services or service settings that Medi-Cal managed care plans may offer as a medically appropriate, cost-effective alternative to Medi-Cal eligible services or settings. Provision of community supports is voluntary for Medi-Cal managed care plans to provide and voluntary for Medi-Cal beneficiaries to receive. Plans may change their election of which community supports they provide every six months. The community supports plans may provide include the following:

- Housing Transition Navigation Services – These services assist beneficiaries with obtaining housing and include assessing a beneficiary's housing needs, developing a housing support plan, navigating housing options and applications, assisting with advocacy and securing available income and housing subsidy resources, assisting with reasonable accommodation and move-in readiness, and coordinating necessary environmental modifications.
- Housing Deposits – These services assist beneficiaries with securing or funding one-time housing services that do not constitute room and board including security deposits, setup fees or deposits for utilities or other services, first month coverage of utilities, first and last month's rent if required for occupancy, health and safety services such as pest eradication or cleaning upon moving in, and medically necessary adaptive aids and services such as air conditioners or air filters.
- Housing Tenancy and Sustaining Services – These services assist beneficiaries in maintaining safe and stable tenancy after housing is secured including early identification and intervention for behaviors that may jeopardize housing, education and training on rights and responsibilities of tenants and landlords, coordination and assistance to maintain relationships with landlords and resolve disputes, advocacy and linkage to community resources to prevent eviction, health and safety visits, unit habitability inspections, and training for independent living and life skills.

- Short-Term Post-Hospitalization Housing – These services may include supported housing in an individual or shared interim housing setting and are designed to assist beneficiaries who are homeless and who have high medical or behavioral health needs with the opportunity to continue their recovery immediately after exiting an inpatient hospital, substance abuse or mental health treatment facility, custody facility, or recuperative care.
- Recuperative Care (Medical Respite) – These services provide short-term residential care for beneficiaries who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, the service would include interim housing with a bed and meals with ongoing monitoring of the beneficiary's condition. The service may also include limited or short-term assistance with activities of daily living, coordination of transportation to post-discharge appointments, connection to other necessary health and human services benefits or housing, or stabilizing case management relationships and programs.
- Caregiver Respite – These services provide relief to caregivers of beneficiaries who require intermittent temporary supervision and may be provided by the hour on an episodic basis, by the day or overnight, or include services that attend to the beneficiary's basic self-help needs or other activities of daily living.
- Day Habilitation Programs – These services assist beneficiaries in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the beneficiary's natural environment. These services may include training or assistance with the use of public transportation, personal skills development in conflict resolution, community participation, developing and maintaining interpersonal relationships, daily living skills, community resource awareness (e.g. police, fire, other local services), selecting and moving into a home, locating and choosing suitable housemates, locating household furnishings, settling disputes with landlords, managing personal financial affairs, managing needs for personal attendants, dealing with and responding to governmental agencies and personnel, asserting rights through self-advocacy, and coordinating health and human services benefits.
- Nursing Facility Transition/Diversion to Assisted Living Facilities – These services assist beneficiaries to live in the community or avoid institutionalization by transitioning to a Residential Care Facility for Elderly and Adult (RCFE) or Adult Residential Facility (ARF). These services, which do not include room and board, may include assessing housing needs and presenting options, assessing onsite service needs at the RCFE or ARF, assisting in securing a residence, communicating with facility administration and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other in-lieu-of services necessary for stable housing.
- Nursing Facility Transition to a Home – These services assist beneficiaries to live in the community and avoid institutionalization by transitioning to a private residence. These services, which do not include room and board, may include assessing housing needs and presenting options, assisting in securing housing, communicating with landlords and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other ILOS necessary for stable housing.
- Personal Care and Homemaker Services – These services assist beneficiaries with activities of daily living such as bathing, dressing, toileting, ambulation, or feeding. These services also assist beneficiaries with instrumental activities of daily living such as meal preparation, grocery shopping and money management. These services are provided in addition to any approved In-Home Supportive Services (IHSS) benefits approved by the county or during any IHSS waiting period.

- Environmental Accessibility Adaptations (Home Modifications) – These services provide physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a beneficiary, or enable the beneficiary to function with greater independence in the home. Adaptations may include installation of ramps and grab-bars, doorway widening for beneficiaries who require a wheelchair, installation of stair lifts, bathroom or shower accessibility, installation of specialized electric or plumbing systems to accommodate medical equipment or supplies, installation and testing of a Personal Emergency Response System for beneficiaries who are alone for significant parts of the day without a caregiver and otherwise require routine supervision.
- 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.

The availability of community supports in each county, by date of implementation are as follows:

- Housing Transition Navigation Services
  - **January 1, 2022**: Alameda, Amador, Butte, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Mendocino, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Sonoma, Sutter, Tehama, Tulare, Ventura, Yuba
  - **July 1, 2022**: Alpine, Calaveras, Del Norte, Humboldt, Inyo, Lake, Lassen, Modoc, Mono, Siskiyou, Solano, Stanislaus, Trinity, Tuolumne, Yolo
  - **January 1, 2023**: San Benito
- Housing Deposits
  - **January 1, 2022**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Mendocino, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Sonoma, Sutter, Tehama, Tulare, Tuolumne, Ventura, Yuba
  - **July 1, 2022**: Del Norte, Humboldt, Imperial, Lake, Lassen, Modoc, Siskiyou, Solano, Stanislaus, Trinity, Yolo

- Housing Tenancy and Sustaining Services
  - **January 1, 2022**: Alameda, Amador, Butte, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Mendocino, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Sonoma, Sutter, Tehama, Tulare, Ventura, Yuba
  - **July 1, 2022**: Alpine, Calaveras, Del Norte, Humboldt, Inyo, Lake, Lassen, Modoc, Mono, Siskiyou, Solano, Stanislaus, Trinity, Tuolumne, Yolo
  - **January 1, 2023**: San Benito
- Short-Term Post-Hospitalization Housing
  - **January 1, 2022**: Contra Costa, Kern, Los Angeles, Madera, Marin, Mendocino, Napa, Nevada, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Shasta, Sonoma
  - **July 1, 2022**: Del Norte, Humboldt, Lake, Lassen, Merced, Modoc, Monterey, Santa Cruz, Siskiyou, Solano, Trinity, Yolo
  - **January 1, 2023**: Alameda, Fresno, Imperial, Kings, Tulare, Ventura
  - **July 1, 2023**: Alpine, Butte, El Dorado, Inyo, Mono, San Francisco, Santa Clara
  - **January 1, 2024**: Amador, Calaveras, Colusa, Glenn, Mariposa, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, Yuba
- Recuperative Care (Medical Respite)
  - **January 1, 2022**: Alameda, Amador, Contra Costa, Kern, Kings, Los Angeles, Marin, Mendocino, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Shasta, Sonoma, Ventura
  - **July 1, 2022**: Del Norte, El Dorado, Humboldt, Lake, Lassen, Merced, Modoc, Monterey, San Luis Obispo, Santa Barbara, Santa Cruz, Siskiyou, Solano, Stanislaus, Trinity, Yolo
  - **January 1, 2023**: Imperial, Inyo, Madera, Mono, Tulare
  - **July 1, 2023**: Alpine, Butte, Fresno, Mariposa
  - **January 1, 2024**: Calaveras, Colusa, Glenn, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, Yuba
- Caregiver Respite
  - **January 1, 2022**: Nevada, Sacramento, San Diego, San Mateo
  - **July 1, 2022**: Los Angeles, Madera
  - **January 1, 2023**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Francisco, San Joaquin, Santa Clara, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba
  - **July 1, 2023**: Contra Costa
- Day Habilitation Programs
  - **January 1, 2022**: Alameda, Contra Costa, El Dorado, Fresno, Kings, Madera, Nevada, Placer, Sacramento, San Diego, San Francisco, Santa Clara, Tulare
  - **July 1, 2022**: Imperial, Riverside, San Bernardino
  - **January 1, 2023**: Kern, Los Angeles, Placer, San Joaquin, Stanislaus, Sutter, Yuba
  - **July 1, 2023**: Alpine, Amador, Butte, Calaveras, Colusa, Glenn, Inyo, Mariposa, Mono, Plumas, Sierra, Tehama, Tuolumne
  - **January 1, 2024**: San Benito
- Nursing Facility Transition/Diversion to Assisted Living Facilities

  - **January 1, 2022**: Riverside, Sacramento, San Bernardino, San Diego, San Mateo, Santa Clara
  - **January 1, 2023**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Yuba
- Nursing Facility Transition to a Home
  - **January 1, 2022**: Riverside, Sacramento, San Bernardino, San Diego, San Mateo, Santa Clara
  - **January 1, 2023**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Yuba
- Personal Care and Homemaker Services
  - **January 1, 2022**: Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara
  - **July 1, 2022**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Glenn, Inyo, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne
  - **January 1, 2023**: Del Norte, Humboldt, Imperial, Kern, Lake, Lassen, Marin, Mendocino, Modoc, Napa, San Joaquin
  - **July 1, 2023**: Fresno, Yuba
- Environmental Accessibility Adaptations (Home Modifications)
  - **January 1, 2022**: Alameda Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Inyo, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Yuba
  - **July 1, 2022**: Imperial, Kern, San Joaquin
- Meals/Medically Tailored Meals
  - **January 1, 2022**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Mono, Monterey, Napa, Nevada, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Sonoma, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Ventura, Yuba
  - **July 1, 2022**: Del Norte, Humboldt, Lake, Lassen, Modoc, San Luis Obispo, Santa Barbara, Siskiyou, Solano, Trinity, Yolo
- Sobering Centers
  - **January 1, 2022**: Amador, Kings, Los Angeles, Madera, Monterey, Placer, Riverside, Sacramento, San Diego, San Joaquin, Tulare
  - **July 1, 2022**: El Dorado, Santa Clara, Stanislaus
  - **January 1, 2023**: Alameda, Fresno, Imperial, Kern, San Francisco
  - **July 1, 2023**: Alpine, Butte, Calaveras, Colusa, Contra Costa, Glenn, Inyo, Kern, San Bernardino
  - **January 1, 2024**: Mariposa, Nevada, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, Yuba
- Asthma Remediation
  - **January 1, 2022**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada,

Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Yuba

Managed Care Plan Incentives. DHCS requests expenditure authority of $300 million ($150 million General Fund and $150 million federal funds) in 2021-22 and $600 million ($300 million General Fund and $300 million federal funds) in 2022-23 for managed care plan incentives. Beginning January 1, 2022, Medi-Cal managed care plans are eligible for incentive payments for investing in expanding and improving delivery of ECM and community supports. Federal regulations allow a percentage above a Medi-Cal managed care plans capitation payment to be allocated for quality improvement programs. To receive incentive payments, Medi-Cal managed care plans must improve delivery system infrastructure, build provider capacity for ECM and community supports services, and achieve certain quality benchmarks.

Medi-Cal Providing Access and Transforming Health (PATH). DHCS requests expenditure authority of $389.7 million ($194.8 million General Fund and $194.8 million federal funds) in 2021-22 and $706.7 million ($353.3 million General Fund and $353.3 million federal funds) in 2022-23 for the Medi-Cal Providing Access and Transforming Health (PATH) initiative. The Medi-Cal PATH initiative is intended to provide a smooth transition between current waiver pilots and statewide services and capacity building, including for effective pre-release care and coordination with justice agencies. PATH funding would support the transition from Whole Person Care pilots to ECM and community supports, including funding for counties, community-based organizations, and other providers to build the capacity and infrastructure necessary for these new statewide services. In addition, PATH funding would help ensure jails and prisons are ready for service delivery for the justice-involved, including mandatory Medi-Cal applications; behavioral health referrals, linkages, and warm hand-offs from county jails to Medi-Cal managed care plans and county behavioral health departments; "in reach" services up to 90 days prior to release, and the re-entry ECM benefit available in January 2023. PATH funding would also support workforce development for the homeless and home- and community-based services systems of care, including outreach, training in evidence-based practices, information technology for data sharing, and training stipends.

Dental Initiatives. DHCS requests expenditure authority of $120.7 million ($58.5 million General Fund and $62.2 million federal funds) in 2021-22 and $243.2 million ($117.7 million General Fund and $125.5 million federal funds) in 2022-23 to support incentive payments to improve dental care for Medi-Cal beneficiaries, available through the Medicaid State Plan. During the previous 1115 Waiver, DHCS implemented the Dental Transformation Initiative, which included four dental "domains", including: 1) incentive payments for increasing preventive services utilization in children; 2) incentive payments for caries risk assessment and disease management; 3) incentive payments to encourage continuity of care; and 4) local dental pilot projects. Beginning January 1, 2022, DHCS has transitioned the three incentive payments programs of the Dental Transformation Initiative into the State Plan and included coverage of silver diamine fluoride as a dental benefit for certain populations. The department reports it has set an initial goal of achieving a 60 percent dental utilization rate for eligible Medi-Cal children and adults.

Population Health Management. DHCS requests expenditure authority of $75 million ($7.5 million General Fund and $67.5 million federal funds) in 2021-22 and $225 million ($22.5 million General Fund and $202.5 million federal funds) in 2022-23 to support implementation of a Population Health Management (PHM) service. The PHM service would utilize Medi-Cal administrative and clinical data

and information for the department, Medi-Cal managed care plans, counties, providers, beneficiaries, and other partners to use in support of the delivery of care for Medi-Cal beneficiaries. According to DHCS, this service would also allow for identification of potential gaps in care, provider or care manager information, information on social determinants of health, as well as allow for population health analytics, health education, and tips for beneficiaries. The PHM system would also provide Medi-Cal beneficiaries with access to their administrative and clinical information.

Transitions of Populations Between Fee-for-Service and Managed Care. CalAIM includes several changes to how certain populations of Medi-Cal beneficiaries would access certain benefits. CalAIM seeks to standardize which benefits are available through the managed care delivery system and which are available through the fee-for-service delivery system. Similarly, CalAIM seeks to standardize the populations of Medi-Cal beneficiaries that would receive services through managed care or through fee-for-service.

Benefit Standardization. CalAIM standardizes which Medi-Cal benefits are provided in the managed care delivery system and which benefits are provided in another delivery system. The proposed changes 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 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 are the responsibility of a beneficiary's managed care plan.

- **Fee-for-Service Benefits ("Carved Out")**
    - Pharmacy – Under the department's Medi-Cal Rx initiative, all prescription drugs and/or pharmacy services billed on a pharmacy claim are provided in the fee-for-service delivery system as of January 1, 2022. This carve-out does 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 July 1, 2023, 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. CalAIM will also 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 will enhance coordination of care and reduce complexity across the Medi-Cal program. The populations transitioning from each system are as follows:

- **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
    - Breast and Cervical Cancer Treatment Program (BCCTP) – non-dual beneficiaries
    - 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 will 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 by 2026. 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.

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

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

CalAIM also seeks 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. These changes will 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 will ensure that eligibility criteria, largely being driven by level

of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, will be the driving factor for determining the delivery system in which a beneficiary should receive services. These changes are being phased in, beginning January 1, 2022.

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 and update of implementation of the following components of CalAIM:

    a. Enhanced Care Management
    b. Community Supports
    c. Behavioral Health Payment and Medical Necessity Reforms
    d. Long-Term Care Transition to Managed Care

2. How will the various components of CalAIM work with other state and local agencies, providers, and community members to ensure a full continuum of health and behavioral health care, and other supports and services that address social determinants of health, for:

    a. Individuals experiencing, or at risk of, homelessness or housing insecurity
    b. Justice-involved individuals, particularly those with serious mental illness
    c. Individuals in skilled nursing facilities, or at risk of institutionalization, who could more appropriately be served in a home- or community-based setting.

3. Please describe the structure of the incentive payments for Medi-Cal managed care plans. What are the benchmarks or other metrics the plans are required to meet to be eligible for incentive payments?

Issue 5: Behavioral Health Continuum Infrastructure Program and Bridge Housing Proposal

Local Assistance – Governor's Budget. DHCS requests expenditure authority of $466 million ($166 million General Fund and $300 million Coronavirus Fiscal Recovery Fund or CFRF) in 2021-22 and $1.7 billion ($1.4 billion General Fund and $218.5 million CFRF) in 2022-23. If approved, these resources would support continuing grant funding rounds for the Behavioral Health Continuum Infrastructure Program (BHCIP).

In addition, DHCS requests General Fund expenditure authority of $1 billion in 2022-23 to support bridge housing projects to address the immediate housing and treatment needs of people experiencing unsheltered homelessness with serious behavioral health conditions.

Program Funding Request Summary – Local Assistance Funding (BHCIP)		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$166,000,000	$1,441,249,000
8506 – Coronavirus Fiscal Recovery Fund	$300,000,000	$218,500,000
Total Funding Request:	**$466,000,000**	**$1,659,749,000**

Program Funding Request Summary – Local Assistance Funding (Bridge Housing)		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$-	$1,000,000,000
Total Funding Request:	**$1-**	**$1,000,000,000**

Background. The 2021 Budget Act included expenditure authority of $755.7 million ($445.7 million General Fund and $310 million Coronavirus Fiscal Recovery Fund or CFRF) in 2021-22, $1.4 billion ($1.2 billion General Fund and $220 million CFRF) in 2022-23 and $2.1 billion General Fund in 2023-24 for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. Of this amount, $150 million was made available to support mobile crisis infrastructure, along with $55 million in federal grant funds from the Substance Abuse and Mental Health Services Administration (SAMHSA), for a total investment of $205 million. DHCS announced the BHCIP funding would be released in six rounds, as follows:

- Round 1: Mobile Crisis - $205 million
- Round 2: County and Tribal Planning Grants - $16 million
- Round 3: Launch Ready - $518.5 million
- Round 4: Children and Youth - $480.5 million
- Round 5: Behavioral Health Needs Assessment Phase One - $480 million
- Round 6: Behavioral Health Needs Assessment Phase Two - $480 million

The following facility types may be considered for project funding through BHCIP:

- Community wellness centers
- Hospital-based outpatient treatment (e.g. outpatient detox or withdrawal management)
- Intensive outpatient treatment

- Narcotic Treatment Programs (NTPs)
- NTP medication units
- Office-based outpatient treatment
- Sobering centers
- Acute inpatient hospitals – medical detox or withdrawal management
- Acute psychiatric inpatient facilities
- Adolescent residential treatment facilities for substance use disorders (SUD)
- Adult residential treatment facilities for SUD
- Chemical dependency recovery hospitals
- Children's crisis residential programs (CCRPs)
- Community treatment facilities (CTFs)
- Crisis stabilization units (CSUs)
- General acute care hospitals (GACHs) and acute care hospitals (ACHs)
- Mental health rehabilitation centers (MHRCs)
- Psychiatric health facilities (PHFs)
- Short-term residential therapeutic programs (STRTPs)
- Skilled nursing facilities with special treatment programs (SNFs/STPs)
- Social rehabilitation facilities (SRF)
- Peer respite
- Recovery residence/sober living homes

Funding may also be used for mobile crisis infrastructure.

Initial Funding Rounds for Mobile Crisis Infrastructure and County Planning Grants. During the fall of 2021, DHCS requested funding applications for Round 1 of BHCIP from county, city, or tribal behavioral health authorities to support planning or implementation of the development and expansion of Crisis Care Mobile Units (CCMUs) in California. During Round 1, DHCS awarded more than $140 million to 45 grantees, which will create or enhance 219 mobile crisis response teams in the state. The grantees were as follows:

Grantee	Type of Award	New teams	Enhanced Teams	Funding Awarded
Alameda	Implementation	0	1	$937,322
Amador	Implementation	1	1	$500,000
Berkeley	Implementation	1	0	$1,000,000
Butte	Implementation	2	3	$5,000,000
Calaveras	Planning	N/A	N/A	$50,000
Contra Costa	Implementation	3	0	$2,992,679
Del Norte	Planning	N/A	N/A	$187,450
El Dorado	Planning	N/A	N/A	$200,000
Fresno	Implementation	0	1	$753,437
Glenn	Implementation	0	2	$500,000
Hoopa Valley Tribe	Implementation	1	0	$750,000

Humboldt	Implementation	0	1	$985,063
Imperial	Implementation	2	1	$3,000,000
Inyo	Planning	N/A	N/A	$200,000
Kings	Planning	N/A	N/A	$186,338
Los Angeles	Implementation	50	30	$51,831,000
Madera	Implementation	2	1	$3,000,000
Marin	Implementation	1	1	$1,971,509
Mariposa	Implementation	1	0	$500,000
Mendocino	Implementation	3	1	$3,742,392
Merced	Implementation	1	0	$1,000,000
Mono	Implementation	1	0	$690,000
Monterey	Implementation	0	1	$999,117
Napa	Implementation	1	0	$500,000
Nevada	Implementation	1	1	$1,000,000
Placer	Implementation	1	3	$4,000,000
Riverside	Implementation	7	0	$7,000,000
Sacramento	Implementation	3	0	$2,999,940
San Bernardino	Implementation	6	18	$7,703,122
San Diego	Implementation	18	0	$18,000,000
San Francisco	Implementation	0	2	$1,977,500
San Joaquin	Implementation	1	8	$1,934,594
San Luis Obispo	Implementation	1	3	$1,000,000
San Mateo	Planning	N/A	N/A	$200,000
Santa Barbara	Implementation	1	0	$1,000,000
Santa Clara	Implementation	0	15	$2,000,000
Santa Cruz	Implementation	1	3	$3,946,123
Shasta	Implementation	1	2	$1,000,000
Siskiyou	Planning	N/A	N/A	$40,400
Solano	Implementation	2	2	$1,000,000
Sonoma	Implementation	2	1	$2,498,899
Sutter	Planning	N/A	N/A	$200,000
Tri-City (LA)	Planning	N/A	N/A	$200,000
Trinity	Implementation	1	0	$499,978
Ventura	Implementation	1	0	$633,390
TOTAL		**117**	**102**	**$140,310,253**

The infrastructure investment in mobile crisis units will allow counties and other entities to deploy behavioral health treatment resources for individuals experiencing a behavioral health crisis, or other acute behavioral health needs, in the community. This infrastructure may also be used to implement the new Medi-Cal mobile crisis intervention services benefit, authorized by the federal American Rescue Plan Act. (see also *Issue 6: Medi-Cal Qualifying Community-Based Mobile Crisis Intervention Services Benefit*)

DHCS also completed its Round 2 application process for county and tribal planning grants. DHCS awarded $5.3 million to 36 grantees including nine tribes and 27 counties. The grantees were as follows:

- Bakersfield American Indian Health Project - $150,000
- Butte County - $150,000
- Contra Costa County - $150,000
- Merced County - $150,000
- Placer County - $150,000
- Riverside County - $150,000
- San Diego County - $150,000
- San Luis Obispo County - $150,000
- Santa Barbara County - $150,000
- Sonoma County - $150,000
- Dry Creek Rancheria Band of Pomo Indians - $145,073
- El Dorado County - $150,000
- Fresno American Indian Health Project - $150,000
- Fresno County - $150,000
- Glenn County - $150,000
- Habematolel Pomo of Upper Lake Tribe - $107,700
- Inyo County - $150,000
- Los Angeles County (Dept. of Mental Health) - $150,000
- Los Angeles County (Dept. of Public Health) - $150,000
- Marin County - $150,000
- Mariposa County - $150,000
- Mendocino County - $150,000
- Middletown Rancheria - $149,315
- Monterey County - $150,000
- Morongo Band of Mission Indians - $150,000
- Nevada County - $150,000
- Orange County - $150,000
- Sacramento County - $150,000
- San Mateo County - $149,873
- Santa Cruz County - $150,000
- Southern Indian Health Council - $150,000
- Stanislaus County - $150,000
- Sutter County - $150,000
- Ventura County - $149,916
- Washoe Tribe of Nevada and California - $150,000
- Wilton Rancheria - $149,880

DHCS plans to re-release this funding opportunity to grant the remaining funds. Applications for this funding will be due at the end of February 2022.

Subsequent Rounds of Funding – Launch Ready, Children and Youth, and Filling Gaps. Round 3 of BHCIP will focus on projects that are considered "launch ready" and will award up to $518.5 million to qualified applicants. To be considered launch ready, the applicant must demonstrate the proposed project has the following:

- Site Control – The applicant must have clear control of the property to be acquired or rehabilitated
- Permits – The applicant must understand approvals and permitting needed, and document the capacity to obtain these approvals and permits.
- Licensure and Certification – The applicant must provide documentation of all required certifications or licenses or, for projects that cannot be licensed or certified until after completion, the applicant must demonstrate understanding of the licensing and certification process and requirements.
- Preliminary construction plans – The applicant must provide preliminary construction plans for the proposed project.
- Acquisition or construction timeline – The applicant must begin acquisition or construction within six months of the award and provide a timeline from a licensed general contractor or construction manager.
- Match requirements – The applicant must have capacity to meet matching requirements.
- Approval and engagement – The applicant must demonstrate organizational support from county officials, active community engagement and support, and a contract for provision of Medi-Cal services in the facility.

The application process for Round 3 opened on February 15, 2022, and will consist of two parts, one closing March 31, 2022, and one closing May 31, 2022.

Round 4 will focus on children and youth-focused behavioral health infrastructure projects and will award up to $480.5 million to qualified entities. The department is currently engaging in stakeholder meetings to inform policies around this application process.

Rounds 5 and 6 are expected to be available in October 2022, and December 2022, respectively, and will award up to $480 million each to qualified entities. These funding rounds are expected to address gaps identified in the department's Behavioral Health Needs Assessment, released in January 2022. The assessment evaluated the need for behavioral health services throughout the state and the capacity for providing those services. Among its conclusions, the assessment found the following:

- 9.2 percent of California adults has a substance use disorder
- 4.5 percent of California adults has a serious mental illness
- The rate of serious mental illness in survey data has increased by more than 50 percent between 2008 and 2019.
- One in 13 California children have a serious emotional disturbance, with higher rates for low-income children and those who are Black or Latino.
- Visits to emergency departments due to a mental health crisis have climbed by 24 percent for children between ages five and 11, and 31 percent for children ages 12 to 17.
- Marginalized groups are at higher risk for behavioral health issues, but also less likely to have access to services.
- 30 percent of adults in prison received mental health treatment services in 2017, more than double the rate since 2000.
- 43 percent of Californians seeking mental health services reported it was somewhat or very difficult to secure an appointment with a provider who accepts their insurance.
- Nearly 90 percent of people living with a substance use disorder do not receive treatment.

- There is considerable county-level variation in the prevalence of behavioral health conditions.

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

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 status update on funding rounds for the Behavioral Health Continuum Infrastructure Programs.

2. When does the department expect "launch ready" projects approved in Round 3 to begin providing services? Does the department have any preliminary information on the types of projects for which qualified entities will be submitting applications in this round?

3. What types of projects will be funded by the Round 4 Children and Youth funding round? How will these projects be coordinated with entities receiving funding or other support through the Children and Youth Behavioral Health Initiative?

4. How will the department utilize the Behavioral Health Needs Assessment released in January to inform the Round 5 and 6 grant process? Will qualified entities be expected to use the assessment to identify local needs and submit applications accordingly? What types of pre-application activities will occur to ensure qualified entities are engaging in pre-planning of projects that meet the needs identified in the assessment, for submission of future applications in Round 5 and 6?

Issue 6: Medi-Cal Qualifying Community-Based Mobile Crisis Intervention Services Benefit

Local Assistance and Trailer Bill Language – Governor's Budget. DHCS requests expenditure authority of $108.5 million ($16.3 million General Fund and $92.2 million federal funds) in 2022-23 to provide qualifying community-based mobile crisis intervention services to Medi-Cal beneficiaries in need of behavioral health services. DHCS also proposes trailer bill language to implement this new benefit.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$-	$16,272,000
0890 – Federal Trust Fund	$-	$92,211,000
Total Funding Request:	**$-**	**$108,483,000**

Background. Section 9813 of the federal American Rescue Plan Act of 2021 authorizes state Medicaid programs to provide qualifying community-based mobile crisis intervention services for a period of up to five years, beginning April 1, 2022, and ending March 31, 2027. States that implement the mobile crisis intervention benefit receive an 85 percent federal match for reimbursement of these services for the first three years of the five year period. DHCS proposes to implement this benefit beginning January 1, 2023.

Mobile crisis intervention services are intended to provide rapid response, individual assessment, and crisis resolution by trained mental health and substance use treatment professionals and paraprofessionals in situations that involve individuals with behavioral health conditions. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) describes three core components of a robust crisis system: 1) a 24 hour clinically staffed call center that can serve as a the hub of an integrated mental health crisis system, 2) mobile crisis response teams that can respond rather than law enforcement, and 3) crisis receiving and stabilization facilities that provide short-term services and can be accessed readily rather than relying on emergency departments or hospital environments.

Implementation of 988 for Suicide Prevention and Behavioral Health Crises. In July 2020, the Federal Communications Commission adopted rules to establish 988 as a new, nationwide, three-digit phone number for people in crisis to connect with suicide prevention and mental health crisis counselors. By July 16, 2022, all phone service providers will be required to direct all 988 calls to the existing National Suicide Prevention Lifeline. The new rules apply to all telecommunications carriers as well as all interconnected one-way Voice over Internet Protocol (VoIP) service providers.

Qualifying Community-Based Mobile Crisis Services. DHCS proposes to add qualifying community-based mobile crisis intervention services, as soon as January 1, 2023, for a five year period as a mandatory Medi-Cal benefit available to eligible Medi-Cal beneficiaries 24 hours a day, seven days a week. The benefit would be implemented through the county behavioral health delivery systems by multidisciplinary mobile crisis teams in the community. The services would cover both mental health and substance use disorder crises, using the specialty mental health benefit and adding crisis intervention as an outpatient service eligible under the Drug Medi-Cal benefit. According to DHCS, the benefit would be provided outside a hospital or other facility setting and include screening and assessment, stabilization and de-escalation, and coordination with and referrals to health, social, and other services and supports.

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

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

1. Please provide a brief overview of this proposal.

2. How would this benefit connect with the 988 crisis hotline being implemented in July 2022?

3. What types of professionals or paraprofessionals would be included in a mobile crisis team? Would there be different teams for different types of crises or specific to the individual in crisis?

5. How does the department plan to reimburse mobile crisis teams, including for the time the team is idle awaiting a call?

Issue 7: Panel Discussion – Creating a Complete Continuum of Care for Medi-Cal Beneficiaries

Panel Discussion – Creating a Complete Continuum of Care for Medi-Cal Beneficiaries. The budget includes several important investments and implementation of previous investments in creating a complete continuum of health and behavioral health care, including social services and other supports that address the social determinants of health and prevent homelessness or housing insecurity, unemployment or other economic dislocations, and involvement with the criminal justice system. These investments include the transformation of Medi-Cal under CalAIM, the multi-year infrastructure capacity building under the BHCIP, support of behavioral health bridge housing for immediate housing needs for individuals experiencing or at risk of homelessness with unmet behavioral health needs, and the implementation of a mobile crisis intervention services benefit in Medi-Cal. Together, these investments have the potential to form the foundation of a complete continuum of care for Medi-Cal beneficiaries and other Californians in need, but require significant oversight and coordination among and between state and local partners, providers, consumers, and other stakeholders.

The subcommittee has requested the following panelists to discuss how these and other potential investments can create a complete continuum of care for Californians:

Linnea Koopmans, Chief Executive Officer, Local Health Plans of California
Dr. Ryan Quist, Behavioral Health Director, County of Sacramento
Le Ondra Clark Harvey, Chief Executive Officer, CA Council of Comm. Behavioral Health Agencies
Kim Pederson, Senior Attorney-Mental Health Practice Group, Disability Rights California
Linda Nguy, Senior Policy Advocate, Western Center on Law and Poverty
Tara Gamboa-Eastman, Legislative Advocate, Steinberg Institute
Peter Ragsdale, Executive Director, Housing Authority-County of San Joaquin

Subcommittee Staff Comment—This is an informational item.

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

Local Health Plans of California

1. Please describe how Medi-Cal managed care plans are implementing the new ECM and community supports services under CalAIM.

2. What types of organizations are plans contracting with to provide the ECM and community services benefits?

3. How does the implementation of these benefits allow plans to serve and stabilize beneficiaries with complex health, behavioral health, and social service needs?

4. How are plans coordinating with other partners, including county behavioral health and social service agencies, to create a complete continuum of care for beneficiaries?

Behavioral Health Directors

5. How are the changes to medical necessity criteria helping behavioral health departments better serve beneficiaries?

6. How are behavioral health departments engaging in the Behavioral Health Continuum Infrastructure Program to fill gaps in local service delivery? How will filling these gaps help provide a complete continuum of care for beneficiaries?

7. How would behavioral health departments propose to implement the behavioral health bridge housing funding? What types of clinically-enriched housing placements do counties anticipate applying for? How would those behavioral health and other support services be delivered?

8. How are behavioral health departments implementing the Round 1 funding for mobile crisis units? How will these units connect with both the implementation of the 988 system, as well as the proposed mobile crisis intervention services benefit in Medi-Cal?

CA Council of Community Behavioral Health Agencies

9. How will the investments in CalAIM, the Behavioral Health Continuum Infrastructure Program, behavioral health bridge housing, and the mobile crisis services benefit support be leveraged by behavioral health providers to support their clients and patients?

10. What further investments might be necessary to create a complete continuum of care that addresses the health, behavioral health, social services, and other needs of Medi-Cal beneficiaries?

Disability Rights California

11. What are the particular challenges for individuals with disabilities in accessing necessary supports and services in the Medi-Cal program? How might these investments help improve that access?

12. What would constitute a complete continuum of care for individuals with disabilities in Medi-Cal, and what additional investments might the state consider to achieve that goal?

Western Center on Law and Poverty

13. What are the barriers currently faced by Medi-Cal beneficiaries in accessing a complete continuum of care?

14. How will the investments in CalAIM, such as ECM and community supports, improve access, and what gaps do you believe still remain?

Steinberg Institute

15. What is your organizations view about whether these investments are sufficient to create a complete continuum of care? What gaps still remain?

16. How might the investment in mobile crisis services connect with efforts to implement the 988 system, or other response resources for individuals experiencing a behavioral health crisis?

San Joaquin Housing Authority

17. How might these investments improve the ability to keep individuals with serious mental illness stably housed?

18. How would your agency benefit from the investment in behavioral health bridge housing? The proposal currently references tiny homes and residential care facilities for the elderly (RCFEs) as bridge housing options. Are there other types of bridge housing that would be appropriate for the immediate needs of individuals experiencing homelessness with serious mental illness?

Issue 8: Children and Youth Behavioral Health Initiative Implementation

Local Assistance – Governor's Budget. DHCS requests expenditure authority of $185.8 million ($153.4 million General Fund and $32.4 million federal funds) in 2021-22 and $1.3 billion ($1.2 billion General Fund and $111.5 million federal funds) in 2022-23. If approved, these resources would support implementation of the components of the Children and Youth Behavioral Health Initiative authorized by the 2021 Budget Act.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$153,415,000	$1,231,621,380
0890 – Federal Trust Fund	$32,415,000	$111,484,900
Total Funding Request:	**$185,830,000**	**$1,343,106,280**

Background. The 2021 Budget Act included expenditure authority of $1.4 billion ($1 billion General Fund, $100 million Coronavirus Fiscal Recovery Fund or CFRF, $222 million federal funds, and $105 million Mental Health Services Fund) in 2021-22, $1.3 billion ($769.2 million General Fund, $429 million CFRF, and $124 million federal funds) in 2022-23, $275.2 million ($175.2 million General Fund and $100 million federal funds) in 2023-24, $262.1 million ($156.1 million General Fund and $106 million federal funds) in 2024-25, and $227.1 million ($121.1 million General Fund and $106 million federal funds) in 2025-26, to support the Children and Youth Behavioral Health Initiative and other interventions to support behavioral health services for students. The total investment over five years is $3.5 billion and includes the following components administered by DHCS:

- *Medi-Cal Managed Care Plan Student Behavioral Health Incentives.* $400 million ($200 million General Fund and $200 million federal funds) for DHCS to support incentives for Medi-Cal managed care plans to provide mild-to-moderate behavioral health services to students in partnership with schools and county behavioral health departments.
- *School-Linked Behavioral Health Partnerships.* $100 million CFRF in 2021-22 and $450 million in 2022-23 for the Department of Health Care Services (DHCS) to support school-linked behavioral health partnerships. Of the two year funding, $400 million would support county behavioral health department partnerships with schools and $150 million would support behavioral health services in higher education.
- *Evidence-Based Behavioral Health Programs.* $429 million CFRF in 2022-23 for DHCS to develop and expand evidence-based behavioral health programs addressing early psychosis, disproportionately impacted communities and communities of color, youth drop-in wellness centers, intensive outpatient programs for youth, and prevention and early intervention services for youth. DHCS will coordinate with MHSOAC to implement these programs and allocate 10 percent of the funding for administration by the commission.
- *Planning for Behavioral Health Services and Supports Platform.* $10 million General Fund in 2021-22 for DHCS to support initial planning for implementation of a behavioral health services and supports platform to expand CalHOPE.
- *Dyadic Services Benefit in Medi-Cal.* $200 million ($100 million General Fund and $100 million federal funds) annually beginning in 2022-23 for DHCS to add dyadic services as a Medi-Cal benefit.

- *Continuation of CalHOPE.* $45 million General Fund in 2021-22 for DHCS to continue CalHOPE, a crisis counseling program that includes a media campaign, web-based resources and services, a 24-hour warm line, and student support for social and emotional learning.
- *State Operations and Administration.* $44 million ($22 million General Fund and $22 million federal funds) in 2021-22, $48 million ($24 million General Fund and $24 million federal funds) in 2022-23, $12 million ($6 million General Fund and $6 million federal funds) in 2024-25, and $12 million ($6 million General Fund and $6 million federal funds) in 2025-26, for DHCS to support state operations and administration of the various components of the initiative.

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

Medi-Cal Managed Care Plan Student Behavioral Health Incentives. DHCS requests expenditure authority of $64.8 million ($32.4 million General Fund and $32.4 million federal funds) in 2021-22 and $129.7 million ($64.8 million General Fund and $64.8 million federal funds) in 2022-23 to support incentive payments to Medi-Cal managed care plans to, in coordination with county behavioral health departments and schools, build infrastructure, partnerships, and capacity statewide to increase access to preventive and early intervention behavioral health services for students. The 2021 Budget Act investment of $400 million for this program is being spread out over several fiscal years as the program phases in.

According to DHCS, the goal of these incentive payments is to break down silos and improve coordination of child and adolescent student behavioral health services; increase the number of students enrolled in Medi-Cal receiving behavioral health services through schools, school-affiliated providers, county behavioral health departments, and county offices of education; increase non-specialty services on or near school campuses; and address health equity gaps, inequalities, and disparities in access to behavioral health services. Participating Medi-Cal managed care plans must work with their partner local educational agencies (LEAs) and county behavioral health departments to conduct a needs assessment of existing behavioral health services for students. The assessment is then used to identify targeted interventions to improve behavioral health for students. Eligible interventions include:

- Behavioral health wellness programs
- Telehealth infrastructure to enable services or access
- Behavioral health screenings and referrals
- Suicide prevention strategies
- Substance use disorder prevention, early intervention, and treatment
- Building stronger partnerships to increase access to Medi-Cal services
- Behavioral health public dashboards and reporting
- Technical assistance support for contracts
- Expanding the behavioral health workforce
- Care teams for outreach, engagement, home visits, and linkage to social services

- Information technology enhancements for behavioral health services
- Access to behavioral health screening and treatment for pregnant students and teen parents
- Evidence-based parenting and family services

For any of these interventions, plans will receive incentive payments based on one of two performance outcome metrics:

- Increased access to behavioral health services for Medi-Cal beneficiaries on or near campus
- Increased access to behavioral health services for Medi-Cal beneficiaries provided by school-affiliated behavioral health providers.

DHCS expects most Medi-Cal managed care plans would begin implementing interventions beginning in 2023.

School-Linked Behavioral Health Partnerships. DHCS requests General Fund expenditure authority of $100 million in 2021-22 and $450 million in 2022-23 to support direct grants to local educational agencies (LEAs), institutions of higher education, publicly funded childcare and preschools, health care services plans, community-based organizations (CBOs), tribal entities, behavioral health providers, city mental health authorities, or counties to build infrastructure, partnerships, and capacity statewide to increase the number of children and youth receiving preventive and early intervention behavioral health services from schools, providers in school, school affiliated CBOs, or school-based health centers. Of the $550 million investment over two years, $400 million is targeted to children pre-school through 12th grade, while $150 million is targeted to higher education. DHCS reports it is still developing the timeline for this grant program. DHCS hired a consultant in January 2022 and is developing a work plan.

Evidence-Based Behavioral Health Programs. DHCS requests General Fund expenditure authority of $429 million in 2022-23 to support scaling and spreading of evidence-based interventions statewide to improve outcomes for children and youth. These resources would support a grant program for counties, tribal entities, commercial plans, managed care plans, CBOs, and behavioral health providers to implement evidence-based practices and programs, including early psychosis intervention and treatment, prevention and early intervention, youth drop-in centers, and other programs. DHCS is partnering with the Mental Health Services Oversight and Accountability Commission (MHSOAC) to develop this program, with 10 percent of the funding allocated to the commission. The program was originally authorized for the 2022-23 fiscal year and included funding from the CFRF. DHCS is requesting to use General Fund for this grant program and redirect the CFRF funding for other purposes.

Behavioral Health Services and Supports Platform. DHCS requests General Fund expenditure authority of $10 million in 2021-22 and $230 million in 2022-23 to procuring a business services vendor to implement a statewide, all-payer behavioral health direct services and supports platform. The platform would support regular automated age appropriate assessments, screenings, and self-monitoring tools, and would develop tools to help families navigate how to access help, regardless of payer source. The platform would provide interactive education, app-based games, videos, book suggestions, automated cognitive behavioral therapy and mindfulness exercises. Those whose interactions demonstrate a need for clinical services would be guided to their health plan to set up assessment visits, allowing ongoing, continuous relationships with licensed clinicians through telehealth or in person. The platform would also include e-consult and e-referrals, as well as being accessible by telephone.

Dyadic Services. DHCS requests expenditure authority of $87.4 million ($40.8 million General Fund and $46.7 million federal funds) in 2022-23 to add dyadic services as a Medi-Cal benefit for children under 21 years old and their parents or guardians, beginning July 1, 202. Dyadic services in Medi-Cal, beginning January 1, 2023. Dyadic services are based on the Healthy Steps model of care, an integrated behavioral health care model in which health care is delivered in the context of the caregiver and family, so that families are screened for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health such as food insecurity and housing instability.

CalHOPE Student Support. DHCS requests General Fund expenditure authority of $11 million in 2021-22 and $17 million in 2022-23 to provide training, technical assistance, technology, and tools to build and enhance positive social-emotional learning environments in schools through administration of the CalHOPE Student Support Program. The program was launched during the COVID-19 pandemic with support from the Federal Emergency Management Agency (FEMA) and the Substance Use and Mental Health Services Administration (SAMHSA) to address the challenges and stressors experienced by children, youth and families including social isolation, lack of school structure, and the need to adapt to distance learning. The CalHOPE Student Support Program is designed to give teachers and staff the skills to prepare a healthy learning environment for children, to be able to easily identify signs of stress and poor functioning, provide support for children and youth, and refer to more intensive services where needed.

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

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

1. Please provide a brief update on implementation progress for the following components of the Children Youth Behavioral Health Initiative:
   a. Medi-Cal Managed Care Plan Student Behavioral Health Incentives
   b. School Behavioral Health Partnerships and Capacity
   c. Evidence-Based Behavioral Health Practices
   d. Behavioral Health Services and Supports Platform
   e. Dyadic Services
   f. CalHOPE Student Support

2. What is the timeline for implementation of the Behavioral Health Services and Supports Platform? How will the department select the vendor for the platform? Has the department engaged with stakeholders to inform how such a platform should be deployed and be most useful?

Issue 9: Full-Scope Medi-Cal for All Adults Regardless of Immigration Status

Trailer Bill Language– Governor's Budget. DHCS proposes trailer bill language to extend full scope Medi-Cal coverage to individuals who are age 26 through 49, regardless of immigration status, no sooner than January 1, 2024.

Background. California provides restricted-scope Medi-Cal coverage, such as emergency and pregnancy-related services, to income eligible adults who are 19 years or older without, or unable to verify, satisfactory immigration status. The 2015 Budget Act expanded full-scope Medi-Cal coverage to income-eligible children, and the 2019 Budget Act expanded coverage to young adults up to age 26. The 2021 Budget Act authorized expansion of full-scope Medi-Cal coverage for income-eligible adults age 50 years of age and older regardless of immigration status, beginning May 1, 2022. The budget includes expenditure authority of $52.5 million ($41.6 million General Fund and $10.9 million federal funds) in 2021-22 and $589.8 million ($496.1 million General Fund and $93.8 million federal funds) in 2022-23 for costs related to the expansion.

Delayed Implementation Related to Systems Readiness Challenges. According to DHCS, the proposed expansion of full-scope coverage to the remaining population age 26 to 49 would be implemented no sooner than January 1, 2024, due to challenges programming eligibility changes into the Statewide Automated Welfare System (SAWS). Currently, the CalHHS Office of Systems Integration is overseeing the integration of two county subsystems used at county social services agencies to administer Medi-Cal and other social services programs. This project requires scheduling of changes to eligibility for the Medi-Cal program based on when the system changes can be programmed. Several other changes to Medi-Cal eligibility have been previously approved by the Legislature, including full-scope expansion for older adults, extension of post-partum Medi-Cal eligibility, and changes to income requirements for the Aged and Disabled program. DHCS indicates it does not believe the system would be ready for implementation of expansion of full-scope Medi-Cal coverage to adults age 26 to 49 until January 1, 2024.

As a result of the delayed implementation, DHCS is not requesting resources for 2022-23, but is requesting trailer bill language to implement the expansion in 2024. DHCS estimates this expansion would result in costs of $819.3 million ($613.5 million General Fund and $205.8 million federal funds) in 2023-24. DHCS estimates there are 708,786 adults age 26 to 49 currently enrolled in restricted-scope Medi-Cal coverage, who would be transitioned immediately upon implementation of the expansion in 2024. DHCS estimates there are 55,094 adults age 26 to 49 who are eligible but not enrolled in restricted-scope coverage and that 10 percent or 5,509 of those adults would enroll in full-scope coverage in 2024.

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. Please describe the systems readiness challenges that result in this proposal being implemented no sooner than January 1, 2024.

Issue 10: Elimination of Premiums and Copayments in the Medi-Cal Program

Local Assistance and Trailer Bill Language – Governor's Budget. DHCS requests General Fund expenditure authority of $53.2 million ($19.1 million General Fund and $34.1 million federal funds) in 2022-23 to eliminate premiums for children and working disabled beneficiaries in the Medi-Cal program. DHCS also proposes trailer bill language to eliminate its ability to collect copayments in the Medi-Cal program.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$-	$19,080,250
0890 – Federal Trust Fund	$-	$34,082,750
Total Funding Request:	**$-**	**$53,163,000**

Background. Currently, Medi-Cal beneficiaries in the Optional Targeted Low Income Children Program (OTLICP), the County Children's Health Initiative Program (CCHIP), the Medi-Cal Access Program (MCAP), and the 250 percent Working Disabled Program (WDP) pay premiums to receive coverage in the Medi-Cal program. In OTLICP, which provides Medi-Cal coverage to children with incomes up to 266 percent of the federal poverty level (FPL), premiums are imposed on individuals with family income above 160 percent of the FPL at a monthly cost of $13 per child and a maximum of $39. In CCHIP, which provides coverage for low-income children, premiums are imposed on all beneficiaries, at a monthly cost of $21 per child and a maximum of $63. In MCAP, which provides coverage for pregnant women and their infants up to age two, premiums are imposed on pregnant women equivalent to 1.5 percent of gross income, and for infants a monthly cost of $13 per child and a maximum of $39. For the WDP, which provides Medi-Cal coverage for certain working disabled individuals, premiums are imposed based on an individual or couple's net countable income and ranges from a minimum of $20 or $30 to a maximum of $250 or $375 per month for an individual and couple respectively.

DHCS proposes to eliminate all of these premiums, effective July 1, 2022.

Trailer Bill Language – Copayments. According to DHCS, current law requires Medi-Cal beneficiaries to pay a nominal, non-enforceable copayment for certain covered services. Beneficiaries are charged by providers, and the provider retains the copayments, which are not passed on to the Medi-Cal program. Federal regulations require states to track copayments to ensure beneficiaries do not pay more than five percent of their income on premiums and cost-sharing. DHCS indicates it does not currently have a mechanism to track cost-sharing. The federal Centers for Medicare and Medicaid Services (CMS) has indicated DHCS must either comply with the tracking requirement or eliminate copayments. As a result, DHCS is proposing trailer bill language to eliminate copayments in an effort to remove potential barriers in access to care and avoid costly system changes to comply with federal 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 these proposals.

Issue 11: Align Medi-Cal Redeterminations with Federal Guidelines

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to align state law with federal guidelines on redeterminations of eligibility for Medi-Cal.

Background. According to DHCS, beneficiaries who are discontinued from Medi-Cal as a result of not providing required information are given 90 days to submit the information without needing to reapply for Medi-Cal. This period is referred to as the 90-day cure period. State law requires that if a discontinued beneficiary provides the information within the 90-day cure period and was continuously eligible, the beneficiary's eligibility may be reinstated back to the date of discontinuation with an annual renewal data 12 months later. However, CMS guidance released in December 2020 clarifies that discontinued beneficiaries returning information during the cure period must be treated as new applicants, with eligibility only reinstated for previous months if requested and the beneficiary is found eligible. In addition, the annual renewal date must be set 12 months after the reinstatement, rather than based on any retroactive eligibility.

In addition, counties conduct eligibility reviews when they receive information about a change in a beneficiary's circumstances that may affect eligibility, such as a new job or when they get married. Existing law requires the county to send a form to the beneficiary pre-populated with information received by the county during its review. Federal regulations do not require a pre-populated form, which are more restrictive and burdensome for beneficiaries and for county eligibility workers. DHCS reports it never updated the change in circumstance form to be pre-populated, but is nonetheless required to do so by state law.

DHCS proposes trailer bill language to align state law with these federal guidelines. The proposed language would align with CMS guidance on retroactive eligibility and annual renewal dates for beneficiaries reinstated during the 90-day cure period. The language would also repeal the requirement to send a pre-populated change of circumstance form to beneficiaries, consistent with federal requirements.

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: Discontinue CHDP and Expand Presumptive Eligibility

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to sunset the Child Health and Disability Prevention Program and expand presumptive eligibility for children in the Medi-Cal program, effective July 1, 2023.

Background. The Child Health and Disability Prevention (CHDP) Program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. Health assessments provided in CHDP include a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculosis test, laboratory tests, immunizations, health education, anticipatory guidance, and a referral for any needed diagnosis or treatment. The program also oversees the screening and follow-up components of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for Medi-Cal eligible children and youth.

CHDP is operated at the local level by city and county health departments. Local programs carry out community activities including planning, evaluation and monitoring, case management, providing health education materials, provider recruitment, quality assurance, and client support services.

The CHDP Gateway program is an automated pre-enrollment process for non-Medi-Cal, uninsured children, serving as an entry point for these children to enroll in health care coverage in Medi-Cal. Enrolling providers

DHCS proposes trailer bill language to sunset the CHDP program effective July 1, 2023. DHCS indicates its goal is to streamline the Medi-Cal program under the CalAIM initiative. As part of the proposal, DHCS will implement the Children's Presumptive Eligibility Program to replace the CHDP Gateway to allow applicable Medi-Cal providers to enroll children into Medi-Cal through the presumptive eligibility process.

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

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

1. Please provide a brief overview of this proposal.

Issue 13: Family PACT Human Papillomavirus Vaccine Coverage

Local Assistance – Governor's Budget. DHCS requests expenditure authority of $8 million ($4.6 million General Fund and $3.5 million federal funds) in 2022-23 to provide human papillomavirus vaccination as a covered benefit in the Family Planning, Access, Care and Treatment Program.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$-	$4,581,000
0890 – Federal Trust Fund	$-	$3,459,000
Total Funding Request:	**$-**	**$8,040,000**

Background. The Family Planning, Access, Care, and Treatment (Family PACT) Program provides family planning and reproductive health services at no cost to California residents of reproductive age under 200 percent of the federal poverty level. The program offers comprehensive family planning services, including contraception, pregnancy testing, sterilization, sexually transmitted infection testing, and certain cancer screening services. According to DHCS, Family PACT serves approximately 1.1 million eligible men and women of childbearing age through a network of 2,400 providers.

The human papillomavirus (HPV) is a common viral infection spread through intimate skin-to-skin contact. According to the federal Centers for Disease Control and Prevention (CDC), more than 42 million Americans are currently infected with HPV types that can cause disease, with 13 million Americans infected each year. Some HPV infections may lead to cancers of the: 1) cervix, vagina, and vulva in women; 2) penis in men; 3) anus in both women and men; 4) back of the throat in both men and women. HPV can also lead to genital warts. HPV causes approximately 36,000 cases of cancer in men and women each year.

Vaccination against HPV has demonstrated a significant reduction in cancer causing infections and pre-cancers. According to the CDC, infections with HPV types that cause cancers and genital warts have dropped 88 percent among teen girls and 81 percent among young adult women. Among vaccinated women, the rate of cervical precancers caused by HPV has dropped 40 percent.

The CDC recommends two doses of the HPV vaccine for children ages 11 to 12, given six to 12 months apart. HPV vaccines can be given starting at age nine. If the HPV vaccine is given after age 15, the CDC recommends three doses over six months. HPV vaccination is recommended for everyone through age 26, and up to age 45 depending on the risk of possible HPV infection.

HPV Vaccination in Family PACT. DHCS requests expenditure authority of $8 million ($4.6 million General Fund and $3.5 million federal funds) in 2022-23 to provide HPV vaccination as a covered benefit in the Family PACT Program. The benefit would be provided to females and males, ages 19 through 45, beginning July 1, 2023. DHCS estimates that 10,830 Family PACT clients would be vaccinated in 2022-23, at a reimbursement rate of $742.38 for the three dose vaccination.

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: Medi-Cal Rx Implementation

Governor's Executive Order on Prescription Drug Purchasing. On January 7, 2019, the Governor issued Executive Order N-01-19, ordering state departments to implement several directives intended to reduce the cost of prescription drugs for both public and private purchasers, including a transition of Medi-Cal prescription drug benefits from the managed care to the fee-for-service delivery system. The Executive Order directed DHCS to take all necessary steps to transition all pharmacy services provided by Medi-Cal managed care plans into the Medi-Cal fee-for-service delivery system. The transition is intended to create additional negotiating leverage on behalf of the state's 14.2 million Medi-Cal beneficiaries and standardize the Medi-Cal drug benefit, reduce confusion among beneficiaries without sacrificing quality or outcomes, and result in hundreds of millions of dollars in additional savings from supplemental drug rebates.

Medi-Cal Rx. As of January 1, 2022, under the Medi-Cal Rx program, all pharmacy benefits are carved out of managed care and are available on a fee-for-service basis. DHCS contracted with Magellan Medicaid Administration, Inc., as the Medi-Cal Rx vendor, providing pharmacy support systems including: 1) claims administration and utilization management, 2) pharmacy drug rebate administration, and 3) provider and beneficiary support. According to DHCS, the net impact of Medi-Cal Rx will result in net costs of $435 million ($149 million General Fund) in 2021-22, net savings of $414 million ($178 million General Fund) in 2022-23, and net savings of $827 million ($307 million General Fund) annually when fully implemented. The components of these savings figures are as follows:

(dollars in millions)	**2021-22**		**2022-23**		**Annual**	
Policy	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
Reduction in Managed Care Rx Costs	($2,588)	($810)	($6,350)	($1,987)	($6,544)	($2,047)
Managed Care Admin Cost Savings	($110)	($35)	($271)	($85)	($279)	($87)
Increased Fee-for-Service Rx Costs	$3,052	$955	$6,942	$2,172	$7,106	$2,223
340B Savings	($61)	($31)	($147)	($74)	($147)	($74)
340B Clinic Supplemental Payments	$53	$26	$105	$53	$105	$53
Additional Savings from MAIC in Fee-for-Service	($7)	($2)	($15)	($5)	($15)	($5)
Fee-for-Service Admin Cost Savings	($1)	($0)	($5)	($1)	($5)	($1)
New Rx Related Admin Costs	$99	$46	$99	$23	$99	$25
Additional Supplemental Rebates – Carve-Out	$0	$0	($595)	($204)	($853)	($292)
Additional Supplemental Rebates – Fee-for-Service	$0	$0	($75)	($20)	($192)	($50)
Medical Supply Rebates	$0	$0	($101)	($51)	($101)	($51)
TOTAL	**$435**	**$149**	**($414)**	**($178)**	**($827)**	**($307)**

Consumers and Providers Reporting Issues With Prescriptions. After the implementation of Medi-Cal Rx on January 1, 2022, stakeholders have reported several issues with beneficiary access to medications. These issues have included requiring new prior authorization for existing prescriptions and difficulties accessing specialty medications. In response, DHCS reports it has been working with Magellan to address these issues and indicates the following results:

- The backlog of prior authorizations was cleared as of February 11, 2022.
- By February 14, 2022, Magellan was on track to achieve a 24 hour turnaround time for prior authorizations
- In its call center, while Magellan is considerably underperforming its contractual requirements, there has been a 20 percent improvement in overall average speed of answer including live and callbacks combined. DHCS reports Magellan plans to hire and train 136 new associates by February 21.
- System changes have resulted in a reduction in point-of-sale claim rejections from 20 percent in January, to eight to ten percent in February.
- DHCS reports it is working with DHCS to implement an escalation process for beneficiaries and providers with issues accessing medications.

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

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

1. Please provide a brief update on the implementation of Medi-Cal Rx, including addressing the challenges with accessing medications reported by consumers, providers, and other stakeholders.

Issue 15: Pharmacy Recoupment

Local Assistance – Governor's Budget. DHCS estimates net savings of $99.9 million ($37.2 million General Fund and $62.6 million federal funds) in 2021-22 and $110.2 million ($49.3 million General Fund and $60.9 million federal funds) in 2022-23 for retroactive adjustments to payments for pharmacy providers related to a federally required change in the pharmacy reimbursement methodology implemented in April 1, 2017.

This estimate assumes retroactive adjustments begin January 1, 2022. However, due to factors related to ongoing litigation, DHCS is pausing these recoupments until further notice.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	($37,221,800)	($49,307,200)
0890 – Federal Trust Fund	($62,632,200)	($60,936,800)
Total Funding Request:	**($99,854,000)**	**($110,244,000)**

Background. The federal Affordable Care Act requires state Medicaid agencies, including Medi-Cal, to adopt a new reimbursement methodology for covered outpatient drugs, based on the actual acquisition cost. States are also required to adjust pharmacy professional dispensing fees, as well. DHCS submitted a State Plan Amendment to the federal Centers for Medicare and Medicaid Services (CMS) in 2017 to implement the new reimbursement methodology. CMS approved the state's request with an implementation data of April 1, 2017.

Due to delays in implementation of system and other changes necessary to begin using the new reimbursement methodology, providers were reimbursed using the previous methodology until February 23, 2019, when the new methodology was implemented. As a result, for the 23 month period between April 1, 2017, and February 23, 2019, DHCS informed providers it would recoup the higher payments they had received. In June 2019, providers filed a lawsuit, *California Pharmacists Association, et al., v. Kent, et al.* to enjoin the department from implementing the retroactive adjustments. As a result, DHCS paused the adjustments and attempted to address the providers' concerns by approving alternative payment arrangements, which allowed the recoupments to occur over as long as 48 months, rather than 12 months.

DHCS reports it planned to resume recoupments in February 2021, but has continued to pause the recoupments due to factors related to the litigation.

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

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

1. Please provide a brief update on the status of implementation of the pharmacy recoupment and any plans for its resumption.

Issue 16: Medi-Cal Dental Policy Evidence-Based Practices

Local Assistance and Trailer Bill Language – Governor's Budget. DHCS requests expenditure authority of $37.1 million ($12.9 million General Fund and $24.2 million federal funds) to support implementation of evidence-based dental practices, including laboratory processed crowns on posterior teeth for adult Medi-Cal beneficiaries. DHCS also proposes trailer bill language to implement these new services.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$-	$12,915,800
0890 – Federal Trust Fund	$-	$24,194,200
Total Funding Request:	**$-**	**$37,110,000**

Background. The Medi-Cal program currently covers stainless steel crowns for adult beneficiaries, but does not cover laboratory-processed crowns, which are consistent with guidelines from the American Association of Pediatric Dentists and the American Dental Association. According to DHCS, the use of stainless steel crowns can lead to decay and possible damage to the gum tissue around the tooth because the margins of the stainless steel crowns are not custom fitted to the tooth. Laboratory-processed crowns, which are custom fitted to the tooth, are currently covered for children, but not adults.

DHCS proposes to include coverage for laboratory-processed crowns on posterior teeth for adult Medi-Cal beneficiaries beginning in 2022-23.

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

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

1. Please provide a brief overview of this proposal.

Issue 17: Extension of Dental Managed Care

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to extend the operation of existing dental managed care contracts in Sacramento and Los Angeles Counties until December 31, 2023, and to require DHCS to procure and execute new contracts to continue the dental managed care delivery system in these counties through the end of the 1915(b) waiver period.

Background. DHCS contracts with six dental managed care plans that provide dental care to approximately 896,000 Medi-Cal beneficiaries in Sacramento and Los Angeles counties. These plans are regulated by the Department of Managed Health Care and licensed under the Knox-Keene Act. The department contracts with Access Health Plan, Health Net and Liberty Health Plan to provide dental benefits in both Sacramento and Los Angeles.

CalAIM – Fully Integrated Plans. One of the long-term goals of the California Advancing and Innovating in Medi-Cal (CalAIM) initiative is the development of fully integrated plans. A fully integrated plan would provide Medi-Cal beneficiaries with physical health, behavioral health, and oral health services in one managed care plan. All of these services would be consolidated under a single contract between the plan and DHCS. As this is a long-term project, DHCS expects implementation of fully integrated plans no sooner than January 2027.

One-Year Extension of Contracts in 2021 Budget Act. In 2021-22, the Administration proposed to eliminate dental managed care in Sacramento and Los Angeles Counties to allow for a more effective and uniform provider and beneficiary outreach on a statewide basis. In addition, DHCS had concerns about lower rates of dental utilization for dental managed care, particularly among children, compared to the fee-for-service delivery system. However, to avoid changes to dental coverage for a significant number of Medi-Cal beneficiaries during the COVID-19 pandemic, the Legislature adopted trailer bill language to extend the dental managed care contracts for one year, until December 31, 2022.

DHCS proposes trailer bill language to extend the operation of existing dental managed care contracts in Sacramento and Los Angeles Counties until December 31, 2023, and to require DHCS to procure and execute new contracts to continue the dental managed care delivery system in these counties through the end of the 1915(b) waiver period. The 1915(b) waiver is the federal authority governing the CalAIM initiative.

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 18: Maternal Care and Services (SB 65)

Budget Change Proposal – Governor's Budget. DHCS requests expenditure authority of $510,000 ($255,000 General Fund and $255,000 federal funds) in 2022-23 and $492,000 ($246,000 General Fund and $246,000 federal funds) in 2023-24 to examine and evaluate the implementation of doula services in Medi-Cal, pursuant to the requirements of SB 65 (Skinner), Chapter 449, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24**
0001 – General Fund	$255,000	$246,000
0890 – Federal Trust Fund	$255,000	$246,000
Total Funding Request:	**$510,000**	**$492,000**
Total Requested Positions:	**0.0**	**0.0**

Background. SB 65 (Skinner), Chapter 449, Statues of 2021 requires DHCS to convene a workgroup between April 1, 2022, and December 31, 2023 to examine implementation of doula services as a new Medi-Cal benefit. The workgroup would include doulas, health care providers, consumer and community advocates, health plans, county representatives, and others experienced with doula services. The workgroup would:

- Ensure that doula services are available to eligible Medi-Cal beneficiaries who want doula services.
- Minimize barriers and delays in payments to doulas or reimbursement to Medi-Cal beneficiaries for doula services received.
- Make recommendations for outreach efforts so all eligible beneficiaries and other target populations are aware of the option to use doula services.

SB 65 also requires DHCS to publish a report by July 1, 2024, on the number of Medi-Cal recipients utilizing doula services, including information about race, ethnicity, primary language, health plan, and county of recipients. The report must identify barriers that impede access to doula services, make recommendations to the Legislature and DHCS on ways to reduce identified barriers, and provide a comparison of birthing outcomes of Medi-Cal recipients who receive doula services compared with those who do not.

Resource Request. DHCS requests expenditure authority of $510,000 ($255,000 General Fund and $255,000 federal funds) in 2022-23 and $492,000 ($246,000 General Fund and $246,000 federal funds) in 2023-24 to examine and evaluate the implementation of doula services in Medi-Cal, pursuant to the requirements of SB 65 (Skinner), Chapter 449, Statutes of 2021. Specifically, DHCS requests the following:

- Resources equivalent to **one Health Program Specialist I** position would track implementation, manage the stakeholder process, and perform a variety of administrative, health program management, technical, and analytical tasks.
- Resources equivalent to **one Associate Governmental Program Analyst** would develop the scope of work of the external evaluation contractor; collaborate with the contractor, data staff, and program staff to help design the program evaluation; work with data staff to get required data; review and

provide feedback on drafts of the evaluation; and finalize and disseminate recommendations to program staff, the Legislature, and on the DHCS website on ways to reduce barriers to access to doula services.

- DHCS requests expenditure authority of $215,000 ($108,000 General Fund and $107,000 federal funds) in 2022-23 and 2023-24 to support an external contractor that would conduct a program evaluation of the different models of doula care implemented in Medi-Cal to: describe utilization; identify barriers to access; make recommendations to reduce barriers; compare efficacy and birthing outcomes of Medi-Cal recipients who receive these services and those that do not; evaluate community-based organization involvement; and describe qualitative and quantitative health equity outcomes.

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: Indian Health Grant Program

Budget Change Proposal – Governor's Budget. DHCS requests General Fund expenditure authority of $12 million in 2022-23 to restore local assistance grant funding to the Indian Health Program.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24**
0001 – General Fund	$12,000,000	$-
Total Funding Request:	**$12,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. American Indians experience significant health disparities, including lower life expectancy, disproportionate disease burden, as well as higher prevalence of preterm births, suicide, substance use disorders, drug-induced death, diabetes, and other chronic diseases. The Indian Health Program, established in 1975, is responsible for conducting studies, providing technical and financial assistance, staffing the American Indian Policy Advisory Panel, and coordinating with other similar agencies. The program distributed $6.5 million of local assistance grant funding annually to support clinic infrastructure, including provider salaries, operational costs and training, as well as two regional Traditional Health Programs. In the midst of the Great Recession, the 2009 Budget Act eliminated funding for the program.

Resource Request. DHCS requests General Fund expenditure authority of $12 million in 2022-23 to restore local assistance grant funding to the Indian Health Program. Of this amount, $11.6 million would support local assistance grants in the following categories:

- Primary care recruitment and retention - $6.4 million would support recruitment and retention efforts for primary care providers, and would be distributed using service population to provider ratios and other factors, such as distance to the nearest source of tertiary care and specialists, vacancy rates, and proximity to medical schools or residency programs.
- Population Service Index - $1.7 million would be provided based on the number of individual patients served during the preceding calendar year.
- Quality measures - $3.5 million would be distributed based on federal clinical performance measures including care for patients with diabetes, cancer screening, immunization, behavioral health screening, oral health screenings, pre- and post-natal care, and other prevention measures.

In addition, DHCS requests General Fund expenditure authority of $424,000 in 2022-23 to support the following:

- Resources equivalent to **three Associate Governmental Program Analysts** would review request for application responses, determine awardees, administer local assistance grants, develop funding allocations, and provide technical assistance to Indian health clinic corporations.

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. Please explain why this funding is only proposed for a single year, rather than ongoing?

Issue 20: Transforming Quality Outcomes and Health Equity in Medi-Cal

Budget Change Proposal – Governor's Budget. DHCS requests 19 positions and expenditure authority of $4.7 million ($2.3 million General Fund and $2.3 million federal funds) in 2022-23, $4.5 million ($2.2 million General Fund and $2.2 million federal funds) in 2023-24, and $4.1 million ($2 million General Fund and $2 million federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to administer and lead quality improvement and health equity efforts in the Medi-Cal program.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$2,345,000	$2,232,000
0890 – Federal Trust Fund	$2,344,000	$2,231,000
Total Funding Request:	**$4,689,000**	**$4,463,000**
Total Requested Positions:	**19.0**	**19.0**

* Additional fiscal year resources requested: 2024-25 and ongoing: $4,083,000.

Background. According to DHCS, recent data and reports have suggested quality improvement in the Medi-Cal program to date has been stagnant. In particular, DHCS sites:

- A 2018 report from the California State Auditor that found an average of 2.4 million children in Medi-Cal did not receive all required preventive services and California's utilization rate for preventive services remained below 50 percent and ranked 40th for all states.
- A 2019 report from the California State Auditor that found nearly half of children ages one and two enrolled in Medi-Cal were not tested for lead poisoning.
- A 2021 audit by the federal Office of Inspector General found deficiencies in quality of care provided to beneficiaries using Opioid Treatment Program services.

DHCS also found, in its 2018 Health Disparities Report, that health disparities for 70 percent of indicators persisted between 2017 and 2019, demonstrating these disparities are not improving.

DHCS attributes its challenges in improving quality an equity in Medi-Cal to the lack of an organizational structure and staff within the department to lead quality improvement and health equity efforts across programs. DHCS has hired a new Deputy Director of Quality and Population Health Management, who also serves as the Chief Quality Officer, and initiated a reorganization of existing workload and staff focused on quality, health equity, and population health management throughout the organization under the supervision of this new position. DHCS identified numerous gaps in its quality and health infrastructure including in the areas of behavioral health, fee-for-service, and long-term services and supports. In addition, DHCS reports it has never developed a comprehensive approach to facilitate program evaluation to utilize data and dashboards to assess program efficacy, in collaboration with external evaluators, and to use this analysis to focus quality improvement activities and program improvement. DHCS believes its staffing and resource request would enable the new Quality and Population Health Management program to achieve effective quality monitoring and compliance to drive expected quality and health equity outcomes desired for the Medi-Cal program.

Staffing and Resource Request. DHCS requests 19 positions and expenditure authority of $4.7 million ($2.3 million General Fund and $2.3 million federal funds) in 2022-23, $4.5 million ($2.2 million General Fund and $2.2 million federal funds) in 2023-24, and $4.1 million ($2 million General Fund and $2 million federal funds) annually thereafter to administer and lead quality improvement and health equity efforts in the Medi-Cal program. Specifically, DHCS requests the following positions and resources:

- **Two Career Executive Appointments (CEA)** would serve as the Quality and Equity Division Chief and the Population Health Division Chief. The Quality and Equity Division Chief would oversee all health care quality functions of the department, lead health equity efforts, and coordinate with other areas within the department, other departments, and external stakeholders to achieve the goal of equitable, quality care in Medi-Cal. The Population Health Division Chief would oversee all population health efforts within the department, including the Population Health Management Program, Enhanced Care Management, and the population health strategy for California Advancing and Innovating Medi-Cal (CalAIM), to support care coordination for all Medi-Cal beneficiaries.
- **One Staff Services Analyst (SSA)** would serve as an assistant to the Deputy Director and Assistant Deputy Director and would perform day-to-day administrative and analytical duties, coordinate any departmental or division drills including bill and legislative analysis requests, and engage and maintain effective flow of communication among DHCS divisions and external partners through Week Ahead Reports (WARs), Daily Action Reports (DARs), and Stakeholder Updates, etc.
- **One SSA** would provide support for the necessary overall contracting process, budgets, and financial drills related to quality and equity; and provide necessary oversight and technical support for contracts development and amendments, reviewing for compliance with State Contracting Manual, Public Contract Code, Government Code and federal guidelines.
- **One SSA** would provide support for personnel work for the Division of Quality and Population Health Management, including processing recruitment and hiring, retaining the most capable workforce, handling personnel-related drills, performance management and consulting, and payroll and benefits.
- **One Health Program Manager (HPM) II** position would serve as the Health Equity Section Chief and provide programmatic and managerial leadership for the professional and technical staff in the section, provide consultation to the internal departmental and external stakeholder partners of the Quality and Equity Division on matters relating to health equity, and lead the implementation of DHCS' health equity strategy.
- **Two Health Program Specialist (HPS) II** positions would serve as Quality Improvement Specialists for the Behavioral Health and Fee-for-Service (FFS)/Long-Term Services and Supports (LTSS) program areas, respectively; develop Behavioral Health (BH) and FFS/LTSS quality improvement frameworks, review existing data and recommendation regarding new health metrics, implement programmatic changes, and measure progress towards achieving these goals.
- **One Health Education Consultant (HEC) III** position would serve as a highly skilled technical program education consultant working to coordinate, implement, and evaluate behavioral health education for department staff and its behavioral health quality improvement initiatives.
- **One HEC III** position would serve as a highly skilled technical program education consultant working to coordinate, implement, and evaluate health education related to FFS/LTSS services for department staff and its FFS/LTSS quality improvement initiatives.
- **One Research Scientist (RS) Supervisor I** position would serve as the Program Monitoring and Evaluation Section Chief; provide administrative guidance and leadership in planning, organizing and directing this new section focusing on program evaluation; supervise scientific and non-scientific staff, and conduct recruitment and training according DHCS policies and procedures, Institutional Review

Board and federal law; and work with external contractors conducting program evaluation on behalf of DHCS and other programs within DHCS to conduct and coordinate DHCS program evaluation efforts.

- **One RS III** position would work with external contractors conducting program evaluation, lead the development of program evaluation designs working with the rest of the division staff, participate in the design and implementation of all phases of evaluation and fidelity studies, lead complex evaluation projects, coordinate data collection, and document and present findings to program staff to facilitate quality improvement efforts.
- **One RS II** position would implement evaluation policies and procedures to evaluate DHCS program quality improvement efforts, work with external contractors, and collect, analyze and leverage evaluation data and research to benefit and optimize DHCS quality improvement efforts.
- **One HPS II** position would serve as the project manager for the development of evaluation models for various DHCS programs, work with DHCS programs and external evaluators to develop scopes of work for external evaluation contracts, review evaluations provided by external contracted evaluators prior to DHCS approval, and work with programs to inform successes and areas for programmatic change/improvement based on final evaluations.
- **One HPM II** position would supervise staff and provide guidance in day-to-day program and policy decisions for the Incentive Program Section.
- **One Staff Services Manager I** position and **three Associate Governmental Program Analysts** would comprise a Health Equity Unit, which would build on contract work with the Center for Applied Research Solutions, which expires on March 31, 2023, that provides training and technical assistance for counties to revamp their strategies related to achieving health equity, workforce diversity, and cultural and linguistic proficiency, based on the current requirement for counties to develop annual cultural competence plans.

Contract Resources

- DHCS requests expenditure authority of $55,000 ($27,000 General Fund and $28,000 federal funds) in 2022-23 for a contractor to provide Lean Quality Improvement training for department staff.
- DHCS requests expenditure authority of $130,000 ($65,000 General Fund and $65,000 federal funds) in 2022-23 and 2023-24 for a contractor to provide expertise on developing and executing a plan to improve health equity among Medi-Cal beneficiaries, focused on health equity training and technical assistance for health equity efforts.
- DHCS requests expenditure authority of $250,000 ($125,000 General Fund and $125,000 federal funds) in 2022-23 and 2023-24 for a contractor to provide expertise on improving health care quality among Medi-Cal beneficiaries in the following priority areas: 1) children's preventive care, 2) integrated behavioral health, and 3) maternity outcomes.
- DHCS requests expenditure authority of $1 million ($500,000 General Fund and $500,000 federal funds) in 2022-23 through 2026-27 for a contractor to extend the current work of the Department of Public Health to provide technical assistance to county behavioral health departments in reducing mental health disparities. The contractor would review county mental health plans and Drug Medi-Cal Organized Delivery System cultural competency plans focusing on resolving behavioral health inequities and achieving a diverse behavioral health workforce.

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: Further Strengthen Fiscal Functions and Outcomes

Budget Change Proposal – Governor's Budget. DHCS requests ten positions and expenditure authority of $2.4 million ($1.2 million General Fund and $1.2 million federal funds) in 2022-23, $2.2 million ($1.1 million General Fund and $1.1 million federal funds) in 2023-24, and $1.5 million ($743,000 General Fund and $742,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to continue to strengthen its fiscal estimates and cash flow monitoring and provide resources for increasing and complex workloads.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$1,181,000	$1,114,000
0890 – Federal Trust Fund	$1,181,000	$1,113,000
Total Funding Request:	**$2,362,000**	**$2,227,000**
Total Requested Positions:	**10.0**	**10.0**

* Additional fiscal year resources requested: 2024-25 and ongoing: $1,485,000.

Background. The 2019 Budget Act included 25 positions and expenditure authority of $3.6 million ($1.7 million General Fund and $1.9 million federal funds) to strengthen fiscal estimates and cash flow monitoring. The primary goals of these positions and resources were: 1) consolidation and improvement of coordination of fiscal functions within DHCS; 2) strengthening DHCS' ability to track expenditures relative to projections; and 3) improving and increasing the transparency of projections of DHCS' expenditures. This budget augmentation allowed DHCS to achieve the following:

- Hire a deputy director-level Chief Financial Officer to oversee and coordinate accounting, budgets, and fiscal forecasting operations.
- Reorganized and streamlined departmental divisions and units.
- Convened the first of several fiscal stakeholder workgroup meetings in August 2019.
- Established a Cash Management Section, which produces monthly internal cash reports and quarterly external updates that explain major sources of variation between expenditures and estimates.
- Dedicated staff resources to increasing estimate development capacity in key policy areas, including managed care and pharmacy, as well as strengthening research capacity and developing new tools to assist with the estimates.
- Introduced a number of initial enhancements to improve transparency and usability of the Medi-Cal Estimate, including "how-to" documentation that provides guidance on how to interpret estimate displays and navigation aids in the form of tables of contents, with a fully-hyperlinked alphabetical index of policy changes.
- The Cash Flow Reporting Unit was created within the accounting section and is responsible for the accounting functions related to monitoring, tracking, and managing DHCS' cash flow.

DHCS has identified additional gaps and opportunities for improvement in its fiscal estimates and other activities, including: 1) programmatic process improvement initiatives; 2) additional, more complex workload related to the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Children and Youth Behavioral Health Initiative, and responses to the COVID-19 pandemic; and 3) an increase in cash management transactions and workload.

Staffing and Resource Request. DHCS requests ten positions and expenditure authority of $2.4 million ($1.2 million General Fund and $1.2 million federal funds) in 2022-23, $2.2 million ($1.1 million General Fund and $1.1 million federal funds) in 2023-24, and $1.5 million ($743,000 General Fund and $742,000 federal funds) annually thereafter to continue to strengthen fiscal estimates and cash flow monitoring and provide resources for increasing and complex workloads. Specifically, DHCS requests the following positions and resources:

Fiscal Deputy Director's Office – One position

- **One Staff Services Manager (SSM) I** position would assist with providing support to fiscal staff members and programmatic process improvement initiatives; enhance financial reporting, monitoring, and oversight for internal and external partners; increase workforce training to enhance accounting knowledge and improve financial reporting; assist with managing Fiscal strategic initiatives impacting multiple DHCS divisions; develop training opportunities based on Fiscal strategic initiatives to improve workforce accounting and reporting knowledge; assist with researching and understanding complicated federal and state reporting regulations; and assist staff in gaining the skills necessary to manage the volume of significant and sensitive policy issues within DHCS.

Fiscal Forecasting Division – Four positions

- **One Health Program Specialist (HPS) I** position would redistribute workload from existing staff and alleviate excess workload and increase capacity for cross-training; and create additional capacity to address workload associated with numerous new programs and policies in the behavioral health area implemented in recent years.
- **One SSM II** position would create additional supervisory oversight of base estimate development functions, leading a new section to align estimate workload and free up capacity to focus on critical DHCS priorities related to cash management.
- **One Research Data Specialist (RDS) II** position would research existing tools, develop new tools, and improve the overall federal reporting process resulting in increased federal grant budget accuracy and reduced workload for the team.
- **One HPS II** position would support operations and special projects, assist with emergent workload that exceeds workload capacity, manage and implement Estimate improvement projects, manage and track complex intradepartmental information requests for the division, and assist with compiling Estimate summary documentation.

Financial Management Division – Accounting Section – One position and resources equivalent to three positions

- Resources equivalent to **one Accounting Administrator I Specialist** would assist with the increase in workload and to improve retention of quality staff, including: managing the CMS deferral process, implementation of Federal Draw and Reporting, and additional federal grant awards for behavioral health, and federal stimulus packages.

- Resources equivalent to **one Associate Accounting Analyst (AAA)** would support additional workload created by the increase in funds and increase in funding for existing funds that have to be reconciled and reported on and increase in GAAP accruals.
- **One AAA** would assist with reconciliation of various complex reports from internal program systems.
- Resources equivalent to **one AAA** would meet increased workload demands, including cashiering services for all programs with the DHCS, payments made to the department for revenues, reimbursement, Intergovernmental Transfers (IGTs) via checks, cash, and electronic fund transfer for depositing, posting in FI$Cal and remitting to the State Controller's Office for approval, reviewing the balance in the un-cleared collections Centralized Treasury System account, and remit to the appropriate State Funds within required timeframes.

Financial Management Division – Budget Branch – Four positions

- **One SSM II, one SSM I,** and **two Associate Governmental Program Analysts** would support increased workload related to overlapping due dates and shortened turnaround times, review of contract requests, new funds and enhanced reporting and oversight, training and technical assistance for internal partners regarding budget forecasting, and an increase in DHCS positions.

Business Operations Technology Services Division – Resources equivalent to two positions

- Resources equivalent to **two Information Technology Specialist I** positions would make needed upgrades to estimate systems and facilitate additional improvements to estimate transparency and usability.

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 22: Increased Program Workload

Budget Change Proposal – Governor's Budget. DHCS requests 35.5 positions and expenditure authority of $5.6 million ($2.5 million General Fund, $2.8 million federal funds, and $304,000 reimbursements) in 2022-23 and $5.3 million ($2.4 million General Fund, $2.6 million federal funds, and $286,000 reimbursements) annually thereafter. If approved, these positions and resources would allow DHCS to address increased program workload related to benefits, behavioral health financing, dental services, and administration.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$2,521,000	$2,390,000
0890 – Federal Trust Fund	$2,783,000	$2,644,000
0995 – Reimbursements	$304,000	$286,000
Total Funding Request:	**$5,608,000**	**$5,320,000**
Total Requested Positions:	**35.5**	**35.5**

* Positions and resources ongoing after 2023-24.

Background. According to DHCS, several of its divisions have experienced increased workload related to program administration. These divisions include the Benefits Division, the Local Government Financing Division, the Medi-Cal Dental Services Division, and various administrative divisions. The increases in workload are as follows:

- The Benefits Division reports increased workload related to: 1) new telehealth policies implemented during the pandemic; 2) benefit policies for new provider types, such as doulas and community health workers; 3) addition of the dyadic services benefit; 4) coverage of continuous glucose monitors; 5) development of COVID-19 vaccine coverage policies and incentives; 6) updates and clarifications to provider manuals; 7) increase in regulations; 8) increase in updates to Interagency Agreements; 9) updating policies for long-term care facilities; 9) review of benefit coverage questions in life care plans; 10) increase in the number of State Plan Amendments submitted to the federal Centers for Medicare and Medicaid Services (CMS); and 11) redirected responsibilities for coordination of policies for community clinics.
- The Local Governmental Financing Division reports increased workload related to its review of three behavioral health service delivery systems, including: 1) processing manual claims for reimbursement of administrative costs, utilization review and quality assurance costs, and interim and final cost settlements; 2) developing or processing interim rates; and 3) developing the November and May Medi-Cal Local Assistance Estimates.
- The Medi-Cal Dental Services Division reports increased workload related to its administration of the Administrative Services Organization and Fiscal Intermediary contracts for Denti-Cal, administration of contracts for Dental Managed Care, Proposition 56 supplemental payments for dental services, provider application and enrollment, supplemental payments available through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, and the dental integration pilot in San Mateo County.
- Various administrative divisions report increased workload due to the addition of significant resources to implement CalAIM, Quality Population Health Management, and the Children and Youth

Behavioral Health Initiative. This increased workload includes an increase in the number of contract and procurement requests with short deadlines, an increase in Enterprise Technology Services contract requests, and other personnel-related workload.

Staffing and Resource Request. DHCS requests 35.5 positions and expenditure authority of $5.6 million ($2.5 million General Fund, $2.8 million federal funds, and $304,000 reimbursements) in 2022-23 and $5.3 million ($2.4 million General Fund, $2.6 million federal funds, and $286,000 reimbursements) annually thereafter to address increased program workload related to benefits, behavioral health financing, dental services, and administration. Specifically, DHCS requests the following positions and resources:

Benefits Division – 11 positions

- **Two Staff Services Manager (SSM) III** positions would assist the Division Chief in planning, organizing, and directing the activities of the division; oversee Medi-Cal policies and procedures related to Medi-Cal benefits, as well as benefit programs, program financing, and federal claiming.
- **One Medical Consultant (MC) II** position would provide a licensed clinician to formulate policy for existing and new Medi-Cal benefits; give professional advice and guidance on the medical aspects of DHCS' programs, collaborate with a group of medical consultants and technical staff to review and establish medical policy while assuring uniformity, quality, and up-to-date decisions in the development of policies and standards relative to the BD's programs; provide technical guidance to other Division staff, DHCS divisions, providers, professional and community organizations, and other interested stakeholders; and assist with the implementation and interpretation of state and federal laws, as well as formulation of regulations, policies, and procedures relating to medical aspects of DHCS programs.
- **One Nurse Consultant (NC) III** position would provide expert nursing consultation and serve as a key member of the licensed professional team with responsibility for benefit policy planning, development and implementation; review and implement program initiatives; analyze legislation; develop appropriate policies and procedures for covered benefit; and assist in other program areas including but not limited to community health workers, and health education.
- **Two Health Program Specialist (HPS) II** positions would independently and in a lead capacity perform a variety of administrative, health program management, highly technical, and analytical tasks necessary to accomplish the goals and objectives of the program; coordinate and implement initiatives derived from the Preschool Development Grant (PDG) project, and enhancements and improvements to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); develop and implement department projects including telehealth policy, preventive services provided by community health workers and doulas, and support management by interpreting data, creating reports, and coordinating long-term projects; and coordinate the development of program policy and problem resolution recommendations with multiple departmental, immediate, and long-range impacts.
- **One HPS I** position would perform a variety of high level analytical tasks necessary to accomplish the goals and objectives of the program; work on extensive stakeholder engagement necessary to implement or update benefits, including developing State Plan Amendments, regulations, communication plans, and all associated notices for outreach to stakeholders; and ensure compliance with state and federal laws for benefits.
- **Four Associate Governmental Program Analysts (AGPAs)** would be responsible for oversight of eight interagency agreements (IAs), including invoice processing, updating IAs, contracts, program

evaluation, policy analysis, budgeting, and documentation reviews relating to the scope and duration of the program; and work on the PDG grant, EPSDT, and improvements to Medi-Cal for children.

Local Government Financing Division – Six positions

- **One SSM II** position would manage the Behavioral Health Fiscal Policy Section, be responsible for the planning and implementation of new and ongoing fiscal policies that impact the three behavioral health programs, including revisions to state plan amendments and federal waivers, overhaul of billing codes in the Short Doyle claims systems, implementation of behavioral health payment reform, cost report policies, updates to Short Doyle, and oversight of the county customer service support program.
- **Two SSM I** positions would supervise two new units within the Behavioral Health Fiscal Policy Section, which would be responsible for analyzing proposed fiscal policies, developing guidance and informational bulletins for stakeholders, developing Short Doyle system change requests and business rules for new policies, maintaining cost report templates and instructions, and providing support and technical assistance to counties via monthly calls and through the county customer support program.
- **One HPS I** position would be responsible for the additional workload related to the CalAIM initiatives and payment reform, and for ongoing fiscal policy analysis, including analyzing and developing rate methodologies for payment reform and providing technical assistance to counties related to CalAIM system changes.
- **Two AGPAs** would update cost report templates for the three behavioral health programs, assist with implementation of behavioral health payment reform including the transition to intergovernmental transfers, and develop technical assistance materials for counties.

Medi-Cal Dental Services Division – Four positions

- **One HPS II** position would provide subject matter expertise regarding the managed care final rule, serve as a division-wide resource to sustain business operations and administrative efficiencies, support the Division on special projects across various program areas and dental delivery systems, along with coordinating efforts across multiple divisions and external organizations, and discuss ongoing issues and develop recommendations for executive level management, verify knowledge transfer of takeover and turnover efforts, and deliver training and development of materials to division staff.
- **One Research Data Specialist (RDS) II** position would provide analytic support to the Division through tracking, monitoring, collaborating with other program areas, and responding to data requests from stakeholders and through the Public Records Act; and data mine, research, and analyze the Medi-Cal dental benefit for progress towards utilization goals and compliance with state and federal statutory reporting requirements.
- **Two AGPAs** would sustain the Division's operational and administrative workload that has increased since 2016 by supporting other units experiencing an influx of workload; continue oversight of six dental managed care (DMC) plans including validating timely receipt and review of all contract deliverables, verifying compliance with all contract and network adequacy requirements, providing ongoing technical assistance, and responding to plan inquiries; provide DMC performance insights, and create All-Plan Letters to convey policy interpretations and directives from federal and state policy changes to DMC plans.

Administration – 14.5 positions

- **One SSM I** position in the Contracts Division would provide technical and administrative knowledge required to formulate and implement solutions tailored to procurements.
- **Four SSM I** positions, **one Senior Personnel Specialist, one personnel Specialist,** and **three Associate Personnel Analysts** in the Human Resources Division would support increased workload related to additional department staff, including, classification, performance management, and management consultant issues with the Divisions; administration of the appropriate laws, rules, regulations, and contract language pertaining to personnel transactions, employee relations, and performance management; and address all facets of payroll, benefits, and various medical leaves.
- **One SSM I** and **3.5 AGPAs** in the Program Support Division would perform increased business services functions commensurate with the requested program staffing increases, including Records Management Program, Forms Management, Asset Management, and space planning to accommodate newly authorized positions and the transition to telework and a hybrid work environment.

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 23: Medi-Cal Enterprise Systems Modernization–Federal Draw and Reporting Operations

Budget Change Proposal – Governor's Budget. DHCS requests expenditure authority of $4.6 million ($2.3 million General Fund and $2.3 million federal funds) in 2022-23 and $4.6 million ($1.1 million General Fund and $3.4 million federal funds) in 2023-24. If approved, these resources would support the Federal Draw and Reporting system operations as part of the Medi-Cal Enterprise System Modernization project.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24**
0001 – General Fund	$2,290,000	$1,145,000
0890 – Federal Trust Fund	$2,289,000	$3,434,000
Total Funding Request:	**$4,579,000**	**$4,579,000**
Total Requested Positions:	**0.0**	**0.0**

Background. According to DHCS, the technology that supports the Medi-Cal program's ability to support its beneficiaries, the Medi-Cal Enterprise System (MES), is a fragile patchwork of systems that struggles to meet business needs, react timely to changing state and federal requirements, and is inefficient and unnecessarily costly to maintain. These issues prevent the Medi-Cal program from being able to deliver health services in modern ways that, for example, utilize data to understand local population needs and allow beneficiaries to have better access to services and their health care information. Much of the current systems were built during a time when the main method used for delivering services was a fee-for-service model. However, during the last few decades, major shifts have occurred such that over 80 percent of the Medi-Cal beneficiary population is covered through the managed care plan service delivery model. MES Modernization will take in to account the recent change in service delivery model and also plan for such changes in the future.

The MES Federal Draw and Reporting (FDR) project is replacing the legacy system, CMS-64, which supports federal expenditure reporting. The CMS-64 system has been fully supported by contract resources. As the FDR Design, Development and Implementation phase comes to a close at the end of June 2022, the FDR project will end and in July of 2022 will enter operations. The increase in operations cost supports monitoring system performance, making bug fixes, developing the Post Implementation Evaluation Report (PIER), security updates, patches, certification activities, testing the application after any changes are made, managing release activities and coordinating implementation tasks. Ongoing funding will be required in order to meet the operational responsibilities of FDR and to provide development, testing, and implementation activities for ongoing operations

Resource Request. DHCS requests expenditure authority of $4.6 million ($2.3 million General Fund and $2.3 million federal funds) in 2022-23 and $4.6 million ($1.1 million General Fund and $3.4 million federal funds) in 2023-24 to support the Federal Draw and Reporting system operations as part of the Medi-Cal Enterprise System Modernization project. Specifically, DHCS requests the following resources:

- $4.6 million in 2022-23 and 2023-24 would support contracts for engineering services ($3.3 million) and digital support services ($1.3 million)

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 24: Community Mental Health - Overview

Community Mental Health – *Three Year Funding Summary*			
Fund Source	**2020-21**	**2021-22**	**2022-23**
1991 Realignment (base and growth):			
Mental Health Subaccount	$220,057,000	$302,716,000	$363,202,000
2011 Realignment (base and growth):			
Mental Health Subaccount	$1,148,655,000	$1,141,311,000	$1,133,307,000
Behavioral Health Subaccount	$1,488,359,000	$1,769,398,000	$1,976,998,000
Realignment Total	**$2,857,071,000**	**$3,213,425,000**	**$3,473,507,000**
Medi-Cal SMHS Federal Funds	**$2,985,445,000**	**$2,966,042,000**	**$2,936,719,000**
Medi-Cal SMHS General Fund	**$420,571,000**	**$419,206,000**	**$384,449,000**
MHSA Local Expenditures	**$2,773,591,000**	**$3,350,340,000**	**$3,469,384,000**
Total Funds	**$9,036,678,000**	**$9,949,013,000**	**$10,264,059,000**

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:

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 –** 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

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

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 Department of Health Care Access and Information (HCAI, formerly 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 25: Short-Term Residential Therapeutic Program Support for IMD Exclusion Transition

Local Assistance – Governor's Budget. DHCS requests General Fund expenditure authority of $712,000 in 2021-22 and $6 million in 2022-23. If approved, these resources would support Medi-Cal services provided to Medi-Cal beneficiaries in short-term residential therapeutic programs classified as Institutes for Mental Disease.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$712,000	$6,017,000
0890 – Federal Trust Fund	($712,000)	($6,017,000)
Total Funding Request:	**$-**	**$-**

Background. The federal Families Firs Prevention Services Act (FFPSA), enacted in 2018, was intended to restrict the use of congregate care, unless absolutely necessary by limiting payments to specific types of congregate care settings meeting certain requirements. The act added Qualified Residential Treatment Programs (QRTPs) as an allowable congregate care setting for children and youth requiring a therapeutic placement as long as specific criteria are met. In California, regulatory requirements for short-term residential therapeutic programs (STRTPs) are similar to QRTPs. However, some of the definition criteria for QRTPs overlap with the criteria used to determine if a facility is an Institute for Mental Disease (IMD), for which federal matching funds are prohibited under Title XIX of the Social Security Act, which governs the Medicaid program.

In July 2020, CMS indicated that it could not provide a blanket assurance that all of the STRTPs operated in the state are not IMDs. As a result, DHCS must assess each STRTP to determine whether it meets the criteria as an IMD. In addition, DHCS reports that CMS has developed a waiver opportunity for states to receive federal funds for mental health services provided to populations with a serious mental illness or serious emotional disturbance. DHCS intends to apply for the waiver in fall 2022.

Local Assistance Request. DHCS requests General Fund expenditure authority of $712,000 in 2021-22 and $6 million in 2022-23 to support Medi-Cal services provided to Medi-Cal beneficiaries in short-term residential therapeutic programs classified as Institutes for Mental Disease.

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 26: Short-Term Residential Therapeutic Program Approval, Oversight, and Monitoring

Budget Change Proposal – Governor's Budget. DHCS requests nine positions and expenditure authority of $1.3 million ($661,000 General Fund and $661,000 federal funds) annually. If approved, these positions and resources would allow DHCS to provide oversight, monitoring, and reviews of short-term residential therapeutic programs, mental health program approval, and children's crisis residential programs.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$661,000	$661,000
0890 – Federal Trust Fund	$661,000	$661,000
Total Funding Request:	**$1,322,000**	**$1,322,000**
Total Requested Positions:	**9.0**	**9.0**

* Positions and resources ongoing after 2023-24.

Background. Continuum of Care Reform (CCR) requires DHCS, the California Health and Human Services Agency, the Department of Education, the Department of Social Services, Associations, the Legislature and stakeholders to collaborate, in a transparent manner, and make statutory, regulatory, and administrative changes to improve timely access for children to available level of care options. In particular, CCR requires a state-level focus on increasing access to children's residential and community-based services to better meet therapeutic, outpatient, and inpatient behavioral health needs.

Consequently, the intended outcome for children and youth when placed in a short-term residential therapeutic program (STRTP) with a mental health program approval (MHPA) is greater access to available services, reduction in lengths of stay in residential placement, improved health outcomes, and a defined established pathway, especially for those in California's foster care system, to family reunification or adoption in a home-based community setting.

DHCS, or its delegated county mental health plan (MHP), is required to approve initially and annually thereafter the MHPA for STRTPs. Prior to 2020, 11 of the 57 MHPs accepted delegation of the MHPA but subsequently, two relinquished delegation. As a result, only nine of the 57 MHPs currently maintain their delegation of the MHPAs. Due to the low amount of counties accepting delegation, DHCS is tasked with the review of applications and all documents required as part of the program statement, initial onsite reviews, and annual onsite reviews for all of the STRTP providers throughout the remaining 48 counties, as well as overseeing the nine delegate counties to meet compliance with mental health program standards.

DHCS oversight activities may include interviews with residing children and clinical staff as well as reviewing any complaint files. When applicable, DHCS also takes administrative actions against STRTPs, including the denial, suspension, or revocation of MHPA approvals or imposition of sanctions or corrective action plans. Other actions undertaken by DHCS may include carrying out formal complaint investigations and due process functions resulting from provider informal disputes or appeals regarding identified deficiencies or corrective action plan findings resulting from DHCS or delegate compliance review.

Although nine MHPs have delegated authority to issue MHPAs, DHCS continues to provide oversight and policy guidance to delegate counties to meet program consistency in meeting MHPA standards throughout the state. In addition, DHCS recently received interest from three counties to develop CCRP programs. CCRP is in a developmental phase, which includes updates to interim and final promulgation of regulations, application process, onsite review protocols, staff training, and technical assistance resources for STRTPs to convert or expand their programs.

Staffing and Resource Request. DHCS requests nine positions and expenditure authority of $1.3 million ($661,000 General Fund and $661,000 federal funds) annually to provide oversight, monitoring, and reviews of short-term residential therapeutic programs, mental health program approval, and children's crisis residential programs. Specifically, DHCS requests the following positions and resources:

- **One Staff Services Manager (SSM) II** position would direct and oversee the STRTP Section; provide oversight and personnel management of the section; plan, organize, monitor and oversee the statewide MHPAs for all STRTPs and CCRPs; communicate with upper management regarding the status of provider MHPAs, delegate county assignments, and provide recommendations on any areas of concern; direct and coordinate the review process for initial and annual reviews, supervise the Section to allow DHCS to meet its obligations and all work associated with the MHPA, and address the most complex issues; collaborate with the Department of Social Services (CDSS) as the licensing authority, delegate counties and the county MHPs, providers, and other stakeholder groups, and make certain accurate information is available in order to provide updates to the Legislature; and ensure that MHPA data is maintained and organized accurately on an ongoing basis to brief upper management, executive staff, and legislative aides.
- **Two SSM I** positions would assume supervisory responsibility of assigned regions of the state and direct the work of their unit in carrying out the required initial and annual MHPAs and all associated work; be responsible for recruitment, hiring, training and managing of staff; and manage and coordinate each MHPA application, provide oversight, training, and technical assistance to staff regarding continuum of care reform, MHPA processes and procedures, relevant statutory requirements, the delegation of tasks, and legislative bill analyses impacting STRTPs and CCRPs.
- **Two Health Program Specialist (HPS) II** positions would perform the most complex reviews and investigations of STRTPs statewide and lead the timely development and publication of MHPA regulations and policy guidance that communicates to group homes and STRTPs the administrative and regulatory requirements and expectations specified in published STRTPs/CCRPs interim regulations; conduct ongoing statewide and individualized intensive technical assistance required to assist STRTPs, state-level partners, and stakeholders in understanding the administrative operational actions necessary to maintain MHPAs/CCRPs pursuant to federal and state law.
- **Two HPS I** positions would serve as subject matter experts assisting staff and conducting initial and annual reviews for the STRTP and CCRPs throughout California when there is the need for assistance due to the intensity of the review or needs of the provider; conduct research and analysis to develop recommendations to challenges identified during onsite reviews, assist in developing policy and regulatory changes; oversee data tracking elements of all STRTPs statewide and provide management with a current tracking log of all approvals, denials, average time to process approvals, trending of program deficiencies and any other reporting requirements management and executive leadership require to report to the Legislature; and provide oversight of delegated counties.

- **Two Associate Governmental Program Analysts** would be responsible for performing the oversight and monitoring of STRTPs and CCRPs, including conducting the initial review of MHPA applications and supporting documents and issuing approvals.

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 27: Behavioral Health Workload

Budget Change Proposal – Governor's Budget. DHCS requests 34 positions and expenditure authority of $21.2 million ($9.8 million General Fund, $10.6 million federal funds, and $883,000 reimbursements) in 2022-23, $20.9 million ($9.6 million General Fund, $10.4 million federal funds, and $883,000 reimbursements) in 2023-24 and 2024-25, $5.2 million ($1.8 million General Fund, $2.6 million federal funds, and $883,000 reimbursements) in 2025-26, $4.3 million ($1.8 million General Fund and $2.6 million federal funds) in 2026-27, and $3.6 million ($1.4 million General Fund and $2.2 million federal funds annually thereafter. If approved, these positions and resources would allow DHCS to address increased workload related to behavioral health services.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$9,755,000	$9,629,000
0890 – Federal Trust Fund	$10,601,000	$10,430,000
0995 - Reimbursements	$883,000	$883,000
Total Funding Request:	**$21,239,000**	**$20,942,000**
Total Requested Positions:	**34.0**	**34.0**

* Addl. fiscal year resources - 2024-25: $20,942,000; 2025-26: $5,230,000; 2026-27: $4,347,000; 2027, ongoing: $3,643,000.

Background. According to DHCS, unprecedented federal and state attention to addressing behavioral health needs has required increased workload to ensure behavioral health services are accessible, timely, high-quality, equitable, culturally appropriate, and integrated. County behavioral health departments are also transitioning from serving as provider organizations to assuming responsibilities required due to implementation of new federal rules. DHCS is tasked with setting a high standard for county performance, aligning expectations across the department for all delivery systems, and ensuring that mental health plans (MHPs), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) meet these high standards. The following divisions expect additional workload in achieving these goals:

- The Medi-Cal Behavioral Health Division expects additional workload to meet state and federal requirements and rising expectations of performance of the behavioral health system, including:
  - Network adequacy oversight
  - Data and operational quality improvement
  - Expansion of the Behavioral Health Quality Improvement Program (BHQIP)
  - Implementation of the Medi-Cal Mobile Crisis Intervention Benefit
  - Implementation of the 90 day justice-involved in-reach program
  - Technical assistance to counties for compliance with federally required interoperability standards
  - Support of the federal Families First Prevention Services Act (FFPSA), related to services for foster youth
  - Support for administration of the Children's Crisis Continuum Pilot program
- The Office of Legal Services expects increased investigation and enforcement workload for substance use disorder treatment providers.
- The Community Services Division is experiencing increased workload across many programs, including administration of recurring federal grants, including the Substance Abuse Block Grant

(SABG), the Mental Health Block Grant (MHBG), Projects for Assistance in Transition from Homelessness (PATH), State Opioid Response grants, and COVID-19 related grants.

Staffing and Resource Request. DHCS requests 34 positions and expenditure authority of $21.2 million ($9.8 million General Fund, $10.6 million federal funds, and $883,000 reimbursements) in 2022-23, $20.9 million ($9.6 million General Fund, $10.4 million federal funds, and $883,000 reimbursements) in 2023-24 and 2024-25, $5.2 million ($1.8 million General Fund, $2.6 million federal funds, and $883,000 reimbursements) in 2025-26, $4.3 million ($1.8 million General Fund and $2.6 million federal funds) in 2026-27, and $3.6 million ($1.4 million General Fund and $2.2 million federal funds annually thereafter to address increased workload related to behavioral health services. Specifically, DHCS requests the following positions and resources:

Medi-Cal Behavioral Health Division – 27 positions and resources equivalent to five positions

- **One Staff Services Manager (SSM) I** position, **one Health Program Specialist (HPS) II** position, **two HPS I** positions, and **five Associate Governmental Program Analysts (AGPAs)** would support network adequacy and oversight, including developing and implementing new network adequacy measures such as adequate residential and inpatient networks, mobile crisis services, foster care services, and other top network adequacy priorities, in consultation with the County Behavioral Health Directors Association and other stakeholders; assist in developing reporting strategies; provide technical assistance to counties for the understanding of requirements and reporting; collect and analyze county data; review and respond to alternate access standard requests; issue corrective action plans or sanctions; monitor corrective action plans and assist counties in achieving compliance; and continue to evolve measures and oversight approach year by year, including leading consultation with stakeholders.
- **One SSM I** position and **seven AGPAs** would work closely with counties on the building blocks of quality data and operations, and verifying the core quality assurance functions are met; develop new standards for Quality Improvement (QI) plans and county QI projects, issuing guidance to reflect the new standards, and meeting with individual county MHPs and DMC-ODS plans frequently to provide technical assistance; aligning county improvement efforts with DHCS statewide priorities; monitoring and overseeing development of goals, milestones and metrics; analyzing county submissions and data; working with counties on improvement opportunities; problem-solving through barriers; and ensuring the county plan makes continuing progress.
- **Two HPS II** positions to support the expansion of BH-QIP, including the new 5-year limited term mobile crisis intervention services Medi-Cal benefit, implementation of the DHCS 90-day justice in-reach program, and compliance with new interoperability standards
- **Three AGPAs** would work with stakeholders on implementation plans for community-based mobile crisis intervention services, including how crisis teams would interplay with the new national 988 line, submit a new state plan amendment, develop and issue guidance, amend regulations, and provide oversight to counties to make sure services are billed appropriately on an ongoing basis.
- Resources equivalent to **one SSM I** position, **one HPS II** position, **one HPS I** position, and **two AGPAs** would support start-up workload related to FFPSA, including multi-year policy and program implementation, facilitation of workgroups, engagement with stakeholders, and providing trainings and technical assistance to MHPs.
- **One SSM I** position, **two HPS I** positions, and **two AGPAs** would support the development and realization of the full spectrum continuum of care for youth with an emphasis on crisis service

expansion; provide leadership to the DHCS team and direct supervision of the work activities of the team; serve key roles in rendering a needs assessment to determine how to best allocate resources, and support the team to leverage existing resources in conjunction with new resources to assure the continuum fully addresses the complex needs of the foster care population; and engage with counties and stakeholders around the specific needs of the continuum, assuring details like capacity ration and co-location of service levels are met.

- DHCS also requests expenditure authority of $15 million ($7.5 million General Fund and $7.5 million federal funds) in 2022-23 through 2024-25 for contract resources to provide county technical assistance and training for three initiatives: 1) mobile crisis intervention services, 2) 90 day jail in-reach, and 3) county compliance with new interoperability standards.

Community Services Division – Five positions

- **One SSM III** position, **one SSM II** position, **one SSM I** position, and **two HPS I** positions would support administration of federal grants in the Community Services Division, alleviating increased workload related to annual county applications, county performance contracts, and other certification workload.

Office of Legal Services – One position

- **One Attorney IV** position would supports the Behavioral Health, Licensing and Certification Division (LCD), in the investigation, suspension, and revocation of licenses for Alcohol and Other Drug (AOD) Recovery and Treatment Programs, including assisting and advising on investigations of program providers, drafting accusations suspending or revoking licenses, and representing LCD and DHCS before the Office of Administrative Hearings in settlement conference and evidentiary hearings.

Deputy Director's Office – One position

- **One Career Executive Appointment B** position would serve as Assistant Deputy Director; provide the necessary leadership to help implement the Administration's ambitious behavioral health policy agenda; guide initiatives and respective staff in making sure the timelines are met; and focus primarily on the crisis continuum of care, children and youth issues in behavioral health, emergency response initiatives such as CalHOPE and other crisis counseling programs, collaborative efforts between the CDSS and DHCS to improve the foster care system, and data transparency.

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 28: Behavioral Health Timely Access to Care Oversight (SB 221)

Budget Change Proposal – Governor's Budget. DHCS requests eight positions and expenditure authority of $1.3 million ($660,000 General Fund and $660,000 federal funds) in 2022-23 and $1.2 million ($624,000 General Fund and $624,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to perform compliance oversight of Medi-Cal managed care plan timely access to care requirements for follow-up behavioral health services, pursuant to the requirements of SB 221 (Wiener), Chapter 724, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$660,000	$624,000
0890 – Federal Trust Fund	$660,000	$624,000
Total Funding Request:	**$1,320,000**	**$1,248,000**
Total Requested Positions:	**8.0**	**8.0**

* Positions and resources ongoing after 2023-24.

Background. SB 221 (Wiener), Chapter 724, Statutes of 2021, codifies existing timely access to care standards for health plans and insurers, applies those requirements to Medi-Cal managed care plans, prohibits contracting providers and employees from being disciplined for informing patients about timely access standards, and adds a new standard for non-urgent follow up appointments for non-physician mental health care or substance use disorder providers that is within 10 business days of the prior appointment. The provisions of SB 221 apply to Medi-Cal managed care plans, county mental health plans (MHPs), and Drug Medi-Cal Organized Delivery System (DMC-ODS) plans.

According to DHCS, SB 221 imposes the following additional requirements:

- SB 221, commencing July 1, 2022, adds an appointment time standard for non-urgent follow-up appointments with a non-physician mental health care or SUD provider, with a follow-up appointment required within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or SUD condition. Currently, there are no timely access requirements for follow-up appointments for any provider type.
- SB 221 requires referrals to a specialist by a primary care provider or another specialist to be subject to the relevant time-elapsed standards established in the bill, unless specified requirements are met. Currently, there are no timely access requirements related to referrals.
- SB 221 requires interpreter services to be coordinated with scheduled appointments for health care services in a manner that facilitates the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment. Currently, the delay of scheduling an appointment in this circumstance is not prohibited.
- SB 221 requires out-of-network coverage if medically necessary treatment of a mental health disorder or SUD is not available in network within the geographic and timely access standards.

Staffing and Resource Request. DHCS requests eight positions and expenditure authority of $1.3 million ($660,000 General Fund and $660,000 federal funds) in 2022-23 and $1.2 million ($624,000 General Fund and $624,000 federal funds) annually thereafter to perform compliance oversight of Medi-

Cal managed care plan timely access to care requirements for follow-up behavioral health services, pursuant to the requirements of SB 221 (Wiener), Chapter 724, Statutes of 2021. Specifically, DHCS requests the following positions and resources:

Managed Care Quality Management Division – Four positions

- **Two Associate Governmental Program Analysts (AGPAs)** would draft updates to managed care contracts, Evidence of Coverage, and All Plan Letters and other policy guidance related to the bill's requirements regarding triaging for SUDs and new timely access requirements; review managed care plan responses on a quarterly basis for instances of non-compliance; provide technical assistance to managed care plans when issues of non-compliance are found; compose analytical reports, and develop and present data-informed recommendations to staff; and monitor the execution of developed planning activities processes and procedures within the developed timeframes.
- **One Health Program Specialist I** position would contribute to the development of implementation timelines, roles and responsibilities, processes and procedures, and other planning activities; work with the External Quality Review Organization to update the timely access methodology; lead policy development related to timely access requirements for follow-up appointments; work with managed care plans on implementation; draft a timely access All-Plan Letter to communicate policy guidance; ensure the managed care plan contract, Evidence of Coverage, and any applicable All-Plan Letters reflect updated policy; monitor efforts to improve plan and provider compliance; and provide technical assistance to plans when necessary.
- **One Staff Services Manager I** position would lead the development of implementation timelines, roles and responsibilities, processes and procedures, and other planning activities; review and approve updates to plan policies and procedures related to the new timely access requirements; oversee technical assistance; lead development of plan guidance to monitor compliance with the new requirements.
- DHCS also requests expenditure authority of $127,000 ($64,000 General Fund and $63,000 federal funds) for additional contractor support from the External Quality Review Organization (EQRO) to monitor compliance with the new timely access requirements of SB 221.

Medi-Cal Behavioral Health Division – Four positions

- **Two Associate Governmental Program Analysts (AGPAs)** would analyze and research the new requirements; develop tools, in collaboration with stakeholders, for implementation; provide technical assistance to MHPs and DMC-ODS counties; assist with drafting Behavioral Health Information Notices (BHIN) or other policy guidance documents; compose analytical reports; develop and present data-informed recommendations to management; and perform ongoing monitoring of MHPs and DMC-ODS counties' compliance with the timely access requirements in SB 221.
- **One Health Program Specialist I** position would contribute to the development of implementation timelines, roles and responsibilities, processes and procedures, and other planning activities; work with the External Quality Review Organization to update the timely access methodology; lead policy development related to timely access requirements for follow-up appointments; work with MHPs and DMC-ODS counties on implementation; draft a timely access BHIN to communicate policy guidance; ensure the MHP and DMC-ODS contract, Evidence of Coverage, and any applicable BHINs reflect updated policy; monitor efforts to improve MHP, DMC-ODS, and provider compliance; and provide technical assistance to MHPs and DMC-ODS counties when necessary.

- **One Staff Services Manager I** position would lead the development of implementation timelines, roles and responsibilities, processes and procedures, and other planning activities; review and approve updates to plan policies and procedures related to the new timely access requirements; oversee technical assistance; lead development of plan guidance to monitor compliance with the new requirements.

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 29: Medication Assisted Treatment Expansion Program

Budget Change Proposal – Governor's Budget. DHCS requests five positions and expenditure authority of $101 million ($96 million General Fund and $5 million Opioid Settlement Fund) in 2022-23 and General Fund expenditure authority of $61 million annually thereafter. If approved, these positions and resources would support the Medication Assisted Treatment (MAT) Expansion Project, which reduces overdose and death related to opioid misuse by expanding MAT access statewide.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
State Operations:		
0001 – General Fund	$3,747,000	$3,702,000
3397 – Opioid Settlement Fund	$250,000	$-
Local Assistance:		
0001 – General Fund	$92,253,000	$57,298,000
3397 – Opioid Settlement Fund	$4,750,000	$
Total Funding Request:	**$101,000,000**	**$61,000,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and resources ongoing after 2023-24.

Background. California has received federal funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) through the State Opioid Response (SOR) grants to reduce the adverse effects of opioid use disorders (OUD) in the state. SOR, SOR Supplement, and SOR 2 are state discretionary, non-competitive grants that have 24 month periods of performance, beginning on September 30, 2018. DHCS created the Medication Assisted Treatment (MAT) Expansion Project which addresses opioid use disorder (OUD) by increasing the available prevention, treatment, harm reduction, and recovery services in the state. The project has a special focus on populations with limited access to MAT, considered to be the evidence-based gold standard for treatment of OUD.

According to DHCS, the goals of the MAT Expansion Project are to increase access to MAT, reduce unmet treatment need, and reduce opioid related overdose deaths through prevention, treatment, harm reduction, and recovery activities. The project has a special focus on populations with limited MAT access, including youth, people in rural areas, and American Indian & Alaska Native tribal communities. DHCS supports projects wherever individuals with a SUD seek help, including health care settings, justice systems, and treatment programs. The project also includes media campaigns, engagement of opioid safety coalitions, naloxone distribution, supportive housing, and other efforts.

DHCS reports the some of the outcomes of the 27 projects in the MAT Expansion Project include: 88,770 patients treated for OUD, 6,848 patients treated for stimulant use disorder, 32,895 stakeholders trained on MAT and the science of addiction, 650 new access point locations and over 50,000 overdose reversals through the Naloxone Distribution Project (NDP). DHCS seeks to expand selected projects within the MAT Expansion Project to enhance the NDP, increase MAT services within state-licensed facilities, support 100 new MAT Access Points, and expand MAT in county jails and drug courts.

Local Assistance, Staffing and Resource Request. DHCS requests five positions and expenditure authority of $101 million ($96 million General Fund and $5 million Opioid Settlement Fund) in 2022-23 and General Fund expenditure authority of $61 million annually thereafter to support the MAT Expansion Project, which reduces overdose and death related to opioid misuse by expanding MAT access statewide. Specifically, DHCS requests the following positions and resources:

Naloxone Distribution Project

- Local assistance funding would allow DHCS to fulfill all requests for naloxone distribution, approximately 400,000 units per year. DHCS estimates this expansion would lead to more than 100,000 additional reported opioid reversals.

Increasing MAT Services in State-Licensed Facilities - $23.5 million in 2022-23, $21.8 million ongoing

- Local assistance funding would assist existing providers to expand the provision of MAT and provide startup funds for new providers that want to provide MAT.

100 New MAT Access Points - $24 million in 2022-23

- Local assistance funding would expand access to additional MAT locations, including stimulant use prevention and treatment in communities of color and treatment in tribal communities.

Expanding MAT in County Jails and Drug Courts - $9 million in 2022-23

- Local assistance funding would continue technical assistance for jails in current counties and to increase county participation in MAT.

State Operations – Community Services Division – Five positions

- **One Staff Services Manager I** position, **one Health Program Specialist II** position, and **three Associate Governmental Program Analysts** would provide oversight and administration of the various MAT Expansion Project programs, including contracts and monitoring, development of program requirements and requests for applications, collection of data, monitoring of grantees, on-site visits, and assuring that all services are provided in accordance with federal and state laws and regulations.

Contract Resources

- DHCS requests General Fund expenditure authority of $3 million annually to support contract resources to increase MAT services within state-licensed facilities, including technical assistance and training during implementation.
- DHCS requests expenditure authority from the Opioid Settlement Fund of $250,000 in 2022-23 to support contract resources to approve NDP applications, work with applicants to facilitate application submission, process invoices, provide technical assistance to DHCS and grantees, and develop and disseminate NDP promotional and educational materials.

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 30: Oversight of Insurance Policies for Recovery or Treatment Facilities (AB 1158)

Budget Change Proposal – Governor's Budget. DHCS requests four positions and expenditure authority from the Residential Outpatient Licensing Fund of $626,000 in 2022-23, and $590,000 annually thereafter. If approved, these positions and resources would address increased workload related to monitoring compliance of insurance policies for licensed alcohol and other drug recovery or treatment facilities, pursuant to the requirements of AB 1158 (Petrie-Norris), Chapter 443, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
3113 – Residential/Outpatient Program Licensing Fund	$626,000	$590,000
Total Funding Request:	**$626,000**	**$590,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and resources ongoing after 2023-24.

Background. AB 1158 (Petrie-Norris), Chapter 443, Statutes of 2021, requires a licensee operating an alcoholism or drug abuse (AOD) recovery or treatment facility and serving more than six residents to maintain specified insurance coverages, including, among others, commercial general liability insurance and employer's liability insurance. AB 1158 requires a licensee that serves six or fewer residents to maintain general liability insurance coverage.

In addition, any government entity that contracts with a privately owned recovery residence or an alcoholism or drug abuse recovery or treatment facility to provide, respectively, recovery services or treatment services for more than six residents, must require the contractor to maintain those insurance coverages. If a residence or facility provides services for six or fewer residents, AB 1158 requires the government entity to require the contractor to maintain general liability insurance coverages, as specified.

According to DHCS, current regulations do not require licensed AOD recovery or treatment facility providers to obtain or maintain insurance coverage. However, general liability insurance is typically obtained by providers because it protects their business against general liability claims. Insurance is often identified on the provider's line item budget which they must provide to the department as a requirement for licensure.

AB 1158 requires a more in-depth level of review and analysis for all licensed AOD recovery or treatment facilities. This new requirement increases the overall volume of workload for DHCS to monitor licensed AOD recovery or treatment facilities for compliance. This responsibility includes ensuring licensed AOD recovery or treatment facilities' compliance by obtaining and maintaining the required minimum insurance policies set forth in the bill. AB 1158 requires DHCS staff to monitor AOD recovery or treatment facilities' insurance coverage, which includes additional analysis during initial application review, expansions, renewals and population changes as well as monitoring of existing providers. DHCS will be responsible for promulgating regulations and DHCS staff will incur additional travel expenses, such as weekly airfare, per diem, taxi fares, and hotel rentals associated with compliance monitoring and investigations of insurance complaints against AOD recovery or treatment facilities. According to DHCS, these requirements would also increase time devoted to licensing activities, inspections, and renewals.

Staffing and Resource Request. DHCS requests four positions and expenditure authority from the Residential Outpatient Licensing Fund of $626,000 in 2022-23, and $590,000 annually thereafter to address increased workload related to monitoring compliance of insurance policies for licensed alcohol and other drug recovery or treatment facilities, pursuant to the requirements of AB 1158. Specifically, DHCS request the following positions and resources:

- **One Associate Governmental Program Analyst (AGPA)** would support processing of additional complaints related to the new requirements of AB 1158.
- **Two AGPAs** would support additional licensing workload related to ensuring program compliance with AB 1158.
- **One Health Program Specialist II** position would verify the accuracy and compliance of insurance policies pursuant to AB 1158, and would promulgate 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.

Issue 31: Home- and Community-Based Services Spending Plan – American Rescue Plan Act

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

The 2021 Budget Act included Control Section 11.95, which authorized expenditure of $3 billion of HCBS funding received under the provisions of ARP. In July 2021, DHCS submitted California's $4.6 billion HCBS Spending Plan to the federal Centers for Medicare and Medicaid Services for review and approval. DHCS estimated that the $3 billion investment of HCBS funds would draw down an additional $1.6 billion of federal Medicaid matching funds. The HCBS Spending Plan included the following programs administered by DHCS:

- **Housing and Homelessness Incentive Program.** $161.1 million ($80.5 million HCBS funds) in 2021-22 and $644.2 million ($322.1 million HCBS funds) in 2022-23 supports payments to Medi-Cal managed care plans to incentivize investments and progress in addressing homelessness and keeping people housed.
- **Community-Based Residential Continuum Pilot.** $287.2 million ($106.1 million HCBS funds) in 2022-23 supports the Community-Based Residential Continuum Pilot, which will provide medical and supportive services in the home, independent living setting including permanent supportive housing and community care settings, to avoid unnecessary healthcare costs such as emergency services or skilled nursing.
- **Non-In-Home Supportive Services (IHSS) Care Economy Payments.** $12.5 million ($6.3 million HCBS funds) would provide a one-time incentive payment of $500 to each current direct care, non-IHSS provider of Medi-Cal home- and community-based services during a minimum of two months between March 2020 and March 2021.
- **Assisted Living Waiver Expansion.** $10.8 million ($3 million HCBS funds) in 2021-22 and $32.4 million ($8.9 million HCBS funds) would support expansion of the Assisted Living Waiver to eliminate the waiting list. This funding would support an additional 7,000 slots, with 5,000 from the community.
- **Contingency Management.** $3.6 million HCBS funds in 2021-22 and $23.1 million ($11.5 million HCBS funds) in 2022-23 would support contingency management as a service under the Drug Medi-Cal Organized Delivery System (DMC-ODS). Contingency management uses small motivational incentives combined with behavioral health treatment as the only effective treatment for stimulant use disorder.
- **CalBridge Behavioral Health Pilot Program.** $40 million HCBS funds in 2021-22 supports grants to acute care hospitals to hire trained behavioral health navigators in emergency departments to screen patients and offer intervention and referral to mental health or substance use disorder programs.

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 American Rescue Plan Act's HCBS provisions and how they provide funding for the HCBS Spending Plan.

2. Please provide a brief overview of the following DHCS programs supported by the HCBS Spending Plan:
   a. Contingency Management
   b. Housing and Homelessness Incentive Program
   c. Community-Based Residential Continuum Pilot
   d. CalBridge Behavioral Health Pilot Program
   e. Non-IHSS Care Economy Payments
   f. Assisted Living Waiver Expansion

Issue 32: Home- and Community-Based Alternatives Waiver

Local Assistance – Governor's Budget. DHCS requests expenditure authority of $263.8 million ($131.9 million General Fund and $131.9 million federal funds) in 2021-22 and $304 million ($152 million General Fund and $152 million federal funds) in 2022-23 to support costs associated with the Home- and Community-Based Alternatives Waiver renewal, which would be effective January 1, 2022.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$131,887,000	$152,000,000
0890 – Federal Trust Fund	$131,887,000	$152,000,000
Total Funding Request:	**$263,774,000**	**$304,000,000**

Background. The Home- and Community-Based Alternatives Waiver offers services in the home or community to Medi-Cal beneficiaries who would otherwise receive care in a skilled nursing facility. The Waiver delivers care management services provided by a multidisciplinary team comprised of a nurse and social worker. The team coordinates Waiver and other Medi-Cal services and arranges for other available long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's home or other community-based residence.

The current HCBA Waiver was implemented effective January 1, 2017, and expired on December 31, 2021. DHCS has submitted a waiver renewal application to the federal Centers for Medicare and Medicaid Services (CMS) for a new five-year term, from January 1, 2022, to December 31, 2026. The new waiver application requested the following new provisions:

- Increased number of slots available under the waiver
- Expansion of Community Transition Services, making it available to participants living in the community who require essential goods or services to make their community-based residence safe and keep them out of an institution.
- Adding Assistive Technology as a new waiver services.
- Increasing the rate paid to Personal Care Agencies that provider Waiver Personal Care Services, in compliance with increases in the state minimum wage.

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

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

1. Please provide a brief update on the changes that would be implemented by the renewal of the HCBA Waiver.

Issue 33: Cognitive Health Assessments (SB 48)

Local Assistance – Governor's Budget. DHCS requests expenditure authority of $341,000 ($170,500 General Fund and $170,500 federal funds) in 2022-23 to support annual cognitive health assessments for Medi-Cal only beneficiaries age 65 or older, pursuant to the requirements of SB 48 (Limon), Chapter 484, Statutes of 2021.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$-	$170,500
0890 – Federal Trust Fund	$-	$170,500
Total Funding Request:	**$-**	**$341,000**

Background. SB 48 (Limon), Chapter 484, Statutes of 2021, requires an annual cognitive health assessment as a covered benefit for Medi-Cal beneficiaries age 65 years and older, if they are otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare Program. The assessment, which is available for Medicare beneficiaries, had not previously been available to the over 180,000 Californians over 65 in Medi-Cal only. The benefit would be implemented as of July 1, 2022 and payments would begin August 2022.

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 34: Managed Care Procurement and Alternative Health Care Service Plan Contract

Reprocurement of Medi-Cal Managed Care and Trailer Bill Language – Governor's Budget. On February 9, 2022, DHCS released a Request for Proposal (RFP) for its commercial managed care plan contracts. According to DHCS, it is seeking managed care plans committed and able to advance equity, quality, access, accountability, and transparency to reduce health disparities and improve health outcomes for Californians. While the RFP is only for commercial plans, DHCS indicates the updated contract released with the RFP will be executed with all Medi-Cal managed care plans, including local initiatives and County Organized Health Systems, as of January 1, 2024.

In addition to the reprocurement process, DHCS proposes trailer bill language to allow it to enter into a direct contract with Kaiser Permanente as a Medi-Cal managed care plan within new geographic regions of the state, effective January 1, 2024, for a five year contract term, with the potential for contract extensions. Under the new contract, Kaiser would operate as a full-risk, full-scope Medi-Cal managed care plan, consistent with other Medi-Cal managed care plans and without specific exceptions or alternative standards. However, Kaiser would not be open to beneficiaries through the traditional Medi-Cal plan choice methods, but would only be available to existing Kaiser members in both Medi-Cal and commercial lines of business. Kaiser would also commit to growth of its Medi-Cal members by 25 percent by the end of the five year term.

Forty Years of Medi-Cal Managed Care. The managed care model of health care service delivery in California began in the 1970s with legislation that culminated in passage of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). In addition to regulatory oversight of the commercial managed care market, the Knox-Keene Act authorized the state to license health maintenance organizations and pre-paid health plans to enroll Medi-Cal beneficiaries. Beginning in 1981, the state began licensing different models of managed care delivery for Medi-Cal beneficiaries in different counties. Today, there are four primary models of managed care delivery in the Medi-Cal program:

- *County Organized Health Systems* – In 1982, the Legislature authorized the creation of three county organized health systems (COHS), which are county-administered managed care plans. Santa Barbara and San Mateo Counties were the first COHS plans to enroll beneficiaries (a COHS was planned in Monterey, but was never implemented), while Congress approved three additional COHS (Santa Cruz, Solano, and Orange) counties in 1990. The authorization for COHS requires that they be an independent, public entity and that they meet the regulatory requirements of the state's Knox-Keene Act. However, they need not obtain a license under the Knox-Keene Act, as they are specifically exempted. There are currently twenty-two counties in the COHS model: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo. Eight of these counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) were part of the expansion of Medi-Cal to rural counties described below (see *Expansion to Rural Counties*, below). Beneficiaries in these counties receive services through Partnership Health Plan of California.
- *Geographic Managed Care* – In 1992, the department designated Sacramento County as a geographic managed care (GMC) county, which allowed many plans to operate within the county to provide services to Medi-Cal beneficiaries. In 1998, San Diego also became a GMC county, and both counties currently contract with several commercial health plans with the goal of providing more choice to

beneficiaries. As these plans are commercial plans, they are required to be licensed under the Knox-Keene Act. Sacramento and San Diego remain the only two GMC counties in the state.

- *Two Plan Model* – In 1995, as part of a significant expansion of Medi-Cal managed care, twelve counties were designated to participate in a new Two Plan Model for managed care delivery. Under this model, one county-developed plan, a local initiative, offers services alongside a commercial plan. Both plans are required to be licensed under the Knox-Keene Act. There are currently fourteen Two Plan Model counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Los Angeles' local initiative, L.A. Care, subcontracts with several other smaller managed care plans to provide services to Medi-Cal beneficiaries.
- *Regional Model* – AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the expansion of Medi-Cal managed care into the twenty-eight rural counties not previously operating managed care plans. These counties phased in between November 2013 and December 2014. 8 counties transitioned into the COHS model, while twenty counties transitioned into a new regional model, including: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba. Beneficiaries in these counties (except San Benito and Imperial) receive services through either Anthem Blue Cross, or California Health and Wellness. Beneficiaries in San Benito County receive services through either Anthem Blue Cross, or fee-for-service Medi-Cal, while beneficiaries in Imperial County receive services through either California Health and Wellness or Molina Health Systems.

New Contract Requirements in Reprocurement. According to DHCS, through the reprocurement process, managed care partners will demonstrate their commitment and ability to meet the following new and enhanced contract requirements:

Transparency. Plan partners will now be required to routinely and publicly report on access, quality improvement, and health equity activities, including their fully delegated subcontractors' performance and consumer satisfaction. These reports will be posted publicly by DHCS to help members choose their plan. Plans will also be required to post their financial performance information and Memoranda of Understanding with third parties.

High Quality Care. Plan partners will be expected to exceed quality improvement benchmarks and create a culture of continuous quality improvement with a focus on primary care, physical and behavioral health, access to and engagement of providers, and continuity and coordination across settings and all levels of care. Plans will be held accountable for their own quality as well as that of their subcontractors. Plans failing to achieve quality benchmarks will face sanctions and potentially be required to surrender a portion of their profits. Plans will be newly required to review utilization reports to identify members not using primary care, and to address those members' needs and health disparities. Plan payment will be linked to quality and equity, and plans will be required to comply with new provider shared risk, savings and incentive arrangements. Plans and their subcontractors are expected to achieve National Committee for Quality Assurance (NCQA) Health Plan Accreditation by 2026.

Access to Care. Plan partners will be required to meet more robust expectations in assisting members and their families with navigating delivery systems and care management services. Plans will maintain comprehensive networks that provide all members timely access to care that is appropriate, culturally and

linguistically competent, high quality, and within geographic access standards, and that include timely access to interpreter services, auxiliary aids and services, and appropriate telehealth modalities.

Increased Health Equity and Reduced Health Disparities. Plan partners will meet new requirements related to reducing health disparities among specific populations and measures identified by DHCS. Plans will be required to identify physical and behavioral health disparities and inequities in access, utilization, and outcomes by race, ethnicity, language (including limited English proficiency), and sexual orientation, and to have focused efforts to improve health outcomes within the most impacted groups and communities. For the first time, plans will be required to have a Chief Health Equity Officer. In addition, both the plans and their subcontractors will be mandated to achieve NCQA Health Equity Accreditation, a new standards program focused on advancing the delivery of more equitable and culturally and linguistically appropriate services across member populations.

Continuum of Care. Plan partners will help members manage their health over time through a comprehensive array of person-centered health care and social services spanning all levels of care, from birth to dignified end of life. Plan partners will be obligated to strengthen their coordination and continuity of care for out-of-network providers and to educate members on, for example, what an advance directive is and their right to have one.

California Advancing and Innovating Medi-Cal (CalAIM) Initiatives. Plan partners will implement and support CalAIM initiatives to improve the quality of life and health outcomes of member populations by establishing broad delivery system, program, and payment reform across Medi-Cal.

Coordinated/Integrated Care. Plan partners must ensure the needs of their entire member population are met across the continuum of care. Plans will systematically coordinate services and comprehensive care management with a whole-person, interdisciplinary approach for populations with complex health care needs. This includes coordination with services provided by local health departments, county behavioral health plans, schools, justice systems, and community-based organizations. Plan partners will be required to facilitate warm hand-offs and closed-loop referrals of members to community resources and follow-up to ensure services are rendered.

Addressing Social Drivers of Health (SDOH). Plan partners will be expected to implement new population health management and care management strategies to address the unmet social needs of members, such as food security and housing, and document members' SDOH needs and services.

Local Presence and Engagement. Plans will partner with local agencies (e.g., local health departments, county behavioral health plans, continuums of care, community-based organizations) to ensure that they understand and meet community needs. These relationships will help plans and providers go beyond the walls of a clinical office to address SDOH. Plans and their fully delegated subcontractors with positive net income will also be required to allocate 5 to 7.5 percent of these profits (depending on the level of their profit) to local community activities that develop community infrastructure to support Medi-Cal members.

Children's Services. Plans will take on new contract obligations for children with special health care needs that require them to implement methods for ensuring care management and care coordination with appropriate programs. Plans will be newly required to provide medically necessary health and behavioral

health services in schools and other settings (i.e., at home and in the community) and implement interventions by school-affiliated providers that increase access to preventive, early intervention, and behavioral health services. For the first time, plans will be required to train providers on Early and Periodic Screening, Diagnostic, and Treatment Services. Plans will be expected to ensure that their Community Advisory Committee membership reflects that of the health plan and the county being served, including children (or parents/caregivers of children) and adolescents.

Behavioral Health Services. Plan partners will expand access to evidence-based behavioral health services focused on earlier identification and engagement in treatment for children, youth, and adults and integrated with physical health care, including establishment of No Wrong Door policies to support access to diagnoses and treatment. Services will align with state-required interventions that increase access to providers within transitional kindergarten through grade 12 publicly funded schools. The contract clarifies substance use disorder coverage – including alcohol and drug screening, brief intervention, and referral to treatment – and medication-assisted treatment services across settings.

Accountability and Commitment to Compliance, Including Monitoring and Oversight of Delegated Entities. Plan partners must demonstrate robust accountability, compliance, monitoring, and oversight programs, including for all delegated entities, to ensure members receive quality care and have access to services. Managed care plans will be held accountable for the quality of care at all levels of delegation. This will include justification for the use of delegated entities and subcontractors to ensure that members' experiences and outcomes are drivers of these decisions. Additionally, for the first time, the contract mandates that MCPs report information on delegated functions.

Emergency Preparedness and Essential Services. During and after emergencies – such as a natural or man-made disaster or health crisis – plan partners will ensure delivery of essential care and services (including telehealth) to members and continuity of business operations.

Value-Based Payment. Plan partners will be mandated to link provider payments to value in the form of higher quality of care, better health care outcomes, and lower cost of care. Building on proposed changes for 2023 to base capitation payment rates on performance on certain high-priority quality and health equity outcome measures, such arrangements include incentive payment arrangements that reward providers for high or improved performance on selected measures or benchmarks. Plan partners will report on what proportion of their spending is on primary and integrated care and tied to alternative primary care payment models.

Administrative Efficiency. Plan partners will reduce administrative waste and enhance efficiency

Source: Department of Health Care Services, Medi-Cal Managed Care Division

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

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

1. Please provide a brief update on the status of the managed care reprocurement process, including an overview of new contract requirements for all managed care plans.

2. Please explain the rationale for entering into a separate, statewide contract with Kaiser, rather than through the reprocurement process.

3. Please provide a brief overview of the provisions of the Kaiser contract, including who would be eligible to enroll, any differences in benefit coverage from other Medi-Cal managed care plans, and the provisions related to supporting community clinics.

Issue 35: Encounter Data Improvement Support

Budget Change Proposal – Governor's Budget. DHCS requests expenditure authority of $17.5 million ($15.7 million federal funds and $1.7 million reimbursements) in 2022-23 and $17.4 million ($15.7 million federal funds and $1.7 million reimbursements) in 2023-24. If approved, these resources would allow DHCS to advance improvements in data quality in managed care and county behavioral health.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24**
0890 – Federal Trust Fund	$15,726,000	$15,701,000
0995 – Reimbursements	$1,747,000	$1,745,000
Total Funding Request:	**$17,473,000**	**$17,446,000**
Total Requested Positions:	**0.0**	**0.0**

Background. DHCS has invested in various efforts to improve data quality for encounter data that is received from managed care plans and counties. These efforts have included the establishment of an Encounter Data Quality Unit, development of quality measures for encounter data, development and implementation of the Post-Adjudicated Claims and Encounters processing and validation system, quarterly reports comparing encounter data submission volumes to managed care plan submitted financial data (Stoplight Reports), yearly studies comparing DHCS' encounter data to beneficiary medical records (Encounter Data Validation Study), enforcement with the use of corrective action plans and fines. These efforts have resulted in significant improvements. However, additional research has demonstrated that there are still significant opportunities for improvements, including:

- Lack of understanding and education among stakeholders regarding encounter data and its value;
- Insufficient incentives for providers to submit timely and complete encounter data;
- Inadequate training on data submission at the provider level;
- Technology challenges and variable technology across clinical settings;
- Variable quality control in encounter data submissions;
- Poor communication among all parties involved in the data submission;
- Lack of standardization – specifically around coding; and,
- Issues specific to Medi-Cal patients, such as increased likelihood of fragmented care, difficulty verifying coverage and encounter data gaps.

Resource Request. DHCS requests expenditure authority of $17.5 million ($15.7 million federal funds and $1.7 million reimbursements) in 2022-23 and $17.4 million ($15.7 million federal funds and $1.7 million reimbursements) in 2023-24 to advance improvements in data quality in managed care and county behavioral health. Specifically, DHCS requests the following resources:

- Resources equivalent to **One Health Program Specialist (HPS) II** position would oversee the programmatic functions and provide highly-skilled technical program consulting, providing policy and consultative advice related to the implementation of the encounter data quality efforts; work closely with data teams and the contractors to monitor and address data quality issues with plans, including with MCPs, and PACE organizations; provide leadership and facilitate internal and external

stakeholder processes; coordinate with responsible divisions conducting managed care plan, Dental Managed Care, mental health plan, Drug Medi-Cal and DMC-ODS contract oversight and engagement to address data quality, and data-sharing, issues identified by the state and contract teams.

- Resources equivalent to **one Staff Services Manager I** position would lead in the administrative and contract management duties related to this effort, including resource planning, reporting, budgeting, contract management, and change management; receive data from programs and the contractors and develop performance reports, issue and risk logs, and risk plans; provide encounter data quality specific information for budgeting, contracting, and invoicing activities; manage any required reporting, including quarterly and monthly CMS reports, annual updates to the state legislature, and yearly Advance Planning Document (APD) updates; review program and contractor activities and recommend solutions to management; and track the performance of the contract work they have been assigned, propose remediation solutions, track resolution, and inform management of progress.
- Resources equivalent to **one Associate Governmental Program Analyst** would perform a variety of analytical activities related to the implementation of the encounter data quality efforts; work closely with data teams and the contractors to monitor and address data quality issues with plans; oversee mental health plan and DMC-ODS contracts and engagement to address data quality issues identified by the state and contract teams; work with staff on improvements to publicly reported data dashboards.
- Contract resources of $2 million ($1.8 million federal funds and $200,000 reimbursements) in 2022-23 and 2023-24 would assist in designing, development, and delivery of secure business intelligence solutions and services that drive health care quality and strategy formulation.
- Contract resources of $15 million ($13.5 million federal funds and $1.5 million reimbursements) in 2022-23 and 2023-24 to provide direct technical assistance and grants to be provided to counties, plans, and providers to support improved data quality.

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 36: Restoration of Specified Medi-Cal Provider Rate Reductions

Local Assistance and Trailer Bill Language – Governor's Budget. DHCS requests expenditure authority of $20.2 million ($9 million General Fund and $11.2 million federal funds) in 2022-23 to support restoration of certain Medi-Cal provider rate reductions implemented by AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. DHCS also requests trailer bill language to implement these restorations.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$-	$8,986,300
0890 – Federal Trust Fund	$-	$11,204,700
Total Funding Request:	**$-**	**$20,191,000**

Background. AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, implemented a ten percent reimbursement rate reduction for most providers of services to Medi-Cal beneficiaries and an actuarially equivalent reduction in capitation rates paid to Medi-Cal managed care plans. The reduction applies to dates of service on or after June 1, 2011. Due to court injunctions, which were subsequently lifted in December 2012, the department was unable to reduce reimbursements during this period. This delay, coupled with system implementation issues, required the department to retroactively recoup the overpayments to providers that occurred while the reductions were enjoined or delayed. Over time, the department eliminated many of the reductions and forgave much of the retroactive recoupment amounts due to concerns that the reductions might adversely impact beneficiaries' access to necessary medical care. In addition, the federal government's approval of the State Plan Amendment to implement these reductions was contingent on the state agreeing to implement an access monitoring plan. The plan identifies 23 separate metrics in the three key areas of beneficiary measures, provider availability, and service use and outcomes. DHCS estimates fee-for-service savings of $166.7 million ($64.3 million General Fund) in 2021-22 and $164.7 million ($63.6 million General Fund) in 2022-23 for the ten percent provider rate reduction implemented pursuant to AB 97.

Restoration of Specified Medi-Cal Provider Rate Reductions. DHCS requests expenditure authority of $20.2 million ($9 million General Fund and $11.2 million federal funds) in 2022-23 to support restoration of certain Medi-Cal provider rate reductions implemented by AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. Specifically, DHCS proposes to restore reimbursement for nurses, alternative birthing centers, audiologists and hearing aid dispensers, respiratory care providers, durable medical equipment oxygen and respiratory services, chronic dialysis clinics, an emergency medical air transportation.

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 37: Equity and Practice Transformation Provider Payments

Local Assistance – Governor's Budget. DHCS requests expenditure authority of $400 million ($200 million General Fund and $200 million federal funds) in 2022-23 to advance equity, reduce COVID-19 driven care gaps, and fund practice transformation to allow Medi-Cal providers to better serve the state's Medi-Cal population.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$-	$200,000,000
0890 – Federal Trust Fund	$-	$200,000,000
Total Funding Request:	**$-**	**$400,000,000**

Background. DHCS is proposing to make equity and practice transformation payments to qualifying Medi-Cal managed care plans, or through plans to their qualified contracted providers, to close health equity gaps; address gaps in preventive, maternity, and behavioral health care measures; and address gaps in care arising out of the COVID-19 pandemic. According to DHCS, the payments are intended to promote a patient-centered model of care in pediatric, primary care, obstetrics and gynecology, and behavioral health settings and to align with the goals of the Medi-Cal Comprehensive Quality and Equity Strategy, including:

- Ensure all health plans exceed 50th percentile for all children's preventive care measures
- Close racial and ethnic disparities in well child visits and immunizations by 50 percent statewide
- Close maternity care disparity for black, American Indian, Alaska Native, Native Hawaiian and Other Pacific Islander (AI/AN/NH/OP) individuals by 50 percent statewide
- Improve maternal and adolescent screening and referral for depression by 50 percent statewide
- Improve follow up after ED visit for Mental Health/Substance Use Disorder by 50 percent statewide

The payments would include both initial planning grants and equity and practice transformation grants. Initial planning grants would help small, medium, or independent practices apply for the practice transformation grants and could be used for staff time to prepare the grant application, hiring a consultant to help conduct a needs assessment, assist in research, tools, strategies, and recommendations to include in the development of the grant proposal. Equity and practice transformation grants would include case management or system mechanisms for identifying and addressing underutilization and closing care gaps, electronic medical system updates, population health improvements, telehealth, or remote patient monitoring.

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 38: Federally Qualified Health Center Alternative Payment Model Project

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to update existing law to authorize DHCS to implement an alternative payment model (APM) reimbursement methodology for federally qualified health centers (FQHCs) to incentivize delivery system and practice transformation through flexibilities and moving away from a volume-based methodology, no sooner than January 1, 2024.

Background. SB 147 (Hernandez), Chapter 760, Statutes of 2015, authorized a three-year pilot program for county and community-based FQHCs. Under the proposed pilot, participating FQHCs would move away from the traditional volume-based prospective payment system (PPS) to one that better aligns with the evolving financing and delivery of health services. As proposed under the FQHC APM pilot, the PPS payment and wrap-around would be replaced by an upfront, clinic-specific capitation rate. The benefit to the participating FQHCs is that they would have a simplified payment process, replacing the previous billing approach and associated delays in payment. FQHCs would receive a comprehensive payment from the health plans on a monthly basis rather than having to wait until the end of the year for a supplemental payment, which is particularly beneficial to cash-strapped health centers. This payment reform would also allow FQHCs the ability to operate more efficiently and deliver care in innovative ways that would expand primary and specialty care access. For example, FQHCs could provide non-traditional services not currently reimbursed under traditional volume-based PPS, including but not limited to: group visits, email visits, phone visits, community health worker contacts, case management, and care coordination across systems. Additionally, the reform removes incentives to increase volume of separate visits instead of same day visits (for example integrated primary and behavioral health visits on the same day). The proposed pilot was also expected to increase collaboration between the Medi-Cal managed care plans and the participating FQHCs. While both would have additional requirements, both would also experience increased value from better coordination of care, thereby helping to reduce unnecessary utilization of services and improve beneficiary experience.

However, DHCS was unable to implement the pilot as outlined due to inability to receive federal approval.

According to DHCS, during stakeholder meetings in 2021, significant progress was made to prepare for implementation of an APM for FQHCs. The updates to the existing statutory authority for an APM pilot would allow DHCS to submit any negotiated APM proposal for federal approval without delay.

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.