Senate Budget and Fiscal Review – Mark Leno, Chair
SUBCOMMITTEE #3 on
Health & Human Services

Chair, Senator Holly J. Mitchell

Senator William W. Monning
Senator Jeff Stone, Pharm. D.

April 23, 2015

9:30 a.m. or Upon Adjournment of Session

Room 4203, State Capitol

Agenda
Part A
(Michelle Baass)

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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4265 Department of Public Health

1. Oral Health Program

Oversight Issue. The 2014 budget included $474,000 ($250,000 General Fund and $224,000 in reimbursements, federal funds from the Department of Health Care Services) to establish a State Dental Director, add an epidemiologist, and provide related consulting services to re-establish a statewide oral health program.

With these resources, DPH proposed to develop a Dental Burden of Disease Report which would help identify dental health issues, disease burden, facts and figures of dental disease, and capacity to address the burden. The report would be the foundation for the development of the State Dental Plan (plan). The plan would serve as the roadmap for California's short-term, intermediate, and long-term priorities, goals, and objectives to address dental disease burden and prevention.

DPH notes the following activities have been accomplished since approval of the 2014 budget request:

- The Oral Health Program (OHP) website was developed.
- The Oral Disease Burden Report is under development.
- Program staff has been meeting with the consultant to plan the first advisory committee meetings. A tentative meeting date is scheduled for June 2015.
- Research on other states oral health plans and determining best practices has been initiated.
- Research on current state and other states dental policy strategies, evidence-based community prevention and care systems was initiated.
- Research on basic elements of a state oral health surveillance system, logic models, and evaluation measures has been conducted.

Despite these activities, DPH is behind in accomplishing the goals set forth in last year's proposal. For example, DPH is projecting that it will complete the State Dental Plan in June 2016 instead of June 2015. See below for updated program timeline with originally proposed dates and projected new dates.

Table: Updated Oral Health Program Timeline

Objectives and Activities	Original Date	New Date
Program Leadership		
Recruit, hire and orient Dental Director	10/2014	06/30/2015
Recruit, hire and orient Epidemiologist		Complete
Develop and execute two contracts (Cal EIS Fellow, California State University Sacramento)		Complete
Orient Cal EIS Fellow		Complete
Oversee administrative and fiscal activities		Ongoing
Partnerships and Coalition		
Convene Dental Program Advisory Committee	12/2014	6/30/2015*
Participate in Chronic Disease Branch Communications, Health Care Systems/Community Prevention Workgroups		Ongoing
Participate in Chronic Disease Branch Evaluation, Surveillance and Epidemiology Workgroups		Ongoing
Convene first Coalition Meeting		09/30/2015
Convene an ongoing Coalition Workgroup to develop the State Dental Plan		09/30/2015
Convene second Coalition Meeting		02/29/2016
Develop and implement a Dental Program Communications Strategy		09/30/2015
Capacity Assessment		
Assess current resources and strategies in dental policy, care systems, community prevention and communications		Ongoing
Assess current resources and strategies in dental surveillance/epidemiology		Complete
Create Dental Program website, with information resources	12/2014	Complete
Finalize Capacity Report (result of assessments)		09/30/2015
State Dental Plan		
In conjunction with Coalition members, develop a Dental State Plan Framework		09/30/2015
In conjunction with Coalition members, develop a Draft Dental State Plan		02/29/2016
Finalize Dental State Plan	6/2015	06/30/2016
Implement plan, including benchmarks and evaluation measures		Ongoing
Surveillance/Epidemiology		
Assess current data sets		Complete
Analyze data and write narrative		Complete
Develop a Draft Dental Burden of Disease Report		Complete
Finalize Dental Burden of Disease Report	3/2015	06/30/2015
Evaluation		
Develop a Dental Program Logic Model		04/30/2015
Develop Dental Program Performance Measures		04/30/2015
Track Dental Program Performance Measures and write Report		Ongoing
Report on Dental Program Performance Measures		6/30/2016 & Ongoing

*Could be moved to July 2015 if Dental Director is not hired in June.

Subcommittee Staff Comment and Recommendation—Informational Item. As noted above, the core activities of this program have been delayed. This means that the implementation of innovative policies and strategies to improve the state's oral health condition are postponed.

Additionally, given the concerns raised by the recent State Auditor Report on the Denti-Cal program, as discussed at this Subcommittee's hearing on March 19, 2015, proactive collaboration between the Oral Health Program and Denti-Cal should be a high priority. For example, DPH's Oral Disease Burden Report that is expected to be completed by June should contain delineated information about the Medi-Cal program, so that the state can understand how Medi-Cal enrollees' oral health conditions compare to the other California residents.

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

1. Please provide an update on the Oral Health Program and highlight key accomplishments in the last year.

2. What are the reasons for the delays in activities regarding this program?

3. Is DPH's Oral Health Program working with the Department of Health Care Services to identify dental health issues, disease burden, facts and figures of dental disease, and capacity to address the burden related to the Medi-Cal program? Please explain.

2. Office of Health Equity

Background. AB 1467 (Committee on Budget), Chapter 23, Statues of 2013 created the Office of Health Equity (OHE) at DPH. The OHE was created by consolidating the following entities:

- Office of Multicultural Health at DPH
- Office of Women's Health at the Department of Health Care Services (DHCS)
- Office of Multicultural Services at the Department of Mental Health (this department was eliminated in 2012)
- Health in All Policies Task Force at DPH
- Healthy Places Team at DPH

OHE was tasked to accomplish all of the following:

1) Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically-isolated communities;

2) Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health;

3) Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically-competent health and mental health care and services; and

4) Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.

OHE Budget. See following table for a summary of OHE's budget.

Table: Office of Health Equity's Budget Summary

Fund	**2014-15**	**2015-16**
General Fund	$362,000	$362,000
Air Pollution Control Fund	$111,000	$112,000
Cigarette and Tobacco Surtax Fund, Unallocated Account	$222,000	$221,000
Federal Trust Fund	$315,000	$191,000
Mental Health Services Fund	$18,557,000	$50,072,000
Cost of Implementation Account, Air Pollution	$211,000	$210,000
Grand Total	$19, 776,000	$51,167,000

Overdue Report. OHE is required to develop a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities in collaboration with external and internal stakeholders. The strategies and recommendations developed will take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan will establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. OHE will seek input from the public on the plan through an inclusive public stakeholder process.

This report was due by July 1, 2014 but has not yet been finalized. DPH indicates that the review and approval process is underway for the draft document, "Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity."

California Reducing Disparities Project (CRDP). One of OHE's responsibilities is the CRDP. The CRDP is a statewide policy initiative (funded with Mental Health Services Act Funds—Proposition 63) to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities in the public mental health system.

The project focuses on five populations: African-American; Latino; Native American; Asian and Pacific Islander; and Lesbian, Gay, Bisexual, Transgender, and Questioning individuals. These groups produced population-specific reports that formed the basis of a statewide comprehensive strategic plan on reducing disparities.

All of the five population reports have been approved and posted on the DPH website. Recommendations from these reports will be incorporated into a comprehensive draft strategic plan. Once finalized, the California Reducing Disparities (CRD) Strategic Plan will be used as a guide to identify new service delivery approaches from multicultural communities using community-defined evidence to improve outcomes and reduce disparities. Furthermore, the strategic plan will serve as a blueprint to implement these strategies at the local level.

In early May of 2015, DPH anticipates the release of multi-component solicitations for the California Reducing Disparities Project (CRDP), Phase II. Phase II will provide four years of funding, totaling $60 million to implement the practices and strategies identified in the CRDP Strategic Plan. The focus of Phase II will be on demonstrating the effectiveness of community-defined evidence in reducing mental health disparities. The CDPH plans to fund selected approaches across the five CRDP-targeted populations: Native Americans, Latinos, Asian/Pacific Islanders, African Americans, and Lesbian, Gay, Bisexual, Transgender, and Questioning with strong evaluation, technical assistance, and infrastructure support components.

There will be approximately five solicitations released under the CRDP Phase II, beginning in early May 2015. CDPH will fund the following:

- One Statewide Evaluator (SWE) contract (award 8/2015);
- Five Technical Assistance Provider (TAP) contracts (award 8/2015);
- Fifteen Capacity Building Pilot Projects (CBPP) grants (award 9/2015);
- Twenty Implementation Pilot Projects (IPP) grants (award 9/2015); and
- The Education, Outreach and Awareness solicitation is still in development.

Table: CRDP Funding Projections for Phase I and Phase II

	2012-13	2013-14	2014-15	2015-16
Phase I				
Appropriated	$2,349,000	$2,201,000	$3,557,000	$3,557,000
Expenditures	2,280,000	1,510,000	*$3,557,000	$3,557,000
Balance	$69,000	$691,000	-	-
Phase II				
Carryover	-	$15,000,000	$30,000,000	$45,000,000
Appropriated	$15,000,000	$15,000,000	$15,000,000	$15,000,000
Expenditures	-	$0	$0	**$15,000,000
Balance	$15,000,000	$30,000,000	$45,000,000	$45,000,000

* Expenditure report as of February 28, 2015 is $1,626,000.
**It is anticipated that $15 million of MHSA funds will be expended in 2015-16, however DPH indicates that there is a possibility that a small portion of the fund may need to be carried over into 2016-17 should there be delays in issuing the final solicitation (Education, Outreach and Awareness).

Subcommittee Staff Comment and Recommendation—Informational Item. The 2012 budget provided DPH with $60 million in Proposition 63 funding to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities in the public mental health system. DPH has not yet awarded any of these funds. While DPH has been complimented by various stakeholders on conducting an inclusive and thoughtful process regarding the California Reducing Disparities Project, the delay in awarding these funds has postponed the ability of these funds to make any impact on the improvement of the public mental health system.

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

1. Please provide an update on the activities of the Office of Health Equity.

2. Please provide an update on the status of the California Reducing Disparities Project. Please explain why it has taken DPH so long to make progress on this effort.

3. Please provide an update on the overdue report (due July 2014) regarding OHE's strategic plan to eliminate health and mental health disparities and inequities. Why isn't this report completed? When does DPH expect to submit this report to the Legislature?

3. Richmond Laboratory – Capital Outlay

Budget Issue. DPH requests a capital outlay appropriation in the amount of $4,333,000 General Fund to fund a construction project at the Viral and Rickettsial Diseases Laboratory (VRDL) in Richmond, California to meet current guidelines for Bio-safety Level 3 (BSL-3) laboratory requirements as determined by the United States, Centers for Disease Control (CDC) and the National Institutes for Health (NIH).

According to DPH, compliance of the CDC and NIH guidelines is essential for the DPH to maintain its BSL-3 certifications of the VRDL. Enhancements will require design and construction to modify VRDL areas such as: Unidirectional shower-out capacity, hands free faucets, pass-through autoclave sterilizer, an equipment decontamination area, High-Efficiency Particulate Absorption (HEPA) filtration of exhaust side of Heating Ventilation and Air Conditioner (HVAC) system, positive sealing dampers on HVAC system and through-wall ports for the safe gaseous decontamination of the laboratory, and electronic monitoring systems within the HVAC system.

Background. DPH's Richmond Campus is a multi-use laboratory/office complex located at 850 Marina Bay Parkway in Richmond, California. The secured campus has six laboratories, approximately 400,000 square feet of offices, a warehouse, and an animal care facility. The six laboratories are used by various CDPH programs involved in the review and analysis of agents from communicable diseases to environmental toxins.

The VRDL is a BSL-3 certified laboratory and serves as the state's reference laboratory to handle BSL-3 select agent and viruses. Select agent viruses that require BSL-3 facilities include but are not limited to, hantavirus, poxviruses, novel influenza (e.g. avian influenza viruses), Middle East Respiratory System (MERS)-CoV, Severe Acute Respiratory System (SARS), Chikungunya virus, Japanese encephalitis virus and West Nile virus. DPH finds that an operational BSL-3 laboratory is needed to be able to identify these viruses for the important public health mission preparing for and responding to deadly emerging viral diseases.

At the time of construction (2000), the Richmond Campus VRDL laboratory was designed to meet the existing BSL-3 requirements as determined by CDC and NIH. However in 2006, the CDC/NIH implemented an enhanced BSL-3 requirement for BSL-3 laboratories. The CDC/NIH BSL-3 enhancement was in response to reports in 2003 and 2004 from the World Health Organization (WHO) that the Avian flu was spreading from Asia to Europe and Africa.

In response to the enhanced BSL-3 requirement, in 2006-07 DPH through the Department of General Services (DGS) contracted with the engineering firm of CUH2A to conduct an evaluation of the VRDL laboratory and identify the upgrades needed to meet the enhanced BSL-3 requirements. CUH2A evaluated the VRDL laboratory and identified that to meet the new enhanced BSL-3 requirements the VRDL laboratory would need retrofits to the existing infrastructure to provide the following capabilities:

- Unidirectional shower with in/out capabilities.
- Pass-through autoclave sterilizer.
- An equipment decontamination area.

- Upgraded high-efficiency particulate absorption (HEPA) filtration of the exhaust side of the heating ventilation and air conditioner (HVAC) system.
- Positive sealing dampers on the HVAC system and through-wall ports for the safe gaseous decontamination of the laboratory.
- Electronic monitoring systems within the HVAC system.
- Mechanical/Valve Room changes to support the laboratory.

To accommodate the above requirements, CUH2A determined that the following infrastructure changes would be needed to the VRDL laboratory:

- Expand the VRDL BSL-3 suite from 1,210 to approximately 2,000 square feet.
- Modify the laboratory's HVAC mechanical and other related building operating systems to provide enhanced filtering capabilities
- Deconstruct some existing wall(s).
- Construction of new walls to create new containment area(s).

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal, no issues have been raised.

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

1. Please provide an overview of this proposal.

2. Please explain why DPH finds it critical that this projected be funded now. How has the state managed without the enhancements outlined in this proposal?

4. Women, Infant, and Children Program

Budget Issue. DPH requests approximately $1.2 billion in federal trust fund and $242 million in Women, Infant, and Children (WIC) Manufacturer Rebate Special Fund for 2015-16. As shown in the table below, the WIC estimate proposes total expenditures of $1,188,528,224 in 2015-16, a $28.5 million (2.5%) increase over the revised estimate for 2014-15, and a $1.6 million (0.14%) decrease from the 2014 budget act

Table: WIC Expenditure Summary

	2014-15 Budget Act	2014-15 Estimate	2015-16 Proposed	BA to BY Change	% Change
Local Assistance	$1,136,320,825	$1,106,113,677	$1,134,668,224	-$1,652,601	-0.15%
State Operations	$53,860,000	$53,860,000	$53,680,000	$0	0%
Total Expenditures	**$1,190,180,825**	**$1,159,973,677**	**$1,188,528,224**	**-$1,652,601**	**-0.14%**

DPH estimates that about 1,389,906 WIC participants will access food vouchers in 2014-15 and 1,403,786 participants in 2015-16.

Background on WIC Funding. DPH states that California's share of the national federal grant appropriation is at about 17 percent. Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:

- **Food**. Funds that reimburse WIC authorized grocers for foods purchased by WIC participants.
- **Nutrition Services and Administration.** Funds that reimburse local WIC agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition, education, breastfeeding support, and referrals to health and social services, as well as support costs.
- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with Infant Formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down federal WIC food funds.

Background on WIC Program. WIC is 100 percent federal fund supported. It provides supplemental food and nutrition to low-income women (185 percent of poverty or below) who are pregnant, breastfeeding, non-breastfeeding postpartum women, infants, and children under age five who are at nutritional risk. WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

WIC participants are issued paper vouchers by local WIC agencies to purchase approved foods at authorized stores. Examples of foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter, and iron-fortified infant formula.

The goal of WIC is to decrease the risk of poor birth outcomes and improve the health of participants during critical times of growth and development. The amount and type of food WIC provides are designed to meet the participant's enhanced dietary needs for specific nutrients during short but critical periods of physiological development.

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support, and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged as being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

Maximum Reimbursement Rate Methodology. The maximum amount that vendors are reimbursed for WIC food is based on the mean price per redeemed food instrument type by peer group with a tolerance for price variances (referred to as MADR). Effective May 25, 2012, the USDA directed CA WIC to remove 1-2 and 3-4 case register WIC vendors from the MADR-determination process and instead set MADR for these vendors at a certain percentage higher than the average redemption value charged by vendors with five or more registers in the same geographic region. The USDA was concerned that California was paying 1-2 and 3-4 cash register stores up to 50 percent higher than prices paid to other vendors.

WIC Vendor Moratorium. WIC implemented a vendor moratorium in April 2011 so that it could address the backlog in new vendor applications. In April 2012, USDA directed California to maintain the moratorium until the peer group and reimbursement rate regulations (discussed above) are in effect. This moratorium has been lifted in phases over the past year... As of February 1, 2015, the moratorium was lifted fully for all types of new stores. Although new stores have come into the program, the overall number of WIC stores has declined, in part due to stores closing in response to the new reimbursement system put into place.

Electronic Benefit Transfer for WIC. In June 2015, DPH plans to formally release a Request for Proposal (RFP) for Electronic Benefit Transfer (EBT) services. DPH is partnering with Supplemental Nutrition Assistance Program/CalFresh on this procurement. WIC is moving to replace its current paper vouchers with EBT cards, per U.S. Department of Agriculture's mandate that all states move to EBT by October 1, 2020. When California moves to EBT for WIC, participants will continue to have regular appointments at the WIC sites to receive the same services that local agencies currently provide. Although SNAP and WIC are joining efforts for the RFP, the two programs will have separate EBT cards for their recipients.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as this estimate will be updated in the May Revision.

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

1. Please provide a brief summary of the WIC budget.

2. Please discuss steps DPH is taking to analyze participation in WIC and make improvements in program participation.

5. California Home Visiting Program

Budget Issue. DPH requests $697,000 in federal funds in 2015-16 to extend 11.0 positions for three years and $27,490,000 in federal funds in 2016-17 to extend an additional 16.0 positions for three years and provide $24 million (federal funds) in local assistance annually for three years for the California Home Visiting Program (CHVP).

Background. CHVP was created as a result of the federal Affordable Care Act (ACA) of 2010. Section 2951 of the ACA established the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program grant. In addition, California Health and Safety Code Section 123491 states that a voluntary home visiting program for expectant first-time mothers and their children be administered by CDPH. CHVP's mission is to provide leadership for integrated, collaborative, high-quality, maternal and early childhood interventions across multiple systems of health and human services to address the complex needs of diverse, high-risk pregnant and parenting women in California. Home visiting has been shown to lower rates of the following: childhood injuries including child maltreatment; infant mortality; emergency department visits; language delays in children; and subsequent pregnancies (lengthen inter-birth intervals). Home visiting has been shown to increase the following: prenatal care; breastfeeding; well-child visits; and school readiness.

The CHVP focus is to provide comprehensive, coordinated, in-home services to support positive parenting and to improve outcomes for families residing in identified at-risk communities. CHVP is an evidence-based, voluntary program offered to pregnant women and their children from birth to age 3. CHVP has sites in 22 local health jurisdictions (LHJs) that are located in 21 counties which provide services using one of two evidence-based, federally approved home visiting models: (1) Healthy Families America (HFA); and (2) Nurse Family Partnership (NFP). These two models were two of six approved models from which HRSA allowed states to choose. The grant funds provide funding to HFA and NFP in the state and LHJs for implementation and administration of home visiting programs at the local level**.** Programs are required to target participant outcomes which include the six federally-mandated benchmark areas: (1) improved maternal and newborn health; (2) prevention of child injuries, child abuse, neglect or maltreatment and reduction of emergency department visits; (3) improvements in school readiness and achievements; (4) reduction in domestic violence; (5) improvements in family economic self-sufficiency; and (6) improvements in the coordination and referrals for other community resources and supports. To date, the 22 CHVP sites have performed 30,296 home visits and 2,577 clients have been enrolled in the statewide program.

CPH was awarded MIECHV Program grants in 2010-11 and 2011-12 and received approval in 2010-11 and 2011-12 for 36.0 five year limited-term positions for the CHVP. To develop the appropriate home visiting models, develop fiscal reporting and compliance policies and procedures and program management, DPH requested and received approval to administratively establish 12.0 of the 36.0 positions on February 1, 2011. The remaining 24.0 positions were established on July 1, 2011. This proposal is requesting 27.0 three year limited- term positions instead of the original 36.0 due to a funding adjustment by HRSA.

The LHJs administer the home visiting program through their county departments of public health where they provide primary oversight of all home visiting activities. The $24,000,000 in local assistance

funding to the LHJs provides the needed funding to employ four to five home visitors and one supervisor per site (22 sites). This funding is also used for the infrastructure needed to successfully run a CHVP program within the county.

On an annual basis, CHVP submits benchmark data into the federal reporting system. These data have been collected throughout the year by the LHJs who continuously enter the data into the statewide data system. CHVP monitors, analyzes, and reports to HRSA every October and has successfully done so over the past three federal reporting year cycles. CHVP also analyzes all quantitative and qualitative data for bi-annual federal progress reports that also include the budgets for CHVP and all 22 sites. Over the past three federal reporting-year cycles, CHVP has successfully met all federally-mandated reporting requirements.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. No issues have been raised.

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

1. Please provide an overview of this proposal.

2. Please provide an update on the federal appropriation of these funds.

6. Ebola Emergency Preparedness

Budget Issue. Through an April Finance Letter, DPH requests an increase of $15.45 million in federal fund expenditure authority in 2015-16 to support accelerated state and local public health preparedness and operational readiness for responding to the Ebola virus. DPH will also receive $250,000 in Ebola grant funds each year from 2016-17 to 2019-20.

Background. DPH's Emergency Preparedness Office coordinates preparedness and response activities for all public health emergencies, including natural disasters, acts of terrorism, and pandemic diseases. The program plans and supports surge capacity in the medical care and public health systems to meet needs during emergencies. The program also administers federal and state funds that support the department's emergency preparedness activities.

The Emergency Preparedness Office is funded primarily by federal Public Health Emergency Preparedness and Hospital Preparedness Program funds. These funds provide operational support to the department, which is responsible for the public health response to emergencies, including coordination between public health and medical care responsibilities. The surveillance of infectious diseases, detection and investigation of outbreaks, identification of etiologic agents and their modes of transmission, development of prevention and control strategies, and providing the public with accurate and timely information on the public health implications of emergencies are the responsibility of DPH and local health departments.

Since October 2014, California has implemented a robust program of preparedness and response for Ebola both at the state, local, and healthcare provider levels. The California Ebola program plan, protocols, and procedures have been coordinated with the operational and emergency response plans for the state, including activation of state and local emergency operations centers in keeping with established communicable disease outbreak response plans. DPH, in collaboration with the 61 local health departments, has implemented a traveler monitoring system to ensure active monitoring, investigation of, and locating any individual who is "lost" or not identified by the federal Centers for Disease Control and Prevention (CDC) but arrives in the jurisdiction, and a process to address noncompliant individuals.

The department, working closely with the California Emergency Medical Services Authority, local health departments, and healthcare systems, has identified eight Ebola treatment hospitals and is in the process of identifying regional Ebola assessment hospitals for the care of suspected/confirmed Ebola cases. The department established and maintains a 24/7 contact number for local health departments and clinicians to report traveler symptoms and consult with a public health clinician on suspected and confirmed cases, and maintains an Ebola hotline (telephone and email system) for questions from the general public. Local health departments have conducted drills focused on the safe and efficient transportation of suspected/confirmed Ebola cases to appropriate facilities. DPH and local health departments have worked with hospitals to ensure preparedness to evaluate, isolate, obtain, and ship laboratory specimens to Laboratory Response Network-certified laboratories able to test for Ebola, after consultation with the CDC.

There are currently four laboratories in California that are able to test for Ebola, including the DPH's laboratory in Richmond, the Los Angeles County Public Health Laboratory, the Sacramento Public

Health Laboratory and the Orange County Public Health Laboratory. California quickly responded to the possible public health threat of Ebola, collaborating with partners across the disciplines and agencies, preparing for the monitoring and management of travelers, and preparing for the care of any suspect or confirmed Ebola case. These activities will continue to be sustained throughout the project period and expanded to ensure protection of the public's health.

The threat of Ebola is a top national public health priority. To ensure that state and local health departments continue to actively monitor travelers and conduct surveillance of Ebola, and to ensure that the healthcare system can assess and treat suspect and confirmed Ebola patients, the federal government is providing $145 million from the CDC for Public Health Emergency Preparedness and $162 million in Part A Hospital Preparedness Program Ebola supplemental funding to existing awardees.

Public Health Emergency Preparedness supplemental Ebola funding supports state and local public health preparedness planning and operational readiness for responding to Ebola. The funding is intended to:

- Support accelerated public health preparedness planning for Ebola within state, local, territorial, and tribal public health systems;
- Improve and assure operational readiness for Ebola;
- Support state, local, territorial, and tribal Ebola public health response efforts; and
- Assure collaboration, coordination, and partnership with the jurisdiction's healthcare system to assist in the development of a tiered system for Ebola patient care.

The PHEP Ebola supplemental funding budget period and project period are 18 months: April 1, 2015 through September 30, 2016. The precise award date is unknown at this time. DPH will receive $7.6 million to support activities in all California counties except Los Angeles, which will receive $3.2 million directly from the CDC. Funding can be used by the state and local health departments to build preparedness capabilities in the following areas: Community Preparedness, Public Health Surveillance and Epidemiological Investigation, Public Health Laboratory Testing, Non-Pharmaceutical Interventions, Public Health Responder Safety and Health, Emergency Public Information and Warning/Information Sharing, and Medical Surge.

Hospital Preparedness Program funds support hospitals, clinics and other health care facilities and emergency medical services systems to respond to any suspected Ebola case. The United States Department of Health and Human Services is awarding a total of $194.5 million in funding for Ebola healthcare system preparedness and response and the development of a regional Ebola treatment strategy across the 50 states and multiple territories. This funding is available over a five-year period with the expectation that most of the funds will be expended in the first year to build capacity. The application is due to the federal government on April 22, 2015 with an anticipated award date after May 18, 2015. The funding is divided into two parts: Part A funds are provided to support infrastructure costs, staff training, personal protective equipment, and annual exercises for California's identified Ebola treatment and assessment hospitals, outside of Los Angeles, to ensure readiness to respond to Ebola virus disease over the five-year project period. DPH will receive $5.6 million in Part A funding and Los Angeles will receive $2.2 million directly to address Ebola Treatment and Assessment Centers located in Los Angeles. Part B funds are provided on a competitive basis to states at high risk, such as California, to build a regional treatment center in each of the ten Health and Human Services regions creating a nationwide, regional treatment network for Ebola and other infectious diseases ($2.25 million in year

one followed by $250,000 each year for four additional years). California will receive a total of $7.85 million in Part A and B funding in year one.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. No issues have been raised.

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

1. Please provide an overview of this proposal.

7. Proposition 99 - California Tobacco Health Protection Act of 1988

Budget Issue. The Governor's budget projects an $8.24 million increase in the Proposition 99 Health Education Account as a result of updated revenue projections and lower than originally projected prior year actual expenditures. DPH requests the following increases in expenditures in Proposition 99's Health Education Account:

Line Item	Proposed Increase	Proposed Use of Funds
State Operations	$471,000	The funds will be used to enhance administrative oversight and programmatic functions related to the statewide media campaign, community grants, and surveillance aimed at preventing and reducing tobacco use. Activities include processing grants and contracts, providing training and technical assistance to community-based organizations, implementing a statewide media campaign, and monitoring tobacco use.
Media Campaign	$3,188,000	The funding will be used for tobacco education advertising to rural markets and increase ethnic media to reach populations that smoke at higher rates.
Competitive Grants	$1,579,000	The funding will be made available to applicants applying for Request for Application 15-100 – Achieving Tobacco-Related Health Equity among California's Diverse Populations (which will fund 25 to 35 five-year grants) for the period July 1, 2015 to June 30, 2020; provide training and technical assistance related to the Healthy Stores for a Healthy Community campaign; emphasize tobacco addiction in the behavioral health population; and promote a system within pharmacies and health plans to support the provision of cessation treatment.
Local Lead Agencies	$2,773,000	This appropriation funds local health department tobacco control programs based on an allocation formula specified in legislation. As a result of this increase, the following 13 local lead agencies will receive additional funding: Alameda, Fresno, Los Angeles, Long Beach, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, Solano, and Sonoma.

Evaluation	$526,000	These funds will continue to support the Behavioral Risk Factor Surveillance System (BRFSS)/California Adult Tobacco Survey (CATS), conduct a one-time surveillance of the illegal sales of electronic nicotine delivery devices/electronic cigarettes to youth, and field a public opinion poll related to emerging issues such as electronic cigarettes.

Background. In November 1988, California voters approved the California Tobacco Health Protection Act of 1988, also known as Proposition 99. This initiative increased the state cigarette tax by 25 cents per pack and added an equivalent amount on other tobacco products. The new revenues were earmarked for programs to reduce smoking, to provide health care services to indigent persons, to support tobacco-related research, and to fund resource programs for the environment. The money is deposited by using the following formula: 20 percent is deposited in the Health Education Account (HEA); 35 percent in the Hospital Services Account; 10 percent in the Physician Services Account; 5 percent in the Research Account; 5 percent in the Public Resources Account; and 25 percent in the Unallocated Account (Revenue and Taxation Code 30124).

E-Cigarettes. DPH uses Proposition 99 cigarette tax revenues for efforts to prevent and reduce the use of tobacco, including e-cigarettes. Since 2010, Proposition 99 funds have been used by local lead agencies and competitive grantees to conduct presentations to community groups, youth, college students and others regarding e-cigarettes as a newly emerged tobacco-related product containing nicotine and concerns about its escalating use among youth and young adults. In 2011, DPH added e-cigarette questions to the California Tobacco Advertising Survey to monitor the extent to which tobacco retailers sold e-cigarettes. In 2013, questions about e-cigarette use were added to adult tobacco use surveys. Similar questions will be added to the 2015 California Student Tobacco Survey. Additionally, in 2013, DPH began conducting focus groups with adults to qualitatively assess knowledge, awareness, and how e-cigarettes are being used by smokers and non-smokers. In January 2015, CDPH released a health advisory related to e-cigarettes and released the State Health Officer's Report on E-Cigarettes. Finally, in March 2015, DPH launched its statewide advertising campaign to inform the public about the dangers of e-cigarettes.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve these changes.

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

1. Please provide a brief review of the changes in expenditures for the Health Education Account

2. Please provide an overview of DPH's efforts to inform the public about the dangers of e-cigarettes.

3. How did DPH work with stakeholders on its efforts to inform the public about the dangers of e-cigarettes?

4260 Department of Health Care Services

1. Family Health Programs

Budget Issue. The DHCS Family Health Estimate covers the non-Medi-Cal budgets of the following four programs: 1) California Children's Services (CCS); 2) Children's Health & Disability Program (CHDP); 3) Genetically Handicapped Person's Program (GHPP); and 4) Every Woman Counts (EWC).

Table: Family Health Estimate Summary

Program	Budget Act 2014-15	Projected 2014-15	Proposed 2015-16	CY to BY $ Change
CCS	$95,781,000	$92,995,000	$91,291,000	-$1,704,000
CHDP	1,713,000	1,662,000	1,677,000	$15,000
GHPP	128,739,000	130,915,000	136,337,000	$5,422,000
EWC	58,583,000	54,311,000	42,356,000	-$11,955,000
TOTAL	**$284,816,000**	**$279,883,000**	**$271,661,000**	**-$8,222,000**

California Children's Services (CCS)

Background. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to: chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, and cancer; traumatic injuries; and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

CCS is administered as a partnership between county health departments and the DHCS. Historically, approximately 70 percent of CCS-eligible children are Medi-Cal eligible; their care is paid for with state-federal matching Medicaid funds. The cost of care for the other 30 percent of children had been split equally between "CCS Only" and "CCS Healthy Families." The cost of care for CCS-only is funded equally between the state and counties. The cost of care for CCS Healthy Families children is funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds, even though these children have transitioned into Medi-Cal.

CCS Budget. Excluding Medi-Cal costs, the proposed 2015-16 CCS budget is $91.3 million ($17 million General Fund), as compared to the 2013-14 estimate of $132 million ($12.4 million General Fund).

Table: CCS Budget Summary (Non-Medi-Cal)

	2014-15	2015-16
Total	**$92,994,800**	**$91,290,600**
Federal Funds	$65,635,300	$4,578,000
General Fund	$27,359,500	$86,712,600

The non-Medi-Cal caseload is 16,062 for 2014-15 and 16,303 for 2015-16. The Medi-Cal caseload is 161,788 for 2014-15 and 164,268 for 2015-16.

CCS Carve Out and Redesign. For many years, the CCS program has operated as a managed care "carve-out," such that children who qualify for CCS services receive those services on a fee-for-service basis, through a network of specialty care providers, all of which is outside of any managed care plan. The most recent extension of the carve-out was approved through AB 301 (Pan), Chapter 460, Statutes of 2011, which extended the sunset on the carve-out until January 1, 2016.

In the fall of 2014, DHCS began a stakeholder process regarding the redesign of the CCS program and anticipates developing a proposal in the summer. The goals of the design process are:

1. Implement Patient and Family Centered Approach: Provide comprehensive treatment, and focus on the whole-child rather than only their CCS eligible conditions.

2. Improve Care Coordination through an Organized Delivery System: Provide enhanced care coordination among primary, specialty, inpatient, outpatient, mental health, and behavioral health services through an organized delivery system that improves the care experience of the patient and family.

3. Maintain Quality: Ensure providers and organized delivery systems meet quality standards and outcome measures specific to the CCS population.

4. Streamline Care Delivery: Improve the efficiency and effectiveness of the CCS health care delivery system.

5. Build on Lessons Learned: Consider lessons learned from current pilots and prior reform efforts, as well as delivery system changes for other Medi-Cal populations.

6. Cost-Effective: Ensure costs are no more than the projected cost that would otherwise occur for CCS children, including all state-funded delivery systems. Consider simplification of the funding structure and value-based payments, to support a coordinated service delivery approach.

Children's Health & Disability Program (CHDP)

Background. CHDP provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment. CHDP oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

In July 2003, CHDP began using the "CHDP Gateway," an automated pre-enrollment process for non Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal or formerly the Healthy Families program.

CHDP Budget. The proposed CHDP budget includes $1.677 million ($1.6 million General Fund and $11,000 Childhood Lead Poisoning Prevention Fund), as compared to the current year estimate of $1.662 million ($1.65 million General Fund and $11,000 Childhood Lead Poisoning Prevention Fund).

Genetically Handicapped Person's Program (GHPP)

Background. GHPP provides medical care for adults with specific genetically-handicapping conditions. Hemophilia was the first medical condition covered by the GHPP and legislation over the years has added other medical conditions including Cystic Fibrosis, Sickle Cell Disease, Phenylketonuria, Huntington's disease, and Von Hippel-Lindau Disease.

The mission of GHPP is to promote high quality, coordinated medical care through case management services through:

- Centralized program administration;
- Case management services;
- Coordination of treatment services with managed care plans;
- Early identification and enrollment into the GHPP for persons with eligible conditions;
- Prevention and treatment services from highly-skilled Special Care Center teams; and,
- Ongoing care in the home community provided by qualified physicians and other health team members.

GHPP Budget. The proposed 2015-16 GHPP budget includes total funds of $136.3 ($118.3 million General Fund), compared to the 2014-15 estimate of $130.9 million ($67.2 million General Fund). The increase in General Fund is to account for the expected loss of federal Safety Net Care Pools funds as part of the state's Section 1115 Medicaid Waiver Renewal proposal.

Table: GHPP Caseload

	2014-15	**2015-16**
GHPP State Only	946	967
GHPP Medi-Cal	866	905
Total	**1,812**	**1,872**

Every Woman Counts (EWC)

Background. The EWC provides breast and cervical cancer screenings to Californians who do not qualify for Medi-Cal or other comprehensive coverage. The EWC was transferred to DHCS from the Department of Public Health in 2012.

EWC Budget. The proposed 2015-16 budget includes $423.4 million ($4.6 million General Fund) for EWC, a $11.9 million (22 percent) decrease from the 2014-15 estimate of $54.3 million ($16.6 million General Fund), which primarily reflects a decrease in caseload as a result of the federal Affordable Care Act and the transition of EWC caseload to Covered California or Medi-Cal.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending updates at May Revision.

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

1. Please provide an overview of the Family Health programs and budgets.

2. Please provide a brief update on the CCS redesign process and timeline and the department's thoughts on continuing to carve out this benefit.

2. Limited Benefit and Special Population Programs Eligibility Requirements

Budget Issue. The Administration proposes trailer bill language to:

a. Require individuals applying for the Genetically Handicapped Persons Program (GHPP), to apply for insurance affordability programs through Covered California (Covered CA), in addition to the existing requirement that they apply for Medi-Cal, or in lieu of these requirements, provide evidence of other health care coverage. To the extent they are found eligible for an insurance affordability program and GHPP, they will be required to enroll in the insurance affordability program and receive only those specialized services in GHPP that would not otherwise be provided through Medi-Cal or Covered CA through their qualified health plan. This proposal does not prohibit eligible individuals from receiving GHPP services during the time they are awaiting an eligibility determination.

b. Require enrolling providers who participate in Every Woman Counts (EWC), Family Planning Access Care and Treatment (FPACT), and IMProving Access, Counseling, and Treatment for Californians with Prostate Cancer (IMPACT), to provide to the enrolling individuals, information on how to apply for insurance affordability programs, in a manner determined by the Department of Health Care Services (DHCS). This proposal does not prohibit eligible individuals from receiving medically necessary services from these programs.

There are no savings associated with this proposal.

According to the Administration, the aim of this proposal is to ensure that individuals who are currently in limited benefit and special population programs that do not qualify as comprehensive coverage are being provided information about and, when appropriate, enrolling into comprehensive coverage, if eligible, in order to maintain eligibility for these specialized services. Additionally, DHCS cites that:

- The federal Affordable Care Act (ACA) requires consumers to obtain comprehensive coverage or pay a penalty. Certain populations, based on their income, will also be afforded financial subsidies which will result in no or low cost coverage.

- Prior to the advent of ACA, limited benefits programs were primarily established to provide limited coverage options to individuals unable to obtain coverage in publicly financed programs such as Medi-Cal or the commercial market.

- Compliance with the ACA requires health plans to cover a list of ten essential health benefits, including, but not limited to: maternity and newborn care, chronic disease management, rehabilitative services and devices, and laboratory services. Some of these essential benefits are duplicative of services provided by the limited benefits programs.

- Under ACA, insurers are no longer able to deny health care coverage due to pre-existing conditions and the expanded coverage options have resulted in declining caseloads for the limited benefit programs. Furthermore, limited benefits programs provide health services that do

not qualify as comprehensive coverage which is inconsistent with state policy goals and may result in enrollees being assessed the financial penalty.

- Many of the individuals enrolled in these limited benefit and special population programs are now eligible for coverage in Medi-Cal, Covered CA, or in the commercial market, and generally with more comprehensive benefits and lower or no cost to the individual.

Background. The FPACT program provides comprehensive family planning and reproductive health services at no cost to California residents at or below 200 percent of the FPL. FPACT currently has 2.8 million individuals enrolled in the program and serves 1.8 million income-eligible men, women, and adolescents annually through a network of 2,300 public and private providers.

The IMPACT program develops, expands, and ensures high quality prostate cancer treatment for, uninsured and underinsured California men who are age 18 and older and whose income is at or below 200 percent FPL. Eligible men are enrolled for twelve months of prostate cancer treatment service. The program collaborates statewide with local hospitals, clinics, and private practitioners to provide treatment services (in the nearest participating facility) including but not limited to surgery, radiation, hormone therapy, chemotherapy, and watchful waiting. Coverage also includes medical tests and services, hospital, outpatient, and pharmaceutical charges. IMPACT currently serves 413 men.

See previous agenda item for background information on GHPP and EWC.

Subcommittee Staff Comment and Recommendation—Modify TBL. It is recommended to modify this proposed trailer bill language by deleting the provisions related to GHPP. While the Administration's goal to promote comprehensive coverage is understandable, the components of this proposal related to GHPP could disrupt care or increase the cost of care for some of the state's most medically vulnerable persons. For example, persons on GHPP would likely have to pay higher prices for expensive drugs, such as clotting factor, if they are eligible and enroll in a Covered CA health plan. Additionally, although this proposal includes a "wrap" to provide specialized services in GHPP that would not be provided through a Covered CA health plan, the state has not yet implemented any Covered CA "wraps" and it is not clear when this could be accomplished.

Finally, in order to keep the cost of premiums affordable, Covered California plans have utilized selective contracting. There have been reports in the media and by stakeholders that enrollees could not find a Covered California plan that included their provider and sometimes it was not clear if the drug they needed would be on the formulary. Continuity of care for the individuals on GHPP is critical given that this is a fragile and chronically ill population.

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

1. Please provide an overview of this proposal.

3. Modification of Major Risk Medical Insurance Program

Budget Issue. DHCS proposes trailer bill language to modify the Major Risk Medical Insurance Program (MRMIP) and the Guaranteed Issue Pilot (GIP) Program, effective January 1, 2016. Specifically, this trailer bill language would:

- Permit subscribers, applicants, and their dependents, who are determined ineligible for coverage through the California Health Benefit Exchange (Exchange), ineligible for full scope no Share of Cost (SOC) Medi-Cal, and are unable to secure adequate private health coverage as defined in Welfare and Institutions Code Section 15884(b), to remain enrolled (subscribers) or to enroll (applicants and their dependents) in the modified program.
    - Individuals with End Stage Renal Disease (ESRD), who are under the age of 65 and have Medicare, would only be required to apply for the Medi-Cal Program to be determined for Medi-Cal eligibility. Those individuals that are determined ineligible for Medi-Cal would not be required to further apply, or show proof of ineligibility from the individual market to remain enrolled or enroll in the modified program.
- Clarify that an individual would not be eligible for MRMIP if:
    - The individual has not applied in a timely manner during any applicable Exchange open enrollment period or any special enrollment period following a qualifying life event; or
    - The application is rejected due to an individual's failure to provide sufficient information necessary for an eligibility determination to be made.
- Permit subscribers, who have applied for other health coverage during open enrollment for policy year 2016 and are still awaiting an eligibility determination, to continue to receive coverage through the modified program until the subscriber's eligibility and ineligibility for other health coverage is determined.
- Require DHCS to develop a notification process to inform all subscribers of the modifications to MRMIP and the coverage options available to them. This notification process would occur no later than 90 and 30 days prior to the start of open enrollment for policy year 2016.
- Allow DHCS to modify or replace the current MRMIP contribution structure.
- Allow DHCS to operate the modified program on such terms as DHCS deems reasonable and necessary if it is unable to secure sufficient health plan and vendor participation.
- Require DHCS to provide the Exchange, or its designee, with subscriber, applicant and dependent information it has collected for MRMIP use, in order to assist the Exchange with its eligibility determination. This information would be limited to the information that MRMIP and the modified program collect from subscribers and applicants for the purposes of determining eligibility for MRMIP and the modified program.
    - Currently, DHCS does not have legal authority to share the subscriber and applicant information it collects with the Exchange. This language would allow DHCS to share what information it currently collects or has collected from subscribers and applicants with the Exchange. Any additional information needed by the Exchange to determine eligibility would be the responsibility of the individual to provide, and the Exchange to collect.

  - As in current practice, if an individual applies directly to, or is referred by the Exchange to the county for a Medi-Cal determination, it would be the responsibility of the individual to provide, and the county to collect, the necessary information for a Medi-Cal eligibility determination.
- Allow DHCS to use plan letters, plan or provider bulletins, or similar instructions in order to implement the modified program, until final regulations are adopted.
- Require DHCS to adopt emergency regulations no later than July 1, 2018. DHCS would be able to readopt the emergency regulations as long as they are the same, or substantially the same as the initial emergency regulations. The initial emergency regulations and one re-adoption would be exempt from review by the Office of Administrative Law (OAL); however, DHCS would be required to submit these to OAL for filing where they would remain in effect for 180 days.
- Extend the period of time to reconcile payments for the GIP Program from six to 18 months which is more consistent with historical timelines.

MRMIP Budget and Caseload. As noted in the table below, the budget includes $27 million in funds for MRMIP in 2014-15; and $26.5 million in funds for MRMIP in 2015-16.

Table: MRMIP Budget Summary

	2013-14	2014-15	2015-16
State Operations	$746,000	$1,304,000	$1,457,000
Local Assistance	$24,854,000	$25,795,000	$25,045,000
Total	$25,602,000	$27,099,000	$26,502,000
Ending MRMIP Fund Reserve	$51,355,000	$45,077,000	$23,073,000

As displayed in the chart below, MRMIP enrollment has dropped dramatically since implementation of the Affordable Care Act as ACA prohibits the denial of coverage to individuals due to a pre-existing condition and also prohibits charging individuals with a pre-existing condition a higher premium due to their condition. As a result, MRMIP has seen a dramatic decline in caseload since ACA open enrollment in the Exchange began.

Chart: MRMIP Enrollment Summary 2014-2015

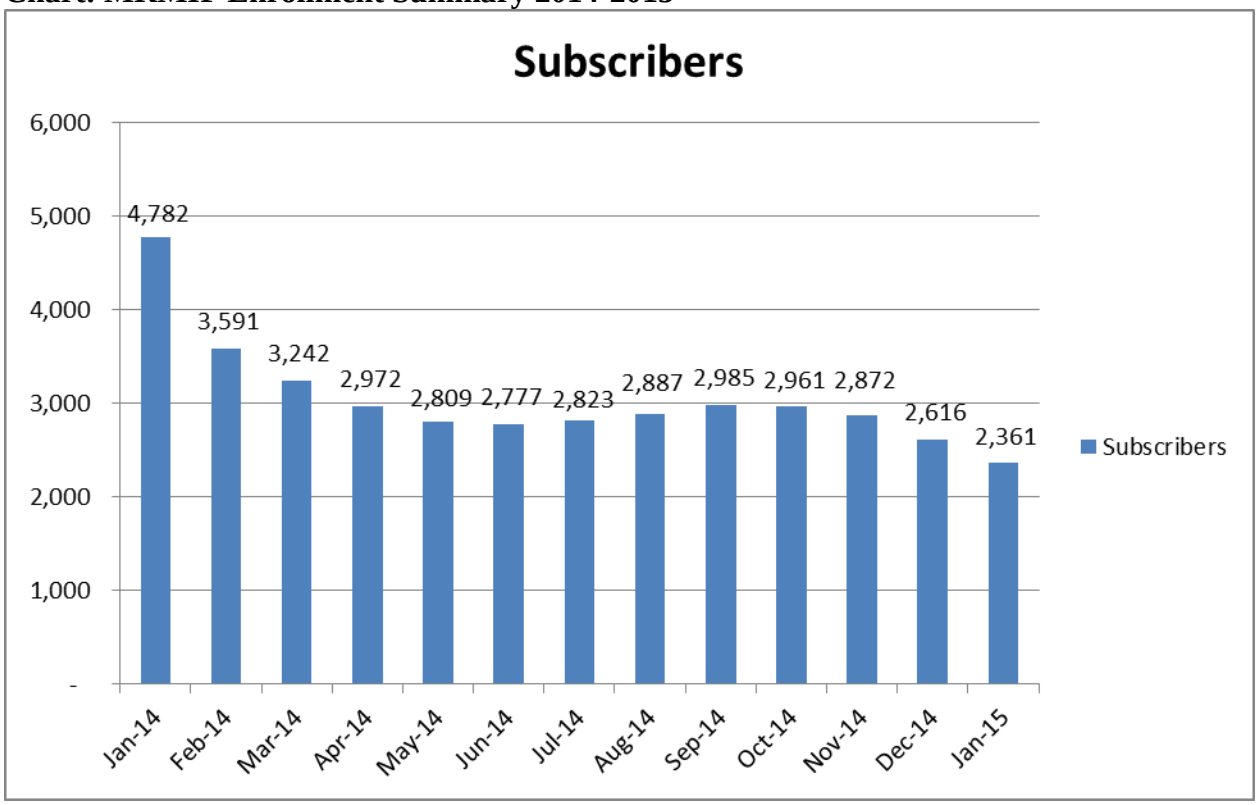

Chart: MRMIP Enrollment Summary 2011-2013

Major Risk Medical Insurance Program Enrollment by Month					
Jan-11	6,913	Jan-12	6,196	Jan-13	5,737
Feb-11	6,679	Feb-12	6,110	Feb-13	5,716
Mar-11	6,648	Mar-12	6,051	Mar-13	5,828
Apr-11	6,622	Apr-12	5,997	Apr-13	6,022
May-11	6,637	May-12	5,971	May-13	6,295
Jun-11	6,632	Jun-12	5,957	Jun-13	6,397
Jul-11	6,610	Jul-12	5,878	Jul-13	6,463
Aug-11	6,560	Aug-12	5,858	Aug-13	6,536
Sep-11	6,563	Sep-12	5,823	Sep-13	6,570
Oct-11	6,499	Oct-12	5,757	Oct-13	6,492
Nov-11	6,420	Nov-12	5,726	Nov-13	6,321
Dec-11	6,334	Dec-12	5,713	Dec-13	5,678
				Jan-14	4,782

MRMIP Background. AB 60 (Isenberg), Chapter 1168, Statutes of 1989, established MRMIP. Since 1991, MRMIP has provided health insurance to Californians who are unable to obtain coverage, or charged unaffordable premiums, in the individual health insurance market due to a pre-existing condition. Californians who qualify for MRMIP contribute to the cost of their health care coverage by

paying monthly premiums equal to 100 percent of the average market cost of premiums (based on the Silver level coverage through the Exchange), an annual deductible and copayments. These monthly premiums are subsidized through the Cigarette and Tobacco Products Surtax Fund (Proposition 99). MRMIP has an annual benefit cap of $75,000, and a lifetime benefit cap of $750,000. MRMIP is not an income-based eligibility program.

MRMIP was originally established as a state high-risk pool; however, the need for high-risk pools has been greatly reduced as a result of the passage of the federal Affordable Care Act (ACA).

DHCS assumed responsibility for MRMIP on July 1, 2014.

MRMIP Meets Minimal Essential Coverage. Effective January 1, 2014, the Affordable Care Act requires every individual to have minimum essential health coverage (known as "minimum essential coverage") for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return. State high risk pool coverage programs established on or before November 26, 2014 qualify as minimal essential coverage.

Individuals with End Stage Renal Disease. When the federal government established the framework for Medicare supplemental coverage, control over the regulation of health insurance and health plans remained with the states. Medicare most commonly provides coverage for persons age 65 and older, and it is also available to persons under age 65 who have a disability or are disabled or diagnosed with ESRD.

The federal framework for Medicare supplemental coverage gives states flexibility as to whether to include persons under age 65 who have a disability or are or diagnosed with ESRD in the Medicare supplemental coverage market. Health and Safety Code Section 1358.11 and Insurance Code Section 10192.11 authorize the Medicare supplemental coverage market to include persons with disabilities but exclude persons under age 65 with ESRD, by specifically allowing insurers and plans to exclude them from coverage. As a result, MRMIP subscribers with ESRD use MRMIP as their Medicare supplemental coverage. About 50,000 Californians are believed to be diagnosed with ESRD and approximately 60 ESRD individuals are enrolled in MRMIP.

Individuals under the age of 65 with ESRD who have Medicare coverage do not qualify for coverage in the Exchange or in the individual market because of federal "anti-duplication" laws. Some of these individuals do not qualify for Medi-Cal because they do not meet eligibility requirements.

Guaranteed Issue Pilot (GIP) Program. In order to address the growing waiting list for MRMIP, the Legislature passed AB 1401 (Thomson) in 2002, which established the GIP. Under the GIP, subscribers were automatically disenrolled from MRMIP after 36 months. At that time, subscribers could select guaranteed continued coverage from insurers in the individual market. Plans were required to offer the same benefit packages as those available under MRMIP, but with a higher annual benefit cap ($200,000 versus $75,000), and a lifetime cap of $750,000. The GIP program sunsetted in 2007.

MRMIP and GIP Reconciliations. DHCS is in the process of reconciling MRMIP and GIP actual plan expenditures and claims with what the state already paid these plans. There is currently a four-year

backlog in the reconciliation process. Consequently, it is unknown how much the state may owe plans or how much plans may owe the state.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue. The following issues should be considered in these discussions:

- **Proposal gives DHCS Broad Authority to Redesign MRMIP.** While the need for high-risk pools has been greatly reduced as a result of the ACA, this proposal gives DHCS very broad authority to redesign MRMIP without input from stakeholders or Legislative approval.

- **MRMIP as Safety-Net Option Would be Eliminated.** Under current law, MRMIP is a program where a person can purchase health coverage throughout the year if they missed the open enrollment period for commercial coverage or do not qualify for Medi-Cal. With this proposal, this safety net coverage option would be eliminated.

- **MRMIP and GIP Reconciliation Backlog Makes it Difficult to Understand Funding.** Based on the actual reduction in caseload for 2014-15 and the projected reduction in caseload for 2015-16, the MRMIP program is over budgeted. For example, given the actual caseload for 2014-15 and the estimated annual cost of $5,500 per subscriber, the Governor's MRMIP local assistance budget is over budgeted by about $13 million in 2014-15. However, as discussed above, there is a four-year backlog in processing MRMIP and GIP, which makes it difficult to quantify how much funding is available for the MRMIP program and for ongoing purposes.

  Subcommittee staff has requested technical assistance from the Administration on methods to facilitate and expedite the reconciliation process. It is important to expedite this process, so that the state has an understanding of the true balance of the MRMIF and can consider options on how to best use these funds and modify the MRMIP.

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

1. Please provide an overview of the Administration's proposed trailer bill language.

2. Please explain the reconciliation process and the projected timeline to address the four-year backlog in reconciliations.

4. Medi-Cal: Coordinated Care Initiative

Budget Issue. The Governor's budget includes a net General Fund savings of $173.8 million in 2015-16 as a result of CCI, including the General Fund savings from the sales tax on managed care organizations. Without the tax revenue, CCI would have a General Fund cost of $399 million in 2015-16. See table below for a fiscal summary.

Factors Affecting the Fiscal Solvency of CCI. SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013, requires the Department of Finance to annually determine if there are net General Fund savings for CCI. If CCI is not cost-effective, all components of CCI would cease operation. As part of the budget, the Administration identified the factors below that have occurred since the 2012 enactment of CCI that may jeopardize the fiscal solvency of this initiative. According to DOF's current analysis, if these factors do not improve, there would be a net General Fund cost for CCI; and consequently, CCI would cease operating effective January 2017. The Administration indicates that it remains committed to implementing CCI to the extent that it can continue to generate program savings.

The following changes have occurred since enactment of 2012 budget act:

- More than 100,000 participants were exempted, including Medicare Special Needs Plans and certain categories of Medi-Cal beneficiaries based on age or health condition.

- Passive enrollment was delayed until 2014, and Alameda County will no longer participate in the demonstration due to concerns regarding one of the health plan's readiness. Orange County will not begin passive enrollment until July 2015.

- Medicare and Medicaid savings were intended to be shared 50:50 with the federal government; however, the federal government reduced the amount of savings California was allowed to retain to approximately 25 to 30 percent.

- The federal government allowed a 3.975 percent tax on managed care organizations through June 30, 2016 which is attributable to the state's participation in the demonstration. However, recent federal guidance indicates that this tax will not be allowed to continue in its current form.

- As of November 1, 2014 approximately 69 percent of eligible participants opted out of Cal MediConnect compared to initial projections of approximately 33 percent. Of the 69 percent that have opted-out, about 80 percent of these individuals are In-Home Supportive Services (IHSS) beneficiaries.

- Due to revised federal Fair Labor Standards Act (FLSA) regulations, IHSS providers are entitled to overtime compensation. Because CCI established a maintenance-of-effort (MOE) funding formula for IHSS, the state's IHSS fiscal exposure has significantly increased. It should be noted that since the Governor's budget was released, a federal district court ruled that the FLSA regulations be vacated; consequently, it is unclear how this change impacts CCI.

Table: Coordinated Care Initiative Cost Savings Analysis

Coordinated Care Initiative (CCI)		
	2014-15	**2015-16**
(In thousands)	General Fund	General Fund
Local Assistance Costs/Savings Total	**$453,828**	**$201,958**
Payments to Managed Care Plans	$2,851,779	$5,632,869
Transfer of IHSS Costs to DHCS	-$723,243	-$1,456,769
Savings from Reduced Fee for Service Utilization	-$1,674,708	-$3,974,142
Payment Deferrals Total	**-$345,729**	**-$74,443**
Defer Managed Care Payment	-$382,473	-$91,688
Delay 1 Checkwrite	$36,744	$17,245
Revenue Total	**-$375,061**	**-$572,871**
Increased MCO Tax from CCI (All Revenue)	-$86,111	-$194,418
Increased MCO Tax from non-CCI (Incremental increase from tax rate of 2.35 to 3.93 percent as part of 2013 agreement with CMS on managed care tax)	-$288,950	-$378,453
State Administrative Costs[1)]	**$34,132**	**$22,893**
Department of Social Services – IHSS County MOE[2)]	**$175,064**	**$248,593**
Department of Social Services – IHSS County MOE, Costs Related to Fair Labor Standards Act	$62,646	$109,897
Net Impact to State	**-$57,766**	**-$173,870**

[1)]Includes administrative costs for DHCS, Department of Social Services, Department of Managed Health Care, Department of Aging, and California Department of Human Resources.

[2)]The IHSS county Maintenance of Effort (MOE), which changes county responsibility from a share of cost to set expenditures tied to the 2011-12 base General Fund costs. All nonfederal costs exceeding the MOE are General Fund.

Background. The 2012 budget authorized the Coordinated Care Initiative1 (CCI), which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits. The CCI is being implemented in seven counties2 (Los Angeles, Orange3, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).

1 Enacted in July 2012 through SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012, and amended by SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013.

2 Alameda County was initially part of CCI but given fiscal solvency issues with one of its plans, it will not participate in CCI.

3 It is projected that Orange County will begin CCI no sooner than July 2015.

CCI is composed of three major parts related to Medi-Cal:

- **Managed Long-Term Supports and Services (MLTSS) as a Medi-Cal Managed Care Benefit**: CCI includes the addition of MLTSS into Medi-Cal managed care. MLTSS includes nursing facility care (NF), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Community Based Adult Services (CBAS). This change impacts about 600,000 Medi-Cal-only enrollees and up to 456,000 persons eligible for both Medicare and Medi-Cal who are in Cal MediConnect.

- **Cal MediConnect Program**: A three-year demonstration project for persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system (health plan). No more than 456,000 beneficiaries would be eligible for the duals demonstration in the eight counties. This demonstration project is a joint project with the federal Centers for Medicare and Medicaid Services (CMS).

- **Mandatory Enrollment of Dual Eligibles and Others into Medi-Cal Managed Care.** Most Medi-Cal beneficiaries, including dual eligibles, partial dual eligibles, and previously excluded seniors and persons with disabilities (SPDs) who are Medi-Cal only, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits.

The purpose and goal of CCI is to promote the coordination of health, behavioral health, and social care for Medi-Cal consumers and to create fiscal incentives for health plans to make decisions that keep their members healthy and out of institutions (given that hospital and nursing home care are more expensive than home and community-based care). See table below for enrollment summary information.

Table: Coordinated Care Initiative Enrollment Summary

County	Cal MediConnect as of March 1, 2015	Medi-Cal-Only Managed Care for MLTSS*
Los Angeles	54,541	350,000
Orange	-	51,000
Riverside	15,396	48,000
San Bernardino	15,202	50,000
San Diego	20,256	64,000
San Mateo	10,100	14,000
Santa Clara	8,744	31,000
Total	**124,239**	**608,000**

*As of January 1, 2015. Medi-Cal-only enrollees will receive only Medi-Cal benefits from the health plan, including MLTSS. These enrollees include full dual eligibles excluded from Cal MediConnect, partial dual eligibles, and senior and persons with disabilities.

CCI In-Home Supportive Services (IHSS) Changes. CCI established a county maintenance-of-effort funding formula for the IHSS program. Additionally, CCI established a Statewide Authority for purposes of collective bargaining with respect to the wages and benefits for IHSS providers in the CCI counties. The Statewide Authority for collective bargaining begins in a CCI county when enrollment

into CCI is completed in the county. San Mateo County transitioned to the Statewide Authority in February 2015, and will be followed by Los Angeles, Riverside, San Bernardino and San Diego counties in July 2015. Santa Clara County is anticipated to transition January 2016 and finally Orange County in August 2016.

CCI Universal Assessment. Lastly, another component of CCI was the development of a universal assessment tool (UAT) to be used to streamline the assessment process for connecting consumer to services, such as those defined as part of MLTSS. The Department of Social Services and the Department of Aging are the leads on this process. It is anticipated that the piloting of the UAT will occur in two CCI counties in 2016-17.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as the following issues are considered and further discussed:

- **Higher Than Expected Cal MediConnect Opt-Out Rate.** The Governor's budget warns that if certain issues are not resolved, CCI and all of its parts, would cease to operate pursuant to current law. Of the key issues cited by the Administration as negatively affecting the CCI, the only issue for which the Administration has any ability to impact—without statutory changes or changes in the agreement with CMS—is the higher than expected opt-out rate for Cal MediConnect.

  DHCS indicates that it is currently undertaking a study as to the demographics of those who have opted-out including trying to get a better understanding for the reasons these individuals opted-out of the demonstration. For example, DHCS is trying to assess why there are geographical differences in the opt-out rate. DHCS is aiming to have this demographic analysis posted on its website in the next couple weeks.

  Cal MediConnect plans have committed significant financial and other resources to the success of this program. Ensuring a certain level of plan enrollment is critical not only to the success of the demonstration but potentially to the financial viability of the plans. It is essential that the Administration evaluate and address the reasons for the higher than expected opt-out rate. A related issue is the difficulty plans have reported in initially contacting enrollees due to inaccurate or missing contact information. The plans believe the inability to contact each new enrollee could be contributing to high opt out rates and is making it difficult to conduct risk assessments in a timely fashion.

- **Real-Time Data Needed to Evaluate if CCI is Meeting Goals of Improved Care Coordination and Health Outcomes.** While, unfortunately, there were implementation issues and disruptions as CCI rolled out, many of these issues are in the process of being resolved. If CCI is to continue, it will be important for the Legislature to have the data and metrics available to evaluate if CCI is meeting its goals of improved care coordination and improved health outcomes. Regardless of the trigger language that ceases operations of CCI if there is a net General Fund impact, the Legislature should consider CCI's overall value to the state and Medi-Cal enrollees. For example, if health outcomes are dramatically improved because health plans

are aggressively using interdisciplinary care teams and providing care plan option services[4] and there are modest increases in General Fund costs, it may be worthwhile to continue CCI.

Critical information necessary to make this evaluation include the type and volume of care plan option services provided by health plans and changes in utilization of services (e.g., change in use of long-term supports and services compared to nursing home care) and health care outcomes for both Cal MediConnect enrollees and the Medi-Cal-only enrollees.

While the Administration and the federal CMS plan to evaluate measures such as these as part of its overall evaluation of Cal MediConnect, this information is needed on a more immediate/real-time and public basis to understand if CCI is meeting its goals and how improvements can be made on a timely basis.

DHCS anticipates that health plans will likely begin submitting Medi-Cal encounter data to the federal system (Palmetto) in the next several months. DHCS still needs to test the data transfer process with Palmetto and the DHCS system. Once this is completed, DHCS would then have the capability to analyze the encounter data to determine, for example, the volume of care plan option services being provided

- **Evaluation Process for MLTSS Not Developed.** Most of the focus for CCI is on the component related to the duals demonstration project, Cal MediConnect. However, CCI's component related to the integration of MLTSS into Medi-Cal Managed Care impacts over 600,000 Medi-Cal enrollees. The state has yet to develop an evaluation plan or metrics to assess how and if managed coordination of long-term supports and services is improving the health outcomes for Medi-Cal only individuals.

  DHCS indicates that is in discussions with an organization to do an evaluation specifically of MLTSS. The project period for this evaluation is proposed to be July 1, 2015 – June 30, 2018. This evaluation would look at LTSS utilization, patient characteristics and rate of institutionalization both pre and post CCI.

- **Planning for Transition of MSSP to Managed Care Benefit is Critical.** One key piece of MLTSS is the transition of MSSP as services provided under a federal home- and community-based waiver into managed care benefit in the CCI counties. This transition would occur 19 months after a county enrolls MSSP beneficiaries into a managed care plan pursuant to CCI or when federal approval is received, whichever is later. As part of this transition, DHCS, the Department of Aging, and the Department of Managed Health Care are required to submit a transition plan to the Legislature on how this transition would occur. The plan is required to incorporate the principles and standards of MSSP in the managed care benefit, and provisions to

4 Care Plan Options (CPO) services are optional services that a Cal MediConnect health plan may provide that are above and beyond MLTSS that could enhance a member's care, allowing them to stay in their homes safely and preventing institutionalization. These services could vary based on the needs of the consumer and the care plan developed for this person. These CPO services may include, supplemental personal care services (above authorized IHSS), nutritional supplements and home delivered meals, home maintenance and minor home adaptation, and medical equipment.

ensure seamless transitions and continuity of care. Managed care health plans are required, in partnership with local MSSP providers, to conduct a local stakeholder process to develop recommendations that the department is to consider when developing the transition plan. See below for a chart on with the MSSP transition timeline.

MSSP Transition Timeline	
County	**MSSP Date of Transition**
Los Angeles	05/01/16
Orange	04/01/17
Riverside	05/01/16
San Bernardino	05/01/16
San Diego	05/01/16
San Mateo	11/01/15
Santa Clara	05/01/16

DHCS is preparing an initial plan to transition MSSP that details the approach to ensuring active engagement of stakeholders and readiness review criteria assuring that health plans as well as MSSP sites are prepared to transition the MSSP participants within respective counties or regions. DHCS indicates that the San Mateo County transition plan will be available mid-May 2015 and will include the MSSP transition plan, summary of stakeholder comments and timeline depicting all major milestones achieved and anticipated. DHCS states that it meets weekly with the California Department of Aging to develop necessary assurances which must be established by health plans and MSSP sites, within a county or region, prior to transition.

Although the state is about one year away from this transition for all counties except San Mateo, as the state learned when CBAS became a Medi-Cal managed care benefit in 2012, ensuring a smooth transition requires significant efforts to establish program standards and consensus on processes between the plans and providers. It also requires substantial outreach and education efforts with regard to providers, enrollees and their families and caregivers.

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

1. Please provide an update on the Coordinated Care Initiative.

2. Please discuss the department's preliminary analysis on the demographics of persons who opted-out of Cal MediConnect. What steps is DHCS taking to address the findings of this analysis?

3. Please describe how DHCS has increased its direct engagement with the Health Care Options call center and how this has improved CCI consumer interactions and the quality of the data.

4. Please describe how DHCS is planning for the transition of MSSP to managed care. Why does DHCS find that the transition of this benefit should occur given the future uncertainty of CCI?

5. Medi-Cal: Skilled Nursing Facility Quality Assurance Fee Extension

Budget Issue. DHCS requests trailer bill language (TBL) to:

a. Extend the sunset date for the skilled nursing facility rate-setting methodology established under AB 1629 (Frommer), Chapter 875, Statutes of 2004, as well as the Quality Assurance Fee (QAF) and Quality/Accountability Supplemental Payment (QASP) programs, from July 31, 2015, to July 31, 2020.

b. Specify that beginning 2015-16, the annual increase in the weighted average Medi-Cal reimbursement rate for skilled nursing facilities would be 3.62 percent. (The rate increase for 2013-14 and 2014-15 was 3 percent.)

c. Set Quality Accountability Supplemental Payment Program (QASP) program payments at the same level as existed for 2014-15 (approximately $90 million per year).

d. Extends the DHCS Administrative Procedure Act (APA) exemption through July 31, 2020, and the California Department of Public Health (CDPH) Public Contract Code exemption through December 31, 2020.

Background. AB 1629 enacted the Medi-Cal Long Term Care Reimbursement Act of 2004, which establishes a reimbursement system that bases Medi-Cal reimbursements to skilled nursing facilities (SNFs) on the actual cost of care. Prior to AB 1629, SNFs were paid a flat rate per Medi-Cal resident. This flat rate system provided no incentive for quality care and reimbursed SNFs for less than it cost to care for their residents.

AB 1629 also allows the state to leverage new federal Medicaid dollars by imposing a quality assurance fee (QAF) on SNFs. This new federal funding is used to increase nursing-home reimbursement rates. (Federal Medicaid law allows states to impose such fees on certain health-care service providers and in turn repay the providers through increased reimbursements.) Because the costs of Medicaid reimbursements to health care providers are split between states and the federal government, this arrangement provides a method by which states can leverage additional federal funds for the support of their Medicaid programs and offset state costs. In 2015-16, it is projected that the SNF QAF will offset over $500 million in General Fund expenditures.

AB 1629 contained a sunset date of July 1, 2008 and has been extended five times.

SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, established the Quality and Accountability Supplemental Payment (QASP) program. Under the QASP program, SNFs that meet minimum staffing standards can earn incentive payouts from a pool of supplemental funds. The payouts are awarded based on SNFs' performance on certain quality measures (including clinical indicators), as well as SNFs' improvement on these measures relative to the previous year. Under SB 853, a portion of each year's weighted average rate increase was to be set aside to fund the QASP payment pool. The set-aside amount was $43 million in 2013-14, and $90 million in the 2014-15 rate year. In 2013-14, about 477 out of 1,000 SNFs earned the QASP payouts.

Stakeholder Comments. The California Association of Health Facilities (CAHF), an association of SNFs and other health facilities, supports the Governor's proposal citing the overall benefits of the QAF and rate methodology contained in AB 1629. CAHF also states that the proposed rate increase will help "move skilled nursing facilities much closer to covering their costs of care by 2020." CAHF states that AB 1629 has benefited: 1) the state by creating an approximate $500 million General Fund offset within Medi-Cal; 2) nursing homes by generating approximately $6.5 billion in increased General Fund and federal fund revenue and by stabilizing the reimbursement system; and 3) patients by increasing quality of care. CAHF states that despite these benefits, the AB 1629 methodology currently reimburses providers at an amount that is less than 93 percent of the benchmarked costs of their services, equating to a shortfall of approximately $14 per patient day.

Advocate groups for nursing home residents, including California Advocates for Nursing Home Reform, oppose this proposal. These groups argue that any reauthorization of AB 1629 should increase mandatory nurse staffing ratio requirements. These groups note that California has not increased minimum staffing requirements since 1999 and request that minimum nursing hours be increased to at least 4.1 nursing hours per resident day (it is currently 3.2), including at least 1.3 hours of care by licensed nurses, by 2019-20.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal. Numerous studies have shown a positive association between nurse staffing levels and the quality of care provided in nursing homes. Additionally, research suggests that the ratio of professional nurses—registered nurses and licensed vocational nurses—to other nursing personnel—such as certified nurse assistants—is an important predictor of the quality of care received. Having a greater number of professional nurses appears to have a positive effect on the lives of residents. However, increasing the nursing staff ratios would have an additional cost to the state. At this point, the fiscal impact of increasing nurse staff ratios is unknown.

It is important to consider this proposal in the context of the long-standing issues with the Licensing and Certification (L&C) program at the Department of Public Health and the state's inadequate oversight of long-term care health facilities. The budget also contains proposals by L&C to increase staffing and improve the state's oversight of SNFs. Improved oversight and monitoring of these facilities should lead to better quality and better care. Additionally, potential augmentations to the Long Term Care Ombudsman Program could also improve the quality of care provided in SNFs.

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

1. Please provide an overview of this proposal.

2. What is DHCS' assessment of AB 1629's impact on the quality of care in nursing homes?

3. Why does the Administration find that skilled nursing facilities should receive an annual 3.63 percent rate increase for the next five years?

6. Medi-Cal: Managed Care Office of the Ombudsman

Budget Issue. DHCS's Medi-Cal Managed Care Office of Ombudsman (OMB), requests nine two-year limited term full-time positions and expenditure authority of $1,045,000 ($522,000 General Fund and $523,000 Federal Fund) to support the increased workloads as a result of the growth in the managed care program. As distinguished from other ombudsman offices, such as the Long-Term Care Ombudsman at the Department of Aging, this office primarily assists Medi-Cal only enrollees of Medi-Cal managed care plans.

Currently, the Medi-Cal Office of the OMB has nine permanent staff, seven who answer phone calls and two who perform clerical support. Additionally, DHCS has redirected 14 temporary staff to OMB to help with the call volume on a limited-term basis.

DHCS acknowledges that with the present staffing levels, staff is unable to answer between 250-350 calls on a daily basis. The inability to answer these calls results in unreported cases of possible inappropriate denials of medically necessary services, inability to effectuate rights to continuity of care or medical exemptions, and poses a potential threat to the health and safety of Medi-Cal beneficiaries. DHCS states that it is requesting limit-term positions because it finds that it is unclear whether the increase in call and case volume is related to initial enrollment into managed care or if it is indicative of ongoing workload.

Background. OMB serves as a resource for Medi-Cal managed care members and helps solve problems; from a neutral standpoint to ensure that members receive all medically-necessary covered services. In addition to assisting Medi-Cal beneficiaries, OMB provides guidance and assistance to county eligibility workers, the Legislature, stakeholders, other state departments, and various associations (foster children, pregnancy related, etc.). OMB currently receives approximately 25,000 calls a month, creating 13,000 new cases requiring detailed investigation.

The OMB works each call completely through resolution. According to DHCS, frequently a caller has already contacted their county, their provider, Health Care Options, the Fiscal Intermediary (Xerox) or others without any resolution. Consequently, OMB often handles complex calls that require coordination with multiple entities and OMB staff performs research, coordination, and may call multiple outside entities with the caller on-line to find a resolution. OMB call handling times range from two minutes to more than an hour.

In addition to handling and researching calls, the OMB processes disenrollment or enrollment for the current or past months of eligibility. This function assures continuity of care for members either with their health plan or in fee-for-service Medi-Cal. On a monthly basis, the OMB averages 1,900 emergency enrollments and disenrollments for managed care members.

Since January 2011, the Medi-Cal managed care program has doubled in enrollment from approximately 4 million enrollees to about 8 million in August 2014. Additionally, over the last few years, recorded call volume has increased between 5 to 15 percent each year with case volumes increasing between 25 to 50 percent each year. Call volumes increased 40 percent between December 2013 and June 2014 and

continue to increase sharply. The number of cases logged by OMB staff has increased by 100 percent since the beginning of the calendar year 2014.

New Telephone System. DHCS is in the final phases of implementing an updated telephone system for OMB, with the system expected to be implemented by June 30, 2015. This Voice over IP (VOIP) system is expected to increase the office's ability to respond to the concerns of beneficiaries significantly. For example, according to DHCS, the current system operates without redundancy leaving the call center at risk of becoming non-operational, while the new system will have built in redundancy and will be able to continuously service beneficiaries. Additionally, with the current system a caller must wait on the line before they can leave a voicemail for call back; on the new system the caller has an option to leave a call back number and not lose their place in the cue. There will also be an increased queue capacity from the current 30 callers to more than 500 callers. DHCS finds that this new phone system will increase the functionality, capacity, and responsiveness of the Ombudsman when compared to the system currently in place.

Additionally, according to DHCS, this new phone system provides the ability to collect data regarding wait times, call times, abandonment rates, and other full call center monitoring functions and provides supervisors the ability to adjust resources.

Subcommittee Staff Comment and Recommendation—Approve. It is clear that OMB needs additional staff to address the growing workload. The new phone system also appears to be a key tool in improving OMB and having the data to monitor the performance of this office.

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

1. Please provide an overview of this proposal.

2. Please describe how the new phone system will help DHCS manage the OMB and whether it is likely to meet the expected operational timeline of June 2015?

3. Although there is no prescribed performance standard for responding to calls, does OMB have any goals with regard to response times? How would this proposal improve response times?

7. Medi-Cal: Impact of President's Executive Order

Budget Issue. The Governor's budget does not include funding for the potential Medi-Cal costs related to the President's executive actions on immigration.

In November 2014, the President announced several executive actions intended to allow certain undocumented immigrants to pass a criminal background check and pay taxes in order to temporarily stay in the U.S. without fear of deportation. The Administration indicates that there is great uncertainty at this time regarding the effect of the President's actions and consequently the budget does not assume any higher costs for individuals that have a recognized immigration status under the President's executive order and, thus be eligible for Medi-Cal.

Background. The President's executive actions expand the Deferred Action for Childhood Arrivals (DACA) program and create the Deferred Action for Parents of Accountability (DAPA) program (also known as the Deferred Action for Parents of Americans and Lawful Permanent Residents program) as follows:

- ***Expands DACA Program.*** Previously, undocumented individuals who were younger than 31 years of age as of June 2012, had entered the United States prior to the age of 16, and had lived in the United States continuously since January 1, 2010, were eligible for DACA. The President's executive actions expand the population eligible for DACA to include people of any age who entered the United States before the age of 16 and meet the other DACA requirements. The President's executive actions also extend the period of DACA eligibility and work authorization from two years to three years.

- ***Creates DAPA Program.*** The President's executive actions also create the DAPA program, which allows undocumented immigrants who have lived in the United States continuously since January 1, 2010 and are parents of United States citizens or lawful permanent residents to request deferred action and work authorization for three years.

A lawsuit was filed in February by officials of 26 states who contend the President's executive actions violated the United States Constitution as an overreach of executive powers. The suit seeks an order blocking the immigration changes from taking effect. Initial arguments in the suit were heard by a United States district judge on January 15, 2015, where the states asked the judge to block the executive actions until they have been able to challenge the actions in court. The judge has halted implementation of the President's actions. Officials from 12 states, including California, and the District of Columbia recently filed an amicus or "friend of the court" brief supporting the President's executive actions.

Estimates for Number of DACA and DAPA Individuals that Could be Eligible for Medi-Cal. In March, the UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research released a report stating that between 360,000 and 500,000 Californians with DACA or DAPA could be eligible for Medi-Cal after several years of implementation. The report notes that analysis of take-up for this population in California has not been conducted and finds that there is great uncertainty to the take-up rate given that it is still unknown how the DACA and DAPA programs will be implemented.

LAO Analysis. The LAO finds that there will be a delay in the fiscal impact to the state if or when the executive actions are implemented because eligible individuals will need to apply for DACA or DAPA and that the United States Citizenship and Immigration Services estimates that it will take up to a year to process all applications from the time that the department begins accepting applications. After this, eligible individuals will then need to apply for Medi-Cal coverage. Additionally, given the lawsuit described above, the LAO finds that the state would at most experience partial-year and minimal costs in the budget year.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of how the President's actions could impact the Medi-Cal caseload.

8. Medi-Cal: Continuation of 1115 Waiver Workload

Budget Issue. DHCS requests to convert 15 limited-term positions to full-time permanent positions and an annual $1 million contract at a cost of $2,311,000 ($812,000 General Fund and $1,499,000 federal funds) in 2015-16. The $3,000,000 in expenditure authority is over a three-year period ($1 million annually, $250,000 General Fund and $750,000 federal funds) for the External Quality Review Organization (EQRO) contract. According to DHCS, these 15 positions will continue to support the activities and programs that provide ongoing support of critical functions of "California's Bridge to Reform" 1115 Waiver. The positions are being requested as permanent positions because the department anticipates a subsequent waiver starting in 2015-16. Each waiver is five years in length and the department anticipates a continued need for waiver funding; consequently, DHCS finds that this workload will continue in the foreseeable future.

Background. The 1115 "Bridge to Reform" Demonstration Waiver Renewal became effective on November 1, 2010. To support the new workload associated with this 1115 waiver, 15 temporary positions were established in 2010-11 and in 2011-12 to operationalize the transition of the seniors and persons with disabilities (SPD) population to Medi-Cal managed care. According to DHCS, the conversion of these positions to permanent full-time permanent is necessary to continue the transition of new populations to Medi-Cal managed care, along with the ongoing monitoring, oversight and reporting for a number of different population groups. DHCS indicates that recruitment of qualified candidates for these classifications, with the duties required, is considerably more challenging when only offered on a limited-term basis. The nature of the workload associated with these positions is complex and requires an extensive working knowledge of the programs. The retention of knowledgeable and experienced staff is essential to the program.

California's Request for Renewal of Section 1115 Waiver Demonstration. On Friday, March 27, 2015, DHCS submitted a request to renew the state's section 1115 Medicaid Waiver for a new five-year term. The new waiver, "Medi-Cal 2020," seeks approximately $17 billion in federal investment to further the achievements California has made in health care reform through a set of payment and delivery system transformation strategies. The application and concept paper (attached) is available on the DHCS website. DHCS is seeking approval of the Waiver from the Centers for Medicare and Medicaid Services (CMS) by November 1, 2015. Over the next few months, DHCS and CMS will collaborate on the terms and conditions of the new Waiver. DHCS has engaged in an extensive stakeholder process over the past four months, using primarily foundation funding. Concurrently, DHCS states it will continue to engage stakeholders, along with Administration and Legislative partners in the refinement of the waiver concepts.

AB 72 (Bonta and Atkins) and SB 36 (Hernandez and De León) pending in this session are intended to contain the necessary statutory changes to implement the 2020 waiver once the Special Terms and Conditions (STCs) are negotiated with CMS.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this item.

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

1. Please provide an overview of this proposal.

2. Please provide a brief overview of the 1115 Waiver Renewal proposal submitted to CMS in March. What is the timeline and process for this renewal proposal?

9. Medi-Cal: Palliative Care

Budget Issue. DHCS requests $125,000 ($63,000 General Fund and $62,000 federal funds) in 2015-16 and $116,000 ($58,000 General Fund and $58,000 federal funds) in 2016-17 and one two-year limited-term position. The requested position (Health Program Specialist I) will implement provisions of SB 1004 (Hernandez), Chapter 574, Statutes of 2014.

SB 1004 requires DHCS to establish minimum standards for eligibility for and delivery of palliative care services concurrent with curative services, and to provide technical assistance to managed care plans to ensure and monitor the appropriate delivery of palliative care services.

Background. Palliative care is specialized, interdisciplinary care and support that focuses on physical, psychological, emotional, and spiritual needs of people with serious and progressive illness and their families. According to the federal Centers for Medicare and Medicaid Services (CMS), palliative care means patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

In California statute, palliative care is defined to mean medical treatment, interdisciplinary care, or consultation provided to a patient or family members, or both, that has as its primary purpose the prevention of, or relief from, suffering and the enhancement of the quality of life, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life (Health and Safety Code, Section 442(e)).

SB 1004 requires DHCS to establish standards for palliative care services delivered concurrent with curative services to Medi-Cal beneficiaries served by Medi-Cal managed care health plans. The goal of palliative care is to improve patient choice and satisfaction and reduce unwanted higher cost services such as hospital stays and readmissions, and emergency room visits.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. No issues have been raised. DHCS has already convened stakeholder meetings to discuss palliative care models and options for implementing SB 1004.

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

1. Please provide an overview of this proposal.

10. Medi-Cal: CA-MMIS

Oversight Issue. DHCS is currently in a multi-year process to replace the California Medicaid Management Information System (CA-MMIS) which processes Medi-Cal fee-for-service health care claims.

The total cost to replace CA-MMIS is $479.7 million ($95.9 million General Fund and $383.8 million federal funds). Additionally, it is anticipated that the Administration will be submitting a Budget Section Letter in the near-term for an augmentation of $21.1 million because of project delays.

On February 19, 2015, the California State Auditor sent a letter to the Governor and Legislature citing its concerns with CA-MMIS. These concerns include:

- Although Xerox implemented the first major release, implementing Release 2 will be significantly more challenging. Release 2 is anticipated to provide functionality for processing claims and for plan management as well as financial management for the Child Health and Disability Prevention program. The state auditor finds that since Release 2 will provide functionality to users beyond DHCS and Xerox; and addresses significantly more functional requirements than Release 1, there is great risk that Release 2 will not be completed on June 2015 as planned.

- In April 2014, this project switched from a "waterfall" approach to an "agile" approach to more quickly and frequently deliver and test enhancements and changes. The state auditor notes that while this presents opportunities for the project, there are risks in that neither DHCS nor Xerox has extensive experience in the agile software development methodology.

- Xerox has experienced problems implementing Medicaid Management Information Systems in other states. The state auditor finds that this suggests that DHCS has a high-risk of experiencing more delays and problems before the new system is fully implemented.

DHCS acknowledges the concerns recently raised by the state auditor. DHCS intends to address these concerns by hiring a recognized industry leader in agile software development to conduct periodic assessments of the project's software development methodology. Additionally, DHCS notes that it has a contract amendment in process that would include 120 discrete pay points (deliverables that trigger payments to Xerox) that are tied to that functionality. The intent of this amendment would be to ensure that Xerox is only paid for business functionality that is successfully delivers into production.

Background. CA-MMIS processes and pays approximately $19.8 billion a year in Medi-Cal fee-for-service health care claims to providers for medical care services provided to Medi-Cal beneficiaries, as well as the claims for other DHCS health care programs. The fiscal intermediary (FI), currently Xerox, operates and maintains the system as a contractor of DHCS.

DHCS is responsible for the overall administration, management, oversight, and monitoring of the FI contract with Xerox and all services provided under the contract. Other FI services include: the operation of a telephone service center and provider relations functions (publications, outreach, and

training), system operations, updates and enhancements, processing eligibility inquiry transactions, treatment authorization requests, and service authority requests. The FI is also responsible for planning, developing, designing, testing, and implementing a new replacement system to replace the current thirty year-old legacy system that will put into effect current technology and support a service-oriented architecture, consistent with the new federally mandated Medicaid Information Technology Architecture (MITA).

SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, requires the California State Auditor (state auditor) to monitor the transfer of operational responsibility for the California Medicaid Management Information System (CA-MMIS) to Affiliated Computer Services, a Xerox company (from the prior contractor, Hewlett-Packard), and the subsequent design, development, and implementation of a replacement system. The legislature has received anecdotal complaints from providers that under the current system there is a very high rate of claims that are inappropriately denied

Subcommittee Staff Comment and Recommendation—Informational Item. Given the significance of this system and the vendor's track record in other states, as noted by the state auditor, it is important that DHCS continue to provide state control agencies and the Legislature with regular updates on the status of this project and be transparent in identifying issues as they arise.

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

1. Please provide an overview of steps DHCS is taking to address the state auditor's concerns.

2. What is the status of the contract amendment?

11. Medi-Cal: Electronic Health Records Incentive Program - Staffing

Budget Issue. DHCS requests the extension of two limited-term positions for two years (July 1, 2015 through June 30, 2017) and the conversion of six limited-term positions to permanent positions for the Medi-Cal Electronic Health Records (EHRs) Incentive Technical Assistance Program. The positions will continue efforts to advance the adoption and meaningful use of EHRs and the establishment of a provider technical assistance program. These positions have never been filled because DHCS was unable to secure external funding to support these positions.

Additionally, DHCS requests funding for a consulting contract with subject matter experts on federal/state administrative oversight and reporting relative to the technical assistance program with a cost of $200,000 per year ($20,000 MRMIF, $180,000 Federal Fund) for 2015-16 through 2017-18. Total annual costs for the positions and contract funding are $1,162,000 ($117,000 Major Risk Medical Insurance Fund (MRMIF) and $1,045,000 Federal Fund).

These requests are made to support the funding ($3.75 million MRMIF) authorized by SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014, to support the Medi-Cal Electronic Health Records Incentive Program and to receive $37,500,000 million in federal funds for a statewide provider technical assistance program for eligible providers.

DHCS also requests the following budget bill language to allow SB 870's funding to be available for encumbrance or expenditure until June 30, 2018:

> 4260-490 – Reappropriation, Department of Health Care Services. Notwithstanding any other provision of law, as of June 30, 2015, the amounts specified in the following citations are reappropriated for the purposes provided for those appropriations and shall be available for encumbrance or expenditure until June 30, 2018:
>
> 0313 ---- Major Risk Medical Insurance Fund,
> (1) Up to $3,750,000 in Section 15, Chapter 40, Statutes of 2014, for purposes of electronic health records technical assistance in accordance with the State Medicaid Health Information Technology Plan as specified in Section 14046.1 of the Welfare and Institutions Code.

Background. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorizes the outlay of federal money estimated to be roughly $4.5 billion for California and $45 billion nationally for Medicare and Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade and use electronic health records in accordance with the act's requirements. The goal of HITECH is to improve the quality, safety, and efficiency of health care through "meaningful use" of EHRs. HITECH will result in a significant increase in provider adoption and use of EHR systems, resulting in HITECH's desired health care improvements, and an overall improvement in public health. The use of EHR technology in this manner includes the use of electronic prescribing (ePrescribing), submission of clinical quality measures, reporting to immunization and disease registries, and exchanging health information among Medi-Cal providers, hospitals and DHCS to improve the quality of patient care.

The Medi-Cal EHR Incentive Program is a multi-year program that began on October 3, 2011 for eligible hospitals, November 15, 2011 for groups/clinics, and January 3, 2012 for eligible providers. The incentive program will operate through December 31, 2021. Since the implementation of the Medi-Cal EHR Incentive Program, DHCS has authorized more than 20,000 incentive payments to over 15,000 providers and 260 hospitals. This has resulted in more than $1 billion in incentive payments made to date. DHCS expects to distribute between $100 and $200 million per year for the remainder of the program. DHCS has estimated approximately $2 billion will be distributed to providers over the course of the ten year program.

DHCS's Office of Health Information Technology (OHIT) received federal approval for 90/10 reimbursement for the implementation of a $37.5 million direct technical assistance program for advancement of EHR adoption and provider participation in the Medi-Cal Incentive program that is similar to the sunsetting REC program. As part of the 2014 budget, $3.75 million from MRMIF was provided to DHCS to draw down the $37.5 million in federal funds. This funding will allow OHIT to procure vendors for the statewide provider technical assistance effort as well as fund state staff and consulting services necessary to implement the program. The program will primarily target providers and specialists not previously supported by the RECs. As discussed above, due to existing workload, current OHIT staff cannot perform the additional work necessary to implement the additional technical assistance program that has been approved by CMS.

According to DHCS, the approval of this proposal will provide the state with resources needed to continue and further advance the Medi-Cal EHR Incentive Program through technical assistance to providers as described in the Project Book above. Advancement of the program constitutes workload above and beyond what OHIT can support without these positions. Without sufficient resources to coordinate and conduct these activities, the department may be unable to continue meeting the requirements for state participation in the program, which is expected to result in a total distribution of $2 billion in federal incentive funds to California providers, and ensure continue enhanced federal funding for administration of the program.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal to continue efforts to advance the adoption and meaningful use of EHRs in the Medi-Cal program.

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

1. Please provide an overview of this proposal.

2. What is the status of the awarding of the $41.25 million ($37.5 million in federal funds) for the direct technical assistance program?

12. Medi-Cal: Behavioral Health Treatment

Oversight Issue. SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014 requires DHCS to add behavioral health treatment (BHT) services, such as applied behavioral analysis (ABA), as a covered benefit in Medi-Cal to the extent required by federal law. Subsequent to the enactment of the 2014 budget, the federal government issued guidance indicating that BHT should be a covered Medicaid benefit for eligible children and adolescents with autism spectrum disorder (ASD). In response to the guidance, DHCS submitted State Plan Amendment (SPA) 14–026 to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2014 to seek the necessary approval to include BHT as a covered Medi-Cal service for individuals under 21 years of age with ASD.

DHCS's interim guidance requires Medi-Cal managed care plans to provide medically necessary BHT services for eligible children and adolescents with ASD effective September 15, 2014. All children receiving BHT services on September 14, 2014 through a regional center will continue to receive those services through the regional center until such time that DHCS and the Department of Developmental Services (DDS) develop a transition plan.

The Medi-Cal budget includes $89 million General Fund in 2014-15 and $151 million General Fund in 2015-16 for the provision of BHT services to eligible children with ASD. As part of the budget, DHCS assumed that the average monthly cost of BHT is $3,000-$3,750 and that an estimated 4,000-5,000 children in 2014-15 and 8,000-10,000 children in 2015-16 would receive these services.

The Governor's proposed 2015-16 budget for DDS also assumes a $2 million decrease ($1 million General Fund) over the current year budget to reflect a reduction in expenditures for an estimated 292 new consumers who would receive BHT services through the DHCS as a Medi-Cal benefit instead of at the regional centers.

Since September 2014, DHCS has convened monthly public stakeholder meetings regarding the implementation of this benefit.

Comprehensive Diagnostic Evaluation. Generally, Medi-Cal children age three or older would be eligible for BHT when a comprehensive diagnostic evaluation (CDE) indicates that evidence-based BHT services are medically necessary and recognized as therapeutically appropriate. The CDE has multiple components and includes evaluations in cognition, speech and language, and other motor skills.

Concerns have been raised regarding waitlists for CDEs. DHCS indicates that it is not aware of any wait lists for CDEs for Medi-Cal beneficiaries. DHCS conducts monitoring of network adequacy through secret shopping; analysis of grievances and appeals, ombudsman calls, and monthly utilization data; stakeholder input; and regular check-ins with Medi-Cal managed care health plans. DHCS is also in the process of convening a CDE workgroup which will provide input into how to best utilize the CDE process.

Transition Plan. DHCS and DDS are in the processing of developing a transition plan that will describe how children receiving BHT services at regional centers will transition to receiving these benefits through Medi-Cal. In 2013-14, there were about 7,700 children and adolescents enrolled in Medi-Cal

who receive BHT services through DDS. DHCS and DDS are in the process of determining how many of these children have Medi-Cal as their primary coverage and would be transitioned to Medi-Cal. Of the 7,700 it is estimated that approximately 1,922 are "institutionally deemed" for Medi-Cal, meaning that only the income and resources of the child (ages 3 to 18) are considered when determining eligibility (instead of the entire family's income and resources). Institutional deeming is part of the federal home and community-based waiver program. If a child/family chose to no longer be deemed eligible for Medi-Cal, they could continue receiving BHT through a regional center.

DHCS notes that it plans to phase this transition based factors such as the number of children in each county receiving these services and the number of regional centers in the county. DHCS indicates that once the state has a draft transition plan, it will seek comments from stakeholders.

DHCS indicates that the regional centers and Medi-Cal managed care plans each have identified liaisons to assist in the transition and coordination of BHT services. The liaisons already are, and will continue, communicating regularly to identify and remedy potential issues that may arise. Additionally, regional centers regularly review implementation of the individual program plan (IPP) with families to determine if satisfactory progress is being made and/or if any changes to the IPP are needed. DHCS notes that these IPP reviews provide an opportunity to verify that the child is receiving BHT services through Medi-Cal.

LAO Assessment. LAO finds that based on the rate of the ongoing phase-in of BHT services and its review of the preliminary data used to estimate the cost of BHT services in the Governor's budget, the estimated costs to provide BHT services (excluding costs in the DDS budget) in 2014–15 and 2015–16 are likely to be lower at the time of the May Revision.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on the implementation of this benefit. The following issues should be considered:

- **Budget to Implement BHT is Overstated** – Subcommittee staff concurs with the LAO assessment that the Medi-Cal budget overstates the level of funding (for the current year in particular) for the implementation of this benefit. As of March 6, 2015, 814 children in Medi-Cal were receiving BHT. As noted above, in the current year the Medi-Cal budget assumes that 4,000 to 5,000 children are receiving BHT, which is thousands more than the number of children actually receiving BHT in Medi-Cal.

- **BHT Rate Not Yet Finalized.** DHCS is still in the process of determining the rate to be paid to Medi-Cal managed care plans to provide this benefit. DHCS expects to have this rate available no sooner than May. This rate level is important because it must be sufficient to ensure enough providers participate.

- **A Thoughtful Transition Plan Will Be Critical.** The policies outlined in the transition plan will be critical to ensure that there are no disruptions in treatment for these children. Subcommittee staff finds that DHCS intends to proceed cautiously and thoughtfully and plans to engage stakeholders prior to the finalization of the transition plan. However, it will be important for DHCS and DDS to (1) engage stakeholders and consumer groups, early

and often, on how the state plans to communicate these changes to consumers, (2) share data to assist in the planning for this transition, (3) make efforts to retain the current providers for continuity, and (4) minimize any impact to consumers and families.

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

1. Please provide an overview of the implementation of BHT as a Medi-Cal benefit.

2. Please provide an update on the development of the transition plan with the Department of Developmental Services. How is DHCS planning to ensure that consumers receiving these services through regional centers do not experience any interruption in services or see a reduction in the quality and quantity of services?

3. How is DHCS engaging with stakeholders in the development of the transition plan?

4. If an ASD diagnosis is not established through the comprehensive diagnostic evaluation, do federal Early and Periodic Screening, Diagnostic, and Treatment requirements provide that a Medi-Cal child could receive BHT, if BHT is determined to be medically necessary?

5. Is DHCS aware of any wait lists or long waits to get a comprehensive diagnostic evaluation? How is DHCS monitoring this?

13. 1991 Realignment Technical Trailer Bill Language

Budget Issue. The Administration proposes trailer bill language to eliminate the need to redirect sales and use tax and vehicle license fee revenues between the Health and Social Services Subaccounts and make necessary technical and clarifying changes related to AB 85 (Committee on Budget), Chapter 24, Statutes of 2013.

Background. AB 85 modified 1991 Realignment Local Revenue Fund (LRF) distributions to capture and redirect county savings resulting from the implementation of federal health care reform effective January 1, 2014. AB 85 established the Family Support Subaccount within the LRF beginning in 2013-14.

The Family Support Subaccount receives sales tax revenues redirected from the Health Subaccount, which then redistributes the funds to counties for the CalWORKs program. While this redirection mechanism frees up General Fund resources to pay for Medi-Cal costs, according to the Administration, the process to achieve this is significantly burdensome for the State Controller's Office and the Department of Finance.

The Administration indicates that this proposal to streamline the distribution of realignment funds will significantly reduce workload and improve administrative efficiencies for the State Controller's Office and the Department of Finance. This proposal does not result in any material change to 1991 State and Local Realignment.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt this proposed placeholder trailer bill language. No concerns have been raised with this technical trailer bill language.

Questions. The Subcommittee has requested the Department of Finance to respond to the following:

1. Please provide a brief overview of this proposal.