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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator William W. Monning
Senator Jeff Stone

Thursday, April 27, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

PUBLIC COMMENT

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4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Overview

Office of Statewide Health Planning and Development - *Three-Year Funding Summary*			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Actual	***Revised***	***Proposed***
0001 – General Fund	$-	$-	$-
0121 – Hospital Building Fund	$53,298,000	$60,501,000	$61,726,000
0143 – CA Health Data & Planning Fund	$31,203,000	$35,930,000	$30,447,000
0181 – Registered Nurse Ed. Fund	$2,081,000	$2,180,000	$2,172,000
0518 – Hlth. Fac. Const. Loan Ins. Fund	$5,891,000	$4,882,000	$4,807,000
0829 – Health Professions Ed. Fund	$9,536,000	$10,855,000	$1,070,000
0890 – Federal Trust Fund	$1,444,000	$1,554,000	$1,447,000
0995 – Reimbursements	$5,096,000	$7,120,000	$863,000
3064 – Mental Hlth. Practitioner Ed. Fund	$391,000	$397,000	$394,000
3068 – Vocational Nurse Ed. Fund	$218,000	$229,000	$224,000
3085 – Mental Health Services Fund	$31,473,000	$49,482,000	$26,023,000
8073 – Med. Underserved Acct., HPE Fund	$2,255,000	$2,302,000	$2,302,000
Total Department Funding:	**$142,886,000**	**$175,432,000**	**$131,475,000**
Total Authorized Positions:	**443.7**	**449.0**	**447.0**

Office of Statewide Health Planning and Development - *Comparison to 2016 Budget Act*			
Fund Source	**2016-17**	**2016-17**	**2016-17**
	Appropriation	***Revised***	***Difference***
0001 – General Fund	$33,334,000	$-	($33,334,000)
0121 – Hospital Building Fund	$60,872,000	$60,501,000	($371,000)
0143 – CA Health Data & Planning Fund	$33,912,000	$35,930,000	$2,018,000
0181 – Registered Nurse Ed. Fund	$2,186,000	$2,180,000	($6,000)
0518 – Hlth. Fac. Const. Loan Ins. Fund	$5,029,000	$4,882,000	($147,000)
0829 – Health Professions Ed. Fund	$10,640,000	$10,855,000	$215,000
0890 – Federal Trust Fund	$1,443,000	$1,554,000	$111,000
0995 – Reimbursements	$4,071,000	$7,120,000	$3,049,000
3064 – Mental Hlth. Practitioner Ed. Fund	$400,000	$397,000	($3,000)
3068 – Vocational Nurse Ed. Fund	$233,000	$229,000	($4,000)
3085 – Mental Health Services Fund	$44,570,000	$49,482,000	$4,912,000
8073 – Med. Underserved Acct., HPE Fund	$2,303,000	$2,302,000	($1,000)
Total Department Funding:	**$198,993,000**	**$175,432,000**	**($23,561,000)**
Total Authorized Positions:	**449.0**	**449.0**	**-**

Office of Statewide Health Planning and Development - *Comparison 2016-17 (Rev) to 2017-18*			
Fund Source	**2016-17**	**2017-18**	**2017-18**
	Revised	***Proposed***	***Difference***
0001 – General Fund	$-	$-	$-
0121 – Hospital Building Fund	$60,501,000	$61,726,000	1,225,000
0143 – CA Health Data & Planning Fund	$35,930,000	$30,447,000	($5,483,000)
0181 – Registered Nurse Ed. Fund	$2,180,000	$2,172,000	($8,000)
0518 – Hlth. Fac. Const. Loan Ins. Fund	$4,882,000	$4,807,000	($75,000)
0829 – Health Professions Ed. Fund	$10,855,000	$1,070,000	($9,785,000)
0890 – Federal Trust Fund	$1,554,000	$1,447,000	($107,000)
0995 – Reimbursements	$7,120,000	$863,000	($6,257,000)
3064 – Mental Hlth. Practitioner Ed. Fund	$397,000	$394,000	($3,000)
3068 – Vocational Nurse Ed. Fund	$229,000	$224,000	($5,000)
3085 – Mental Health Services Fund	$49,482,000	$26,023,000	($23,459,000)
8073 – Med. Underserved Acct., HPE Fund	$2,302,000	$2,302,000	$-
Total Department Funding:	**$175,432,000**	**$131,475,000**	**($43,957,000)**
Total Authorized Positions:	**449.0**	**447.0**	**(2.0)**

Background. The Office of Statewide Health Planning and Development (OSHPD) collects and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes. OSHPD also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities.

Health Care Workforce Program. OSHPD administers programs designed to increase access to healthcare to underserved populations and provide a culturally competent healthcare workforce. Specifically, OSHPD encourages demographically underrepresented groups to pursue healthcare careers, incentivizes primary care and mental health professionals to work in underserved communities, evaluates new and expanded roles for health professionals and new health delivery alternatives, designates health professional shortage areas, and serves as the state's central repository of health education and workforce data.

OSHPD awards scholarships and loan repayments to aspiring health professionals and graduate students who agree to provide direct patient care in medically underserved areas for one to four years. OSHPD serves as California's Primary Care Office supporting the state's healthcare workforce through pipeline development, training and placement, financial incentives, systems redesign, and research and policy with a focus on underserved and diverse communities.

Health Professions Career Opportunity Program – Mini Grants. The Mini Grants program seeks to fund programs that encourage underrepresented and disadvantaged groups to pursue health careers to develop a more culturally and linguistically competent health care workforce for Californians. Mini

Grants fund activities focused on various categories, including health career conferences and workshops, and health career exploration.

Song-Brown Program. The Song-Brown Health Care Workforce Training Act (Song-Brown Program) was established in 1973 to increase the number of family physicians to provide needed medical services to the people of California. The program encourages universities and primary care health professionals to provide healthcare in medically underserved areas and provides financial support to family medicine, internal medicine, OB/GYN, and pediatric residency programs, family nurse practitioner, physician assistant, and registered nurse education programs throughout California. The Song-Brown program is aided by the California Healthcare Workforce Policy Commission (CHWPC), a 15-member citizen advisory board that provides expert guidance and statewide perspectives on health professional education issues, reviews applications, and recommends contract awards.

State Loan Repayment Program. The State Loan Repayment Program (SLRP) is a federally funded, state-run program that provides student loan repayment funding to healthcare professionals who commit to practicing in Health Professional Shortage Areas (HPSAs) in California. Professionals eligible for awards under SLRP include physicians (M.D. and D.O.), psychiatric nurse specialists, dentists, mental health counselors, registered dental hygienists, health service psychologists, nurse practitioners (primary care), licensed clinical social workers, physician assistants (primary care), licensed professional counselors, certified nurse midwives, marriage and family therapists, and pharmacists. Recipients must also, among other requirements, commit to a two-year (four-year, if half-time) initial service obligation at a SLRP Certified Eligible Site (CES) in one of the areas designated as an HPSA.

Facilities Development Division – Hospital Seismic Safety. In 1971, the Sylmar earthquake struck the northeast San Fernando Valley, killing 64 people and causing significant damage to structures. In particular, the San Fernando Veterans Administration Hospital in Sylmar, constructed in 1926 with unreinforced concrete, collapsed, resulting in the deaths of 44 individuals trapped inside the building. In addition, a more recently constructed psychiatric ward at Sylmar's Olive View Community Hospital collapsed during the quake, resulting in three deaths and the evacuation of more than 1,000 patients. In response to these tragic events, the Legislature approved the Alfred E. Alquist Hospital Facilities Seismic Safety Act, which required hospitals to meet stringent construction standards to ensure they are reasonably capable of providing services to the public after a disaster. In 1983, the act was amended to transfer all hospital construction plan review responsibility from local governments to OSHPD, creating the state's largest building department, the Facilities Development Division.

In 1994, the Northridge earthquake struck the San Fernando Valley again, resulting in major structural damage to many hospitals constructed prior to the Alquist Act, many of which were evacuated. In contrast, hospitals constructed in compliance with Alquist Act standards resisted the Northridge earthquake, suffering very little structural damage. In response, the Legislature approved SB 1953 (Alquist), Chapter 740, Statutes of 1994, which amended the Alquist Act to require hospitals to evaluate and rate all their general acute care hospital buildings for seismic resistance according to standards developed by OSHPD to measure a building's ability to withstand a major earthquake. SB 1953 and subsequent OSHPD regulations also require hospitals to submit plans to either retrofit or relocate acute care operations according to specific timeframes. According to OSHPD, there are approximately 470 general acute care hospital facilities comprised of 2,673 hospital buildings covered by the seismic safety provisions of SB 1953. In addition to oversight of seismic safety compliance for acute care hospitals,

OSHPD is responsible for ensuring seismic and building safety compliance for psychiatric hospitals, skilled nursing facilities, and intermediate care facilities.

Cal-Mortgage. OSHPD's Cal-Mortgage Division administers the California Health Facility Construction Loan Insurance Program. Cal-Mortgage provides credit enhancement for eligible health care facilities when they borrow money for capital needs. Cal-Mortgage insured loans are guaranteed by the "full faith and credit" of California, which permits borrowers to obtain lower interest rates. Eligible health facilities must be owned and operated by private, nonprofit public benefit corporations or political subdivisions such as cities, counties, healthcare districts or joint powers authorities. Health facilities eligible for Cal-Mortgage include hospitals, skilled nursing facilities, intermediate care facilities, public health centers, clinics, outpatient facilities, multi-level facilities, laboratories, community mental health centers, facilities for the treatment of chemical dependency, child day care facilities (in conjunction with a health facility), adult day health centers, group homes, facilities for individuals with developmental disabilities, and office or central service facilities (in conjunction with a health facility). As of January 31, 2017, Cal-Mortgage insures 89 loans with a total value of approximately $1.7 billion.

Health Care Information and Quality Analysis. The Healthcare Information Division (HID) collects and disseminates timely and accurate healthcare quality, outcome, financial, and utilization data, and produces data analyses and other products.

Data Collection. The division collects and publicly discloses facility level data from more than 6,000 licensed healthcare facilities including hospitals, long-term care facilities, clinics, home health agencies, and hospices. These data include financial, utilization, patient characteristics, and services information. In addition, approximately 450 hospitals report demographic and utilization data on approximately 16 million inpatient, emergency department, ambulatory surgery patients, and by physician, about heart surgery patients.

Data Products. The division produces more than 100 data products, including maps and graphs, summarizing rates, trends, and the geographic distribution of services. Risk-adjusted hospital and physician quality and outcome ratings for heart surgery and other procedures are also published. The division conducts a wide range of special studies on such topics as preventable hospital admissions and readmission, trends in care, and racial or ethnic disparities. The division also provides information to the public on non-profit hospital and community benefits, and hospital prices and discount policies.

Technical Assistance. The division provides assistance to the members of the public seeking to use OSHPD data and, upon request, can produce customized data sets or analyses for policymakers, news media, other state departments and stakeholders.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of OSHPD's mission and programs.

2. Please describe the ongoing effort to reorganize data collection and IT functions within OSHPD? How will this reorganization benefit stakeholders, policy makers and the public?

Issue 2: Reversion of Health Care Workforce Funding

Budget Issue. The Administration requests reversion of $33.3 million General Fund in 2016-17. These funds are the first year of a three-year, $100 million General Fund allocation approved in the 2016 Budget Act for augmentation of health care workforce initiatives at OSHPD. If the reversion is approved, the Administration would reallocate this funding to other budgetary expenditures and the previously approved health care workforce initiative augmentations would be permanently eliminated.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	($33,334,000)	$-
Total Funding Request:	**($33,334,000)**	**$-**

Background. The 2016 Budget Act appropriated $33.3 million to OSHPD and approved budget bill language to augment existing health care workforce initiatives as follows:

- **$18.7 million** – Grant awards for existing primary care residency slots
- **$3.3 million** – New primary care residency slots at existing residency programs
- **$5.7 million** – Song-Brown Program primary care residency slots for teaching health centers
- **$3.3 million** – Newly accredited primary care residency programs
- **$333,000** – State Loan Repayment Program
- **$2 million** – OSHPD state operations costs for administering the Song-Brown Program

These funds were the first installment of a three-year, $100 million General Fund allocation for these purposes, which included budget bill language to make funds available for expenditure and encumbrance until June 30, 2022. The funds were approved, in part because of reductions in federal and private funding for healthcare workforce development, including the expiration of one-time funding from the California Endowment, the federal Health Resources and Services Administration, and the federal Teaching Health Centers Graduate Medical Education program.

The budget proposes to revert the $33.3 million General Fund allocation for health care workforce initiatives approved in the 2016 Budget Act. The budget also does not include the second-year installment of $33.3 million for health care workforce initiatives and notes that no additional funding is included for this purpose in the future. This proposal is one of several reductions in one-time spending commitments included in the budget to address the state's General Fund deficit. If approved, reversion of these funds would be permanent and the three-year allocation for these initiatives eliminated.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending updates to the state's General Fund condition at the May Revision.

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

1. Please provide a brief overview of this proposal.

2. Please describe the Administration's rationale for reversion of these previously approved funds and elimination of the health care workforce augmentations.

Issue 3: Health Care Workforce Recruitment Legislation (AB 2024 and AB 2048)

Budget Issue. OSHPD requests expenditure authority from the California Health Data and Planning Fund of $400,000 in 2017-18, $250,000 in 2018-19 and 2019-20, and $70,000 in 2020-21 through 2023-24. If approved, these resources would allow OSHPD to implement health care workforce requirements pursuant to AB 2024 (Wood), Chapter 496, Statutes of 2016, and AB 2048 (Gray), Chapter 454, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0143 – CA Health Data & Planning Fund	$-	$400,000
Total Funding Request:	**$-**	**$400,000**
Total Positions Requested:	**0.0**	

Critical Access Hospitals. The federal Centers for Medicare and Medicaid Services (CMS) certifies certain rural, general acute care hospitals as Critical Access Hospitals (CAHs), which allows for cost-based reimbursement from Medicare instead of the standard, fixed reimbursement rates. This reimbursement structure is intended to enhance the financial performance of small, rural hospitals and reduce hospital closures. To be designated by CMS as a CAH, a hospital must: 1) have no more than 25 beds, 2) be located in a rural area, and 3) be over 35 miles from another hospital (15 miles in mountainous terrain or areas with only secondary roads). According to OSHPD, there are currently 34 CAHs operating in California:

Hospital Name	County
Banner Lassen Medical	Lassen
Bear Valley Cmty. Hosp.	San Bernardino
Biggs-Gridley Memorial	Butte
Catalina Island Medical Center	Los Angeles
Colorado River Medical Center	San Bernardino
Eastern Plumas Hosp. Portola	Plumas
Fairchild Medical	Siskiyou
Frank R Howard Memorial	Mendocino
Glenn Medical	Glenn
Healdsburg District Hospital	Sonoma
J. Phelps Community Hospital	Humboldt
John C Fremont Healthcare	Mariposa
Kern Valley Healthcare	Kern
Mammoth Hospital	Mono
Mark Twain St Joseph's	Calaveras
Mayers Memorial	Shasta
Mendocino Coast Dist. Hospital	Mendocino

Hospital Name	County
Mercy Medical Center	Siskiyou
Modoc Medical Center	Modoc
Mountains Cmty. Hospital	San Bernardino
Northern Inyo	Inyo
Ojai Valley Cmty. Hospital	Ventura
Plumas District Hospital	Plumas
Redwood Memorial	Humboldt
Ridgecrest Hospital	Kern
Santa Ynez Vly. Cottage Hosp.	Santa Barbara
Seneca Healthcare District	Plumas
Southern Inyo Hospital	Inyo
St Helena Hospital, Clearlake	Lake
Surprise Valley Cmty. Hospital	Modoc
Sutter Hospital	Lake
Tahoe Forest Hospital	Nevada
Tehachapi Hospital	Kern
Trinity Hospital	Trinity

AB 2024 Allows CAHs to Directly Employ Medical Professionals. AB 2024 establishes an exemption from the ban on the corporate practice of medicine by authorizing CAHs to directly employ medical professionals and charge for professional services when the following conditions are met:

1) The medical staff concur by an affirmative vote that the employment of the medical professional is in the best interest of the communities served by the hospital.
2) The hospital does not interfere with, control, or otherwise direct the professional judgment of a physician or surgeon.

The exemption is operative until January 1, 2024.

AB 2024 requires OSHPD to provide a report to the Legislature, on or before July 1, 2023, regarding the impact of the exemption on CAHs and their ability to recruit and retain physicians and surgeons. The bill also requires CAHs to annually submit a report to OSHPD containing data it would need to prepare the required legislative report.

OSHPD requests expenditure authority of $200,000 from the California Health Planning and Data Fund in 2017-18 and $70,000 in 2018-19 through 2023-24 to meet AB 2024 reporting requirements. According to OSHPD, these limited-term resources would support development of research methods and protocols, systems development, CAH site coordination, responding to technical questions regarding research requirements, data collection and data analysis, and legislative report preparation. OSHPD plans to develop a web-based data collection process for receipt of information from CAHs to develop the required legislative report.

State Loan Repayment Program. The State Loan Repayment Program (SLRP) is a federally funded, state-run program that provides student loan repayment funding to healthcare professionals who commit to practicing in Health Professional Shortage Areas (HPSAs) in California. Professionals eligible for awards under SLRP include physicians (M.D. and D.O.), psychiatric nurse specialists, dentists, mental health counselors, registered dental hygienists, health service psychologists, nurse practitioners (primary care), licensed clinical social workers, physician assistants (primary care), licensed professional counselors, certified nurse midwives, marriage and family therapists, and pharmacists. Recipients must also, among other requirements, commit to a two-year (four-year, if half-time) initial service obligation at a SLRP Certified Eligible Site (CES) in one of the areas designated as an HPSA.

AB 2048 Adds FQHCs to Eligible Sites for State Loan Repayment Program. AB 2048 requires OSHPD to include all federally qualified health centers located in California in the SLRP CES list. According to OSHPD, there are currently 415 healthcare facilities on the CES list. AB 2048 requires the inclusion of approximately 2,500 additional FQHC sites, a six-fold increase. SLRP currently receives an average of 3,500 technical assistance inquires per year. OSHPD believes the addition of 2,500 practice sites on the CES list would increase the number of technical assistance calls exponentially.

OSHPD requests expenditure authority of $200,000 from the California Health Planning and Data Fund in 2017-18 and $180,000 in 2018-19 and 2019-20 to process additional SLRP applications and provide technical assistance to the additional applicants.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 4: Elective Percutaneous Coronary Interventions Reporting

Budget Issue. OSHPD requests two positions (conversion of limited-term to permanent) and expenditure authority from the California Health Data and Planning Fund of $358,000 annually. If approved, these resources would allow OSHPD to continue to collect data and analyze clinical outcomes for the Elective Percutaneous Coronary Interventions (PCI) program authorized by SB 906 (Correa), Chapter 368, Statutes of 2014.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0143 – CA Health Data & Planning Fund	$-	$358,000
Total Funding Request:	**$-**	**$358,000**
Total Positions Requested:	**2.0**	

Background. SB 906 established the Elective PCI program, which allows certified hospitals without on-site surgical backup to perform elective PCIs. Previously, a hospital could only perform elective PCIs if it operated a surgical cardiac unit within the same facility. SB 906 also requires OSHPD to produce an annual report of performance outcomes for all certified hospitals' elective PCI programs including patient mortality, stroke, and emergency coronary artery bypass graft (CABG) surgery.

The California Department of Public Health (CDPH) certifies hospitals participating in the Elective PCI program. These hospitals must submit performance outcomes data to the American College of Cardiology's National Cardiovascular Data Registry (NCDR). OSHPD obtains the data from NCDR to prepare its annual risk-adjusted outcomes report on mortality, post-operative stroke, and post-operative CABG for certified hospitals. SB 906 also authorizes CDPH to establish an advisory oversight committee to analyze the public outcomes report produced by OSHPD and make recommendations for changing the data analysis or risk-adjustment methods and possible outcomes to add in future reports.

Limited-Term Resources Approved in 2015 Budget Act. The 2015 Budget Act approved two limited-term positions, a Research Scientist III and a Research Program Specialist I, to fulfill OSHPD's SB 906 annual reporting requirements. According to OSHPD, these positions have been developing a work plan and gaining knowledge and understanding of the clinical and quality aspects of the data that will be used to develop accurate risk-adjustment models and outcome reports. Hospitals began submitting applications to participate in the Elective PCI Program in the fall of 2015 and CDPH reviewed and started certifying hospitals later that year. Consequently, the first data from hospitals certified to participate in the program are currently being submitted to NCDR. OSHPD obtained initial NCDR data beginning in September 2016.

The previously approved positions will expire on June 30, 2017. OSHPD requests conversion of these two positions from limited-term to permanent. If approved, these positions would continue to perform ongoing workload related to the annual outcomes reporting for the Elective PCI program.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What are the clinical outcomes that will be included in the report?

Issue 5: Relocation Rent Adjustment

Budget Issue. OSHPD requests expenditure authority from special funds of $1.2 million annually. If approved, these resources would support rent increases associated with OSHPD's planned relocation of its Sacramento headquarters and Los Angeles location due to expiring lease agreements.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0121 – Hospital Building Fund	**$-**	$733,000
0143 – CA Health Data & Planning Fund	**$-**	$402,000
0518 – Health Facility Construction Loan Insurance Fund	**$-**	$72,000
0829 – Health Professions Education Fund	**$-**	($11,000)
3085 – Mental Health Services Fund	$-	$4,000
Total Funding Request:	**$-**	**$1,200,000**

Background. OSHPD leases office space for its Sacramento headquarters from the California Public Employees' Retirement System (CalPERS). The Sacramento headquarters houses multiple OSHPD programs and more than 400 employees. OSHPD also leases space in Los Angeles from the Metropolitan Water District (MWD), primarily for the Facilities Development Division.

CalPERS provided OSHPD and the Department of General Services (DGS), serving as OSHPD's real estate agent, notification that it would not renew the Sacramento lease, which expires on November 30, 2020. OSHPD has identified a new location for its headquarters in Natomas and plans to relocate in the Spring of 2017.

MWD also provided OSHPD and DGS notification that it would not renew the Los Angeles lease, which expires on May 31, 2017. MWD is conducting seismic retrofitting of its current building and needs the space occupied by OSHPD to relocate its own staff. OSHPD is currently working with DGS to secure a new location and expects to complete its Los Angeles relocation in late 2017.

As a result of these relocations, the new leases will result in increased rent costs of $1.2 million annually beginning in 2017-18. Approximately $1 million is attributable to the Sacramento headquarters relocation and $200,000 is attributable to the LA relocation.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal 2020 Waiver Implementation Update

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

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

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

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

- **Domain 1: Outpatient Delivery System Transformation and Prevention**. These projects are meant to ensure patients experience timely access to high-quality, efficient, and patient-centered care. In addition, these projects identify and increase rates of cost-effective standard approaches to prevention services for a select group of high-impact clinical conditions and populations such as cardiovascular disease, breast, cervical and colorectal cancer, and obesity. The projects also aim to reduce disparities and variation in performance of targeted prevention services within their systems. Required and optional projects under this domain and the number of approved projects are as follows:
  i. Integration of Physical and Behavioral Health (required) – 23 Projects
  ii. Ambulatory Care Redesign: Primary Care (required) – 24 Projects
  iii. Ambulatory Care Redesign: Specialty Care (required) – 19 Projects

iv. Patient Safety in the Ambulatory Setting (optional) – 14 Projects
v. Million Hearts Initiative (optional) – 17 Projects
vi. Cancer Screening and Follow-up (optional) – 14 Projects
vii. Obesity Prevention and Healthier Foods Initiative (optional) – 9 Projects

- **Domain 2: Targeted High-Risk or High-Cost Populations.** These projects are focused on specific populations that would benefit most significantly from care integration and alignment. Particular attention will be focused on managing and coordinating care during transitions from inpatient to outpatient and post-acute settings. Required and optional projects under this domain and the number of approved projects are as follows:
  i. Improved Perinatal Care (required) – 20 Projects
  ii. Care Transitions: Integration of Post-Acute Care (required) – 30 Projects
  iii. Complex Care Management for High-Risk Medical Populations (required) – 26 Projects
  iv. Integrated Health Home for Foster Children (optional) – 5 Projects
  v. Transition to Integrated Care: Post-Incarceration (optional) – 3 Projects
  vi. Chronic Non-Malignant Pain Management (optional) – 13 Projects
  vii. Comprehensive Advanced Illness Planning and Care (optional) – 13 projects
- **Domain 3: Resource Utilization Efficiency.** These projects are meant to reduce unwarranted variation in use of evidence-based, diagnostics, and treatments targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects will also eliminate the use of ineffective or harmful targeted clinical services. Optional projects under this domain and the number of approved projects are as follows:
  i. Antibiotic Stewardship – 12 Projects
  ii. Resource Stewardship: High-Cost Imaging – 9 Projects
  iii. Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals – 8 Projects
  iv. Resource Stewardship: Blood Products – 5 Projects

DHCS has approved a total of 17 plans submitted by DPHs and 37 submitted by DMPHs to become PRIME entities. These entities may receive up to $3.7 billion combined in federal Medicaid funding over five years for achieving metrics in implementing clinical projects designed to change the way care is delivered. 1115 Waiver financeing regulations require these funds to be matched with a non-federal share of funding, which is provided by other governmental health entity funds that are transferred to DHCS as intergovernmental transfers (IGTs). The budget includes $2.6 billion ($1.3 billion intergovernmental transfers and $1.3 billion federal funds) in 2016-17 and $1.6 billion ($800 million intergovernmental transfers and $800 million federal funds) in 2017-18 for the PRIME program.

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

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

The budget includes $2.3 billion ($1.1 billion intergovernmental transfers and $1.1 billion federal funds) in 2016-17 and $2.3 billion ($1.2 billion intergovernmental transfers and $1.2 billion federal funds) in 2017-18 for the Global Payment Program.

Whole Person Care (WPC) Pilots. The WPC Pilots are intended to coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. WPC Pilots allow individual public entities or a consortium of public entities to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. WPC Pilot entities will identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population progress. Target populations may include but are not limited to individuals:

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

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

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

Lead Entity	Estimated Five-year Beneficiary Count	Total Five-Year Budget
Alameda County Health Care Services Agency	20,000	$283,453,400
Contra Costa Health Services	52,500	$203,958,160
Kern Medical Center	2,000	$157,346,500
L.A. County Department of Health Services	137,700	$900,000,000
Monterey County Health Department	500	$26,834,630
Napa County	800	$22,686,030
County of Orange Health Care Agency	8,098	$23,500,000
Placer County Health and Human Services Department	450	$20,126,290
Riverside University Health System - Behavioral Health	38,000	$35,386,995
San Bernardino Co. - Arrowhead Regional Med. Center	2,000	$24,537,000
County of San Diego, Health and Human Services Agency	1,049	$43,619,950
San Francisco Department of Public Health	10,720	$118,000,000
San Joaquin County Health Care Services Agency	2,130	$17,500,000
San Mateo County Health System	5,000	$165,367,710
Santa Clara Valley Health and Hospital System	10,000	$225,715,295
Shasta County Health and Human Services Agency	600	$19,403,550
Solano County Health & Social Services	250	$4,667,010
Ventura County Health Care Agency	2,000	$97,837,690

A second round of WPC Pilot applications were scheduled to be submitted by March 1, 2017. The budget includes $480 million ($240 million intergovernmental transfers and $240 million federal funds) in 2016-17 and $720 million ($360 million intergovernmental transfers and $360 million federal funds) in 2017-18 for funding WPC Pilots.

Dental Transformation Initiative (DTI). The DTI is intended to improve the quality of care and increase utilization of dental services. DHCS is implementing the following four dental domains to accomplish this goal:

- **Domain 1: Increase Preventive Services Utilization for Children.** This domain aims to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The domain's goal is to increase the utilization amongst children by at least ten percent over a five year period. DHCS will offer financial incentives for dental service office locations that increase delivery of preventive oral care to Medi-Cal eligible children.
- **Domain 2: Caries Risk Assessment and Disease Management.** Under this domain, dental providers receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under. This domain will initially be implemented on a pilot basis in select counties based on ratios of restorative to preventive services, representative sampling across the state, and likelihood of provider participation.
- **Domain 3: Increase the Continuity of Care.** This domain aims to encourage continuity of care among Medi-Cal beneficiaries age 20 and under. Dental provider service office locations will receive an incentive payment for maintaining continuity of care for enrolled child beneficiaries for two, three, four, five, and six year continuous periods. This domain will initially be implemented on a pilot basis in select counties based on the ratio of service office locations to beneficiaries, current levels of continuity of care at, above and below the statewide continuity of care baseline, and representation throughout the state. Incentive payments will be made annually.
- **Domain 4: Local Dental Pilot Programs (LDPPs).** A maximum of 15 LDPPs will be approved to address one or more of the previous three domains through alternative programs, using strategies focused on rural areas, including local case management initiatives and education partnerships. DHCS will require LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three domains. No more than 25 percent of the annual DTI funding will be allocated to this domain.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of implementation progress for each of the four components of the Medi-Cal 2020 Waiver.

Issue 2: Medi-Cal 2020 Waiver Contract Resources

Budget Issue. DHCS requests expenditure authority of $2 million ($980,000 federal funds and $980,000 reimbursements) in 2017-18 through 2020-21 and $460,000 ($230,000 federal funds and $230,000 reimbursements) in 2021-22. If approved, these resources would fund contracts to facilitate learning collaboratives, provide technical assistance, and conduct an independent evaluation for components of the state's Section 1115 Medicaid Waiver, known as Medi-Cal 2020.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$980,000
0995 – Reimbursements	$-	$980,000
Total Funding Request:	**$-**	**$1,960,000**
Total Positions Requested:	**0.0**	

Background. California's 1115 Waiver renewal, called "Medi-Cal 2020", was approved by the federal Centers for Medicare and Medicaid Services on December 30, 2015. Medi-Cal 2020 will guide DHCS through the next five years as DHCS works to transform the way Medi-Cal provides services to its more than 14 million members, and improve quality of care, access, and efficiency. The Waiver contains four primary components:

i. Public Hospital Redesign and Incentives in Medi-Cal (PRIME) – A program that partners with public hospitals to implement projects to improve care delivery systems in hospitals.
ii. Global Payment Program – A statewide pool of health care funding for the remaining uninsured
iii. Whole Person Care Regional (WPC) Pilots – Pilot projects to allow individual public entities or a consortium of public entities to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes
iv. Dental Transformation Initiative (DTI) – An initiative with various programs and incentives to improve the quality of care and increase utilization of dental services.

PRIME and WPC Pilots Learning Collaboratives. As a condition of approval of the Waiver, the department must support regular learning collaboratives and ongoing required quality improvement activities, including development of data collection and analysis systems for external evaluation and providing technical assistance to PRIME entities on program evaluation requirements. DHCS received $500,000 ($250,000 General Fund and $250,000 federal funds) in 2016-17 for a contractor to comply with the Waiver requirements in the PRIME program. In addition, the Waiver approval requires the department to convene learning collaboratives for public entities participating in WPC Pilot programs.

DTI Evaluation Requirements. The Waiver approval requires an evaluation of the DTI, which must meet all standards of leading academic institutions and academic journal peer review, including standards for the evaluation design, conduct, interpretation, and reporting of findings. According to DHCS, the evaluation is required to determine the causal impacts of the DTI demonstration domains and will include a description of the quantitative and qualitative study design, a rationale for the design selected, descriptive statistics that reflect the socioeconomic status and demographic composition of

those served by the demonstration, and a consideration of the impact of the demonstration on socioeconomic and demographic subgroups.

DHCS Requests Limited-Term Contract Resources. DHCS requests expenditure authority of $2 million ($980,000 federal funds and $980,000 reimbursements) in 2017-18 through 2020-21 and $460,000 ($230,000 federal funds and $230,000 reimbursements) in 2021-22. If approved, these resources would fund contracts to facilitate the required learning collaboratives and provide technical assistance for the PRIME and WPC Pilot participants. These resources would also fund a contract to conduct the required evaluation for DTI. Because the non-federal share of funding for these Waiver programs are provided by intergovernmental transfers (IGTs), these contracts would be funded by a combination of IGTs and federal funds. The annual costs for each contract over four years (five years for DTI) are as follows:

Contract Activity	Reimb. (IGTs)	Federal Funds
PRIME Learning Collaboratives/Tech. Assistance	$250,000	$250,000
WPC Pilot Learning Collaboratives	$500,000	$500,000
DTI Evaluation	$460,000	$460,000
TOTAL EXPENDITURES	**$980,000**	**$980,000**

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Affordable Care Act – Optional Expansion of Medi-Cal

Background. The federal Patient Protection and Affordable Care Act (ACA) authorizes states to expand their Medicaid programs to previously uninsured individuals. ABX1 1 (Perez) and SBX1 1 (Hernandez), Chapters 3 and 4, Statutes of 2013, authorized California's Optional Expansion of the Medi-Cal program. The Optional Expansion, effective January 1, 2014, expanded eligibility for previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level. Optional Expansion beneficiaries are mandatorily enrolled in managed care for their Medi-Cal benefits.

For states that expanded Medicaid, the ACA authorized federal matching funds of 100 percent for services provided to this population until January 1, 2017. After that date, states receive a federal match of 95 percent for calendar year 2017, 94 percent for calendar year 2018, 93 percent for calendar year 2019, and 90 percent for calendar year 2020 and beyond. Medi-Cal assumed a five percent General Fund share for the Optional Expansion population beginning January 1, 2017. In addition, the share of capitation payments for abortion-related services offered by Medi-Cal managed care has been borne by the state's General Fund since 2014, as federal funding is not available for this purpose.

The budget includes $20.1 billion ($888.4 million General Fund and $19.2 billion federal funds) in 2016-17 and $18.9 billion ($1.6 billion General Fund and $17.3 billion federal funds) in 2017-18 for coverage of the Optional Expansion population. The department estimates Optional Expansion enrollment of approximately 4 million beneficiaries in 2016-17 and 4.1 million beneficiaries in 2017-18.

Federal Health Care Proposals Create Significant Fiscal Uncertainty. The new federal Administration and leaders in Congress have proposed significant changes to the Affordable Care Act, including the provisions authorizing the expansion of Medicaid. DHCS and the Department of Finance reviewed the legislation developed by leadership in the U.S. House of Representatives, known as the American Health Care Act (AHCA), and identified significant programmatic and fiscal concerns. The review highlighted AHCA's significant shift of costs from the federal government to states, which would result in nearly $6 billion in costs to California in 2020, growing to $24.3 billion by 2027. The General Fund share of these costs would be $4.3 billion in 2020, increasing to $18.6 billion in 2027.

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of caseload and enrollment trends in the Optional Expansion.

2. Please provide a brief overview of the department's analysis of the American Health Care Act's impact on the Medi-Cal program.

Issue 4: Coordinated Care Initiative – Continuation of Cal MediConnect and MLTSS

Budget Issue and Trailer Bill Language Proposal. The budget includes a certification that the Coordinated Care Initiative does not result in General Fund savings and the program will be eliminated effective January 1, 2018, pursuant to SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013. However, the Administration proposes trailer bill language to continue the duals demonstration project, continue the mandatory enrollment of individuals in managed care for long-term services and supports (MLTSS), except In-Home Supportive Services (IHSS), but eliminate the maintenance-of-effort (MoE) and Statewide Authority for IHSS. The budget includes $626.2 million of General Fund savings in 2017-18 in the Department of Social Services' (DSS) budget from the elimination of the MoE and approximately $20 million of General Fund savings in the DHCS budget from continuation of the demonstration. In addition to the continuation of the Coordinated Care Initiative programs, the proposed trailer bill language repeals four interagency agreements with the Department of Managed Health Care (DMHC) the department reports are unnecessary due to its new oversight and monitoring responsibilities pursuant to new federal regulations governing Medi-Cal managed care plans.

Background. The 2012 Governor's Budget proposed a demonstration project to better integrate the health care delivery system for individuals dually eligible for Medicare and Medi-Cal ("dual-eligibles"). SB 1008 and SB 1036 (Committee on Budget and Fiscal Review), Chapters 33 and 45, Statutes of 2012, and later SB 94, implemented the proposal, known as the Coordinated Care Initiative (CCI). This new program passively enrolled dual-eligibles into an integrated managed care plan for both Medicare and Medi-Cal benefits, known as Cal MediConnect, in seven counties. All other Medi-Cal beneficiaries in those counties, including those that opted out of Cal MediConnect, were mandatorily enrolled in managed care for their Medi-Cal benefits, including long-term services and supports like In-Home Supportive Services (IHSS) and skilled nursing facilities. The program also established a county maintenance-of-effort (MoE) requirement for IHSS, which froze counties' share of costs based on fiscal year 2011-12 expenditures, and established a Statewide Authority, which assumed responsibility for bargaining IHSS workers' wages in the seven demonstration counties. Passive enrollment began in March 2014 and was completed in all seven counties in August 2016. As of March 1, 2017, enrollment in Cal MediConnect plans was 115,613, with 28 percent of eligible beneficiaries enrolled statewide.

SB 94 Provisions Require Statewide General Fund Savings for CCI. SB 94 included a provision requiring the Director of Finance to certify the program results in General Fund savings and, if it did not, the program would be eliminated. The budget includes a certification that the program does not result in General Fund savings and the program will be eliminated effective January 1, 2018. However, the budget proposes to continue the duals demonstration project, continue the mandatory enrollment of individuals in managed care for long-term services and supports, except IHSS, but eliminate the MoE and Statewide Authority for IHSS. The budget includes $626.2 million of General Fund savings in 2017-18 in the Department of Social Services' (DSS) budget from the elimination of the MoE and approximately $20 million of General Fund savings in the Department of Health Care Services' (DHCS) budget from continuation of the demonstration.

Duals Demonstration and MLTSS Continuation Proposal. According to DHCS, based on lessons learned, the budget proposes to continue the Cal MediConnect program, continue mandatory enrollment

of dual eligibles, and integrate long-term services and supports (except IHSS) into managed care. If approved, the department's proposed trailer bill language would result in the following:

1) The duals demonstration would continue in the seven CCI counties, with no change in the beneficiary's experience. Cal MediConnect would continue for those that opt in and integration of MLTSS into managed care would continue for all other beneficiaries in those counties. However, the payments for IHSS services would no longer be accounted for through managed care capitation payments. Despite this change in the flow of funds, the IHSS program experience for beneficiaries would remain nearly identical. The budget assumes approximately $20 million of General Fund savings in 2017-18 from continuation of the demonstration in the DHCS budget.
2) The Statewide Authority would be eliminated. Responsibility for bargaining IHSS workers' wages would return to the counties.
3) The counties' 35 percent share of cost for IHSS would resume and the MoE eliminated. This would result in additional costs for counties, and concomitant reductions in General Fund expenditures in the DSS budget, of $626.2 million in 2017-18.

Repeal of Interagency Agreements with DMHC. DMHC has submitted a request, heard at the subcommittee's March 23 hearing, for a reduction of 18 positions and resources. This request is associated with DHCS' companion request for resources for compliance with the new federal Medi-Cal managed care regulations (See *Issue 6: Federal Medi-Cal Managed Care Regulations*). The two departments report that workload DMHC performs on behalf of DHCS pursuant to four interagency agreements is subsumed by the workload DHCS will accomplish to comply with the new federal regulations. DHCS proposes trailer bill language to repeal the statutory authority for these interagency agreements. These provisions are included in the trailer bill language provided by the Administration for continuation of CCI-related programs.

LTSS Workgroup Proposal - Amendments to Trailer Bill Language. The Assembly Aging and Long-Term Care Committee's Long-Term Services and Supports workgroup, a coalition of advocacy organizations, proposes several amendments to the Administration's proposed trailer bill language. These proposed amendments include the following provisoins:

1) Require counties to coordinate delivery of IHSS services to enable expedited enrollment and reassessment for both Cal MediConnect and MLTSS beneficiaries.
2) Require the development of standardized functional and cognitive assessment elements and guidelines for developing care plans for use by Cal MediConnect and MLTSS plans.
3) Require enforcement of new federal regulations coordinating required LTSS benefits and application to Cal MediConnect and MLTSS beneficiaries.
4) Develop additional data to show availability and quantity of home- and community-based services on a statewide and county-by-county basis.
5) Provide enrollment options for Programs for All-Inclusive Care for the Elderly (PACE) for individuals eligible for both Cal MediConnect and MLTSS.
6) Require the state develop a plan setting priorities for, and measuring progress of, California's integrated service delivery system, along with transition plan timelines.
7) Delete references to lock-in provisions and clarify 12-month continuity of care provisions.

Health Plans Proposal – Amendments to Trailer Bill Language. The California Association of Health Plans also proposes amendments to the Administration's proposed trailer bill language to remove

language referencing the grievance process for Care Plan Option services provided by participating plans.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Please describe the changes to the program proposed in the trailer bill language compared to the current operation of the program.

Issue 5: Federal Medi-Cal Managed Care Regulations

Budget Issue. DHCS requests 15 positions and expenditure authority of $8.9 million ($4.5 million General Fund and $4.5 million federal funds) in 2017-18 through 2020-21 and $2.6 million ($1.3 million General Fund and $1.3 million federal funds) in 2021-22. If approved, these positions and resources would support compliance with new federal rules governing Medi-Cal managed care plans, dental managed care plans, county mental health plans, and Drug Medi-Cal organized delivery system waiver providers.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$4,460,000
0890 – Federal Trust Fund	$-	$4,460,000
Total Funding Request:	**$-**	**$8,920,000**
Total Positions Requested:	**15.0**	

Background. Medi-Cal beneficiaries receive health care services through one of two separate delivery systems: fee-for-service and managed care. The managed care delivery system provides services to more than 78 percent of Medi-Cal beneficiaries through 22 Medi-Cal managed care plans. Each plan maintains its own network of providers and is paid a monthly capitation payment for each beneficiary based on rates calculated annually for each plan, county, and the beneficiary's category of aid. Rate development is based on actual encounter and claims data and is required to be certified as actuarially sound by the department's contracted actuary, Mercer.

Counties have adopted four primary models of managed care systems: two plan model, county organized health systems, geographic managed care, and the regional model. In recent years, several large populations of beneficiaries have transitioned into the managed care delivery system, making it the primary mode of service delivery in the Medi-Cal program. Certain services, however, have been exempted from delivery through managed care, particularly for sensitive populations and services.

In addition to Medi-Cal managed care plans, DHCS contracts with 56 county mental health plans, two primary care case management plans and six dental managed care plans. The county mental health plans provide realigned specialty mental health services to Medi-Cal beneficiaries under the terms of a waiver with the federal government. The two primary care case management plans are AIDS Healthcare Foundation and Family Mosaic, which provide services to specific populations in Los Angeles and San Francisco, respectively. The dental managed care plans provide dental services in two counties: Sacramento and Los Angeles. Enrollment in dental managed care is mandatory in Sacramento and voluntary in Los Angeles.

Medicaid Managed Care Regulations. In May 2016, the federal Centers for Medicare and Medicaid Services (CMS) released a final rulemaking for state Medicaid programs with beneficiaries served by managed care organizations. One of the most significant changes imposed by the regulations is the requirement that capitation rates be set at a single rate, rather than in a range. Another significant change is a restriction on directing payments by managed care plans to specified providers. Both of these new rules could potentially undermine several safety net financing mechanisms, such as the

hospital quality assurance fee and intergovernmental transfers, which DHCS uses to draw down additional federal funding for various health care services.

In addition to capitation rate development rules that complicate existing safety net financing programs, the rules require California's network adequacy standards be expanded from one provider type (primary care) to an additional six provider types; collection of quality data to be used to improve the managed care program; enhanced beneficiary supports; and monthly, rather than semi-annual, updates of provider directories.

The new managed care regulations apply to several different types of managed care providers in Medi-Cal. The regulations apply to the four primary models of managed care systems, mental health plans, primary care case management plans, and dental managed care plans. In addition to these plans, the regulations will apply to county programs participating in the Drug Medi-Cal Organized Delivery System Waiver.

Actuarially Sound Capitation Rates and Prospective Rate-Setting. Federal Medicaid law requires that no federal matching funds be paid to a state for capitation payments to a managed care plan unless, among other requirements, the "prepaid payments to the [plan] are made on an actuarially sound basis". Federal Medicaid regulations further define actuarially sound capitation rates as rates that:

1) Have been developed in accordance with generally accepted actuarial principles and practices.
2) Are appropriate for the populations to be covered and the services to be furnished under the contract.
3) Have been certified, as meeting these requirements, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

DHCS develops capitation rates in consultation with the department's contracted actuary, Mercer. Once rates have been developed, Mercer provides the actuarial soundness certification required by federal regulations. Historically, the rate development process has resulted in a rate range, which represents the minimum and the maximum actuarially sound capitation payment that can be supported by encounter and claims data. The department typically pays the minimum rate in the range, which allows local government entities to provide additional non-federal dollars through intergovernmental transfers (IGTs) up to the maximum of the rate range to draw down additional federal matching funds.

The new managed care regulations prohibit the certification of a rate range, but instead require certification of a single rate. The single rate requirement has led the department to move to a prospective rate-setting process, in which the department and Mercer estimate reasonable, appropriate, and attainable costs under the managed care contract for the rating period. This process includes projecting enrollment and accounting for expected IGTs provided by local government entities, as well as other sources of the non-federal share for higher capitation rates, such as the Hospital Quality Assurance Fee.

Compliance-Related Resources Received in 2016-17. The 2016 Budget Act approved 38 positions and expenditure authority of $10.4 million ($5 million General Fund and $5.4 million federal funds) to complete the workload required to comply with the new regulations. These resources were approved

primarily to begin work on compliance for the 22 Medi-Cal managed care plans. This workload included: monitoring network adequacy, more frequent updates of provider directories, quality measurement, plan technical assistance, new rate development requirements, auditing of plan operations, and legal and research activities.

Additional Compliance Resources Requested in 2017-18. DHCS requests 15 positions and expenditure authority of $8.9 million ($4.5 million General Fund and $4.5 million federal funds) in 2017-18 through 2020-21 and $2.6 million ($1.3 million General Fund and $1.3 million federal funds) in 2021-22. In addition to the 15 permanent positions, the four-year, limited–term expenditure authority is equivalent to 40 additional positions. The request also includes contract funding for external quality review, language accessibility compliance, and technical infrastructure and assistance. The programmatic requests are as follows:

Managed Care Quality and Monitoring Division
Limited-term resources equivalent to four positions: One Research Manager III, one Research Program Specialist II, and two Associate Governmental Program Analysts (AGPAs) would manage increased managed care compliance with the new regulations due to the addition of two new managed care plans. These activities would include monitoring network adequacy and performance, and ensuring quality of data submitted by plans.

Managed Care Operations Division
Limited-term resources equivalent to seven positions: Four AGPAs, one Staff Services Manager II, one Research Program Specialist II and one Health Program Specialist II would manage contract changes, ensure monthly updates to provider directories and consistent enrollee communications, and implement payment system control changes.

Medi-Cal Dental Services Division
Limited-term resources equivalent to seven positions: Three AGPAs, one Staff Services Manager I, one Health Program Specialist II, one Research Program Specialist I and one Office Technician would manage compliance with the new managed care regulations for dental managed care plans. These positions would collect and report data, monitor network adequacy, promulgate necessary regulations, ensure program integrity, and implement quality improvement strategies.

Enterprise Innovation and Technology Services
Limited-term resources equivalent to five positions: One Data Processing Manager II, two Senior Programmer Analysts and two Staff Programmer Analysts would manage required data reporting to the federal government. The required data elements, which must be reported monthly, must be retrieved from several departmental systems with approximately 1,000 data fields.

Information Management Division
Limited-term resources equivalent to two positions: One Research Scientist III and one Research Scientist II would work with staff in the Enterprise Innovation and Technology Services division to collect, report, analyze, and manage data to be reported to the federal government.

Office of HIPAA Compliance
Limited-term resources equivalent to five positions: One Data Processing Manager II, two Senior Information Systems Analysts, and two Staff Information Systems Analysts would be responsible for ensuring HIPAA compliance, quality and integrity of the data being reported to the federal government under the reporting requirements of the new managed care rule.

Office of Legal Services
Limited-Term resources equivalent to two positions: Two Attorney III positions would provide legal support to compliance activities associated with dental managed care plans and mental health plans.

Mental Health Services Division
11 permanent positions and limited-term resources equivalent to three positions: One Staff Services Manager III, one Staff Services Manager II, one Staff Services Manager I, one Health Program Specialist II, two Health Program Specialist I positions, seven AGPAs (four permanent, three limited-term), and one Staff Services Analyst would manage workload related to county mental health plan compliance with the federal managed care regulations. Medi-Cal managed care plans, which are regulated by the Department of Managed Health Care, already have some level of compliance with many of the provisions of the new regulations. However, no such oversight has traditionally been applied to county mental health plans. These positions would manage implementation of new regulations governing provider network adequacy, monitoring and certifying compliance with these requirements, and manage other required quality and regulatory compliance activities for county mental health plans.

Substance Use Disorder – Program, Policy and Fiscal Division
Four permanent positions and limited-term resources equivalent to one position: One Staff Services Manager III, one Staff Services Manager II, and three AGPAs (two permanent, one limited-term) would manage reporting, quality assurance, monitoring, technical assistance, and network adequacy requirements related to the new Drug Medi-Cal Organized Delivery System waiver plans. These plans are categorized as prepaid inpatient hospital plans and are subject to requirements of the new federal managed care regulations.

Negative Position Request from Department of Managed Health Care (DMHC). DMHC has submitted a request, heard at the subcommittee's March 23 hearing, for a reduction of 18 positions and resources associated with this DHCS request. The two departments report that workload DMHC performs on behalf of DHCS pursuant to four interagency agreements is subsumed by the workload DHCS will accomplish to comply with the new federal regulations. These four interagency agreements, which are eliminated in DHCS' trailer bill language proposal for the Coordinated Care Initiative, are as follows:

1115 Waiver Demonstration Project. Beginning in 2010, DMHC conducts medical surveys, medical loss ratio financial examinations, and network adequacy reviews related to the 1115 Waiver, a federal waiver program to enable Medicaid participants to receive benefits through certain providers and permit the State to require certain individuals to receive benefits through managed care providers.

Rural Expansion. AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the transition of approximately 400,000 individuals in 28 rural counties from fee-for-service to Medi-Cal

managed care plans. AB 1468 (Committee on Budget), Chapter 438, Statutes of 2012, required DHCS to enter into an interagency agreement with DMHC to conduct financial audits, medical surveys, and a review of the provider networks with the expansion of Medi-Cal managed care into the 28 rural counties.

Medi-Cal Dental Managed Care. DHCS began contracting with six dental managed care (DMC) plans in 2013. These dental plans receive a negotiated, monthly capitated reimbursement rate for each Medi-Cal beneficiary enrolled in the plan. Beneficiaries enrolled in the contracted plans receive dental benefits from providers within the plan's provider network. Under the interagency agreement, DMHC conducts financial examinations and medical surveys focused on the Medi-Cal line of business for these six DMC plans.

Coordinated Care Initiative. The Coordinated Care Initiative (CCI) seeks to provide better health outcomes for individuals eligible for both Medicare and Medi-Cal (dual-eligibles) by enrolling them into managed health care plans. SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, required DHCS to enter into an interagency agreement with DMHC to perform health plan surveys and financial reviews, readiness review activities, and provide consumer assistance to eligible beneficiaries of CCI. The Ombudsman Program conducts outreach and enhances awareness of Ombudsman service availability, investigates and resolves Cal MediConnect enrollees' issues with managed care plans and refers Cal MediConnect enrollees to various resources and assistance programs.

Managed Care Rate-Setting and Network Adequacy - Overview and Discussion. The subcommittee has requested DHCS to provide an overview of the rate-setting process for Medi-Cal managed care, particularly regarding ensuring adequate provider networks for Medi-Cal beneficiaries.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Please describe the divisions and positions that will manage the workload previously performed by DMHC pursuant to the four interagency agreements.

3. Will all of the federal regulatory requirements be recapitulated in state regulations? If not, which provisions will be excluded and why?

4. Please provide a brief overview of the prospective rate-setting process and the department's progress implementing this process.

Issue 6: Medi-Cal Managed Care Ombudsman Staffing

Budget Issue. DHCS requests 15 positions (nine converted from limited-term and six new, permanent positions) and expenditure authority of $1.8 million ($895,000 General Fund and $894,000 federal funds). If approved, these resources would allow the department to continue managing increased call volume and consumer assistance activities in the Office of Ombudsman.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$895,000
0890 – Federal Trust Fund	$-	$894,000
Total Funding Request:	**$-**	**$1,789,000**
Total Positions Requested:	**15.0**	

Background. The 1995 Budget Act authorized DHCS to establish the Office of the Ombudsman within its Medi-Cal Managed Care Operations Division. The primary mission of the Ombudsman is to investigate and find resolution for Medi-Cal managed care beneficiaries' issues regarding access to medically necessary services. The Ombudsman assists beneficiaries in navigating the managed care system by facilitating discussions between beneficiaries and their Medi-Cal managed care plans from a neutral standpoint so appropriate actions are taken for beneficiaries to get the care and services they need, and by coordinating any care and services with facilities and providers.

According to DHCS, from December 2015 through September 2016 there has been a 24.5 percent increase in cases handled by the Ombudsman. This trend is expected to grow based on the following increases in managed care caseload and managed care transitions:

- Affordable Care Act optional expansion enrollment
- Implementation of the Whole-Child Model for California Children's Services
- Full-scope Medi-Cal benefits to all children under age 19, regardless of immigration status
- Geographic Managed Care expansion in Sacramento and San Diego

Limited-Term Resources Approved in 2015. The 2015 Budget Act approved nine limited-term positions to allow time for the Ombudsman to properly assess the number of staff needed to properly manage the number of calls received daily. These positions had previously been redirected from other divisions to manage a significant increase in call volume due to various transitions of fee-for-service populations into managed care.

According to DHCS, call volume data support that OMB is unable to successfully operate its call center with less than the current number of staff. DHCS proposes to make the nine limited-term positions permanent and add six new positions to allow redirected contract staff from Health Care Options to return to their original workload.

Stakeholder Proposal for Reporting of Ombudsman Complaint Data. The California Pan-Ethnic Health Network proposes trailer bill language to accompany the department's request. If approved, the proposed language would require quarterly reporting on calls received by the Ombudsman, including:

1) Number and type of contacts received

2) Wait time for callers or average speed to answer
3) Number of calls abandoned
4) Result of contacts, including destination of referred calls and time to resolution of complaint or grievance.

The collected data would include demographic, coverage and complaint-related information, in coordination with the Office of Patient Advocate, which reports on consumer managed care complaints at four state reporting entities. The proposed language would also require the reports be posted on the department's website and compiled into an annual report that also includes training protocols for staff, including cultural and linguistic competency; an assessment of trends; and protocols for call or complaint referrals.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What information is currently collected by the Office of the Ombudsman and reported to the Office of Patient Advocate? Does the reported data include demographic information, such as language spoken, race, or ethnicity?

Issue 7: Provider Panel - Barriers Preventing Access to Care for Medi-Cal Beneficiaries

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

Ten Percent Reduction of Provider Reimbursement Rates. AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, implemented a ten percent reimbursement rate reduction for most providers of services to Medi-Cal beneficiaries and an actuarially equivalent reduction in capitation rates paid to Medi-Cal managed care plans. The reduction applies to dates of service on or after June 1, 2011. Due to court injunctions, which were subsequently lifted in December 2012, the department was unable to reduce reimbursements during this period. This delay, coupled with system implementation issues, required the department to retroactively recoup the overpayments to providers that occurred while the reductions were enjoined or delayed. Over time, the department eliminated many of the reductions and forgave much of the retroactive recoupment amounts due to concerns that the reductions might adversely impact beneficiaries' access to necessary medical care. In addition, the federal government's approval of the State Plan Amendment to implement these reductions was contingent on the state agreeing to implement an access monitoring plan. The plan identifies 23 separate metrics in the three key areas of beneficiary measures, provider availability, and service use and outcomes. The most recent monitoring plan was completed in September 2016 and is available on the DHCS website. The budget includes savings of $570.8 million ($188.3 million General Fund and $382.5 million federal funds) in 2016-17 and $565.4 million ($191.1 million General Fund and $374.3 million federal funds) in 2017-18.

Audit Findings for Denti-Cal Program Suggest Limitations to Beneficiary Access. In 2014, the California State Auditor performed an audit of the Denti-Cal program which found several weaknesses in the program's operation that limited children's access to dental care. In particular, the audit reported the following:

1. Children's utilization rate of dental services, 43.9 percent, was twelfth worst among states submitting data to CMS in 2013.
2. Many counties had insufficient providers, with five counties reporting no providers at all.
3. Reimbursement rates for the ten most common dental procedures were 35 percent of the national average in 2011.
4. The department had not performed annual reimbursement rate reviews, as required by law, between 2001 and 2011.
5. The department had not enforced provisions of its contract with Delta Dental designed to improve outreach and increase utilization of services.

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

Provider Panel. The subcommittee has asked the following speakers to address the topic of barriers preventing access to care for Medi-Cal beneficiaries:

- **John D. Stobo, M.D.** – Executive Vice President, UC Health
- **Naomi Fuchs –** Chief Executive Officer, Santa Rosa Community Health Centers
- **Dr. John Luther –** Chief Dental Officer, Western Dental and Orthodontics
- **Stuart Thompson –** Associate Dir. Governmental Relations, California Medical Association
- **Amber Kemp –** Vice President, Health Care Coverage, California Hospital Association

Subcommittee Staff Comment—This is an informational item.

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

1. Please describe how the department monitors access to necessary medical care for Medi-Cal beneficiaries pursuant to its agreement with the federal government.

2. What metrics does the department utilize to determine whether access is sufficient for a particular provider type?

Issue 8: Medi-Cal Optional Benefits

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

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

Elimination of Medi-Cal Optional Benefits. In 2009, facing a significant General Fund deficit, the budget included several reductions in reimbursement and benefits in the Medi-Cal program. ABX3 5 (Evans), Chapter 20, Statutes of 2009, eliminated several optional Medi-Cal benefits, including adult dental services, acupuncture, audiology, speech therapy, chiropractic services, optician and optical lab services, podiatric services, psychology services, and incontinence creams and washes. These benefits were not eliminated for beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program, beneficiaries in a skilled nursing facility or intermediate care facility, or pregnant beneficiaries. Various budget and legislative actions have restored some adult dental services and acupuncture services.

Costs to Restore Remaining Optional Benefits. According to DHCS, the costs to restore each of the previously discontinued optional benefits in 2017-18 are as follows:

Optional Benefits	FFS	Managed Care	TF	GF
Audiology	$4,454,000	$9,444,000	$13,898,000	$4,372,000
Chiropractic	$557,000	$1,181,000	$1,738,000	$547,000
Incontinence Creams/Washes	$8,197,000	$20,084,000	$28,281,000	$8,856,000
Optician/Optical Lab	$11,051,000	$56,902,000	$67,953,000	$20,879,000
Podiatry	$2,459,000	$5,214,000	$7,673,000	$2,414,000
Speech Therapy	$283,000	$600,000	$883,000	$278,000
Dental	$175,430,000	$15,255,000	$190,685,000	$69,458,000
Grand Total	**$202,431,000**	**$108,680,000**	**$311,111,000**	**$106,804,000**

Various stakeholders have proposed restoration of previously discontinued optional benefits. These proposals may be found in *Issue 9: Allocation of Proposition 56 Tobacco Tax Funding – Proposals for Investment*.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of the optional Medi-Cal benefits discontinued under ABX3 5 that have not yet been restored.

2. How do Medi-Cal beneficiaries typically access these services, when needed, outside of their Medi-Cal coverage?

Issue 9: Allocation of Proposition 56 Tobacco Tax Funding – Proposals for Investment

Background. The budget includes reduced General Fund expenditures of $1.2 billion offset by revenue received from voter approval of Proposition 56, which increased the excise tax rate on cigarettes, tobacco products, and electronic cigarettes. After backfills and specified allocations, Proposition 56 requires 82 percent of the funds remaining be transferred to the Healthcare Treatment Fund for DHCS to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services. Proposition 56 also provided that "funds shall not be used to supplant existing state general funds for these same purposes", "the funding shall be used only for care provided by health care professionals, clinics, health facilities" and "health plans contracting with the State Department of Health Care Services to provide health benefits".

The Administration has interpreted the statutory provisions of Proposition 56 to allow allocation of revenue to fund growth in program expenditures over the level contained in the 2016 Budget Act. Although these expenditures would have otherwise been funded with state General Fund, the Administration asserts this use of funds does not violate the non-supplantation provisions of Proposition 56. According to the Administration, Proposition 56 revenue deposited in the Healthcare Treatment Fund is allocated to the following program growth expenditures in 2017-18:

PC #	PC Title	Amount of New Program Growth Funded by Proposition 56 Compared to 2016 Budget Act Level (Whole Dollars)
96	Two Plan Model	$464,092,000
97	County Organized Health Systems	$166,112,000
99	Geographic Managed Care	$81,150,000
167	Medicare Pmnts.- Buy-In Part A & B Premiums	$37,956,000
168	Medicare Payments - Part D Phased-Down	$285,485,000
102	Regional Model	$16,795,000
104	Pace (Other M/C)	$35,803,000
112	Capitated Rate Adjustment for FY 2017-18	$150,000,000
	Total	**$1,237,393,000**

Stakeholder Proposals for Investment of Proposition 56 Funding. Various stakeholders have proposed the following alternative investments of tobacco tax revenue provided by Proposition 56, as well as other Medi-Cal-related investments of General Fund resources.

Proposition 56-Related Proposals

Supplemental Payments to Physicians and Dentists for Medi-Cal Access. The California Medical Association and the California Dental Association request approximately $900 million in Proposition 56 revenue to provide incentive-based supplemental payments to physicians and dentists based on the number of Medi-Cal patients served.

Expand Full-Scope Medi-Cal Up to Age 26 Regardless of Immigration Status. Health Access, the California Immigrant Policy Center, and others request approximately $90 million in Proposition 56 revenue to fund expansion of full-scope Medi-Cal services to young adults up to age 26 regardless of immigration status.

Restore Full-Dental Benefits to Adult Medi-Cal Beneficiaries. The California Pan-Ethnic Health Network, Health Access, and others request $69.5 million Proposition 56 revenue and $121.2 million federal funds to restore remaining dental benefits to adult Medi-Cal beneficiaries that were eliminated in 2009.

General Fund Investments

Restore Vision Benefits to Medi-Cal Beneficiaries. VSP Vision Care requests $68 million ($20.9 million General Fund and $47.1 million federal funds) and accompanying trailer bill language to restore optician and optical lab services in Medi-Cal. These benefits were eliminated in 2009 pursuant to ABX3 5. The proposed statutory changes are also contained in AB 1092 (Cooley), pending in the Assembly.

Clinical Laboratories Recoupment Forgiveness and Rate Restoration. The California Clinical Laboratory Association requests $39 million General Fund to restore AB 97 reductions for clinical laboratory providers and forgive retroactive recoupment of reductions implemented pursuant to AB 1494 (Committee on Budget), Chapter 28, Statutes of 2012.

Supplemental Payments to In-Home Pediatric Care for Medi-Cal Beneficiaries. Asm. Maienschein and Sen. Bates request $20 million General Fund and $20 million federal funds to provide incentive-based supplemental payments to in-home pediatric care providers in the Medi-Cal program.

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

Issue 10: Nursing Facility/Acute Hospital Waiver Implementation

Waiver Renewal and Trailer Bill Language Proposal. DHCS proposes to renew its Nursing Facility/Acute Hospital Transition and Diversion waiver agreement with the federal government. The department proposes to codify the provisions of its proposed waiver renewal in trailer bill language. If approved, the proposed trailer bill language would allow the department to renew the waiver with specified changes. The budget includes $9.8 million ($4.9 million General Fund and $4.9 million federal funds) for costs related to implementation of the proposed waiver renewal.

Background. According to DHCS, the Nursing Facility/Acute Hospital Transition and Diversion (NF/AH) waiver is an alternative to costly institutional care and affords frail and vulnerable Medi-Cal members the opportunity to remain in a home- or community-based setting or to transition out of an institution into a home- or community-based setting. Federal law requires Medicaid waivers to maintain budget neutrality, which means the cost of services provided by the waiver program must be no more than the services provided to a peer group in an institutional placement. To maintain cost neutrality, individuals on the NF/AH waiver are assigned at the point of enrollment an annual institutional cost limit based on assessed level of care. NF/AH waiver participants have care plans and a menu of services from which they can select and self-direct as long as the cost of these services are within their annual individual cost limit. Nurse case managers have been managing the care plans and the annual individual cost limit and require participants who are at the cost limit to adjust the care plan, even if there is no change in the health status.

The NF/AH model of care provides a medical and social service delivery system using a person-centered planning approach that provides and coordinates all needed LTSS. Services are provided to adults who would otherwise reside in nursing facilities. The NF/AH waiver allows eligible individuals to remain independent and in their homes for as long as possible. The NF/AH waiver was scheduled to expire December 31, 2016. However, DHCS reports it obtained an extension of the current waiver until June 29, 2017.

Proposed NF/AH Waiver Renewal. After consulting with stakeholders, DHCS has submitted a proposal to extend the NF/AH waiver and proposes trailer bill language to codify the provisions contained in the proposed extension. These provisions would:

1) Authorize DHCS, when renewing the NF/AH Waiver, to take the following actions:
    a. Contract with one or more case management contractors qualified to provide care management and waiver services.
    b. Propose that the waiver demonstrates cost neutrality in the aggregate rather than based on individual cost limits. Waiver participants will still be subject to individual cost limits set to their established level of care but would have the ability to exceed institutional cost limits on a case-by-case basis determined by medical necessity.
    c. Expand the number of waiver slots by 5,000 beginning January 1, 2017. These slots would phase in over the course of the waiver term. Expansion of the existing cap, currently 3,964 slots, on the number of waiver participants will allow DHCS to reduce the existing community wait list, currently 1,800 members.
    d. Require care management contractors to enroll 60 percent of all total enrollments from institutional settings to assist members to return to home- and community-based settings.

e. Establish a managed fee-for-service model utilizing a per member per month rate developed with actuarial methods, to prevent further deterioration of existing provider networks and attract new provider organizations to contract with DHCS to provide waiver services.
f. Identify performance outcomes to evaluate quality of services provided by a care management contractor.
g. Develop criteria to evaluate the fiscal solvency of a care management contractor.
h. If the care management contractor is in danger of becoming fiscally insolvent, authorize DHCS to 1) immediately terminate the contract or 2) require the contractor to submit a compliance plan addressing fiscal solvency concerns.
i. Require a care management contractor to immediately notify DHCS in writing of any fact or facts that are likely to result in its inability to meet its financial obligations. The contractor must also submit an improvement plan outlining the steps that will be taken to improve the subsequent years' financial performance.
j. Allow renewal of a care management contract.
k. Require a point of contact, if at any event, either DHCS or the contractor needs to makes changes to the care management contract.
l. DHCS can terminate or decide not to renew a care management contract for any of the following reasons: 1) DHCS determines that the contractor does not meet the requirements for participation in the Medi-Cal or NF/AH waiver program; 2) A waiver participant's health is jeopardized by continuing the contract; or 3) Appropriated funds entered into the care management contract are unavailable. In addition, the care management contractor can terminate the contract for the following reasons: 1) Failure to reach mutual agreements on managed fee-for-service rates or unwillingness to accept the managed fee-for-service rates determined by DHCS; or 2) If the contractor can demonstrate to DHCS that it cannot remain fiscally solvent through the term of the contract due to a change in contractual obligations created by a state or federal change in the Medi-Cal or NF/AH waiver program.

2) Authorize DHCS to implement this section by means of all-county letters, provider bulletins, policy letters or other means to further execute policy direction.
3) Exempt contracts under this section from Department of General Services review and approval.
4) Require DHCS to implement this section only to the extent it can demonstrate fiscal neutrality on the overall health care costs spent by DHCS for waiver participants, as specified and only to the extent federal financial participation is available.
5) DHCS will submit the NF/AH waiver renewal for approval by the federal Centers for Medicare and Medicaid Services prior to implementing these provisions.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the provisions of the NF/AH Waiver Renewal.

Issue 11: Home- and Community-Based Services & Long-Term Care - Proposals For Investment

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

AIDS Waiver Reimbursement Parity With Other HCBS Programs. The HIV Alliance requests $8.1 million ($4.1 million General Fund, $4.1 million federal funds) to increase reimbursement rates in the AIDS Waiver to better align with reimbursement rates received by other home- and community-based service waiver programs. The AIDS Waiver Program is one of eight home- and community-based services waiver programs targeting vulnerable populations in California and provides comprehensive case management and direct, in-home services to people living with HIV or AIDS as an alternative to nursing facility care or hospitalization.

Home Upkeep Allowance and Transitional Needs Fund. Disability Rights California and other organizations request up to $121.9 million ($61 million General Fund and $61 million federal funds) to increase the dollar amount for the Home Upkeep Allowance, which allows Medi-Cal beneficiaries in a nursing facility placement with a share-of-cost to maintain a home in the community. These organizations also propose to create a Transitional Needs Fund to allow share-of-cost Medi-Cal beneficiaries who have lost their homes to save income for six months to secure housing. Costs associated with the Transitional Needs Fund are unknown, but potentially significant.

Skilled Nursing Facility Nursing Hours Per Patient Day. SEIU California requests $70.3 million ($35.1 million General Fund and $35.1 million federal funds) in 2017-2018, $160.3 million ($80.1 million General Fund and $80.1 million federal funds) in 2018-19, and $282.4 million ($141.2 million General Fund and $141.2 million federal funds) annually thereafter. If approved, these resources would fund Medi-Cal local assistance payments to skilled nursing facilities to support a phased increase in the minimum direct care nursing hours per patient day (nhppd) from the current 3.2 nhppd to 4.1 nhppd.

Intermediate Care Facilities-Developmental Disabilities (ICF-DDs) Rate Reforms. The Developmental Services Network requests $28.9 million ($14.5 million General Fund and $14.5 million federal funds) to lift the freeze on reimbursement rates enacted in 2008 and rebase those rates to the unfrozen rates for 2016-17, develop a new rate methodology based on the Centers for Medicare and Medicaid Services skilled nursing facility market basket, implement a Quality Assurance Supplemental Payment program effective August 1, 2018, and establish a new rate for facilities with four beds.

Medically Tailored Meals Program. The Food is Medicine Coalitaion requests $2 million General Fund for three years to make a cost-effective, medically tailored, home delivered meal intervention available to approximately 2,500 Medi-Cal beneficiaries with certain complex and traditionally high-cost health conditions and determine how such an intervention could lead to better outcomes and lower health care costs for recipients and the state Medi-Cal program.

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

Issue 12: SF Community Living Services Benefit Transition to Assisted Living Waiver

Budget Issue and Trailer Bill Language Proposal. DHCS proposes trailer bill language to transition individuals receiving home and community-based services in the San Francisco Community Living Support Benefit (SF CLSB) waiver into the Assisted Living Waiver (ALW). The budget includes savings of $746,340 ($373,170 General Fund and $373,170 federal funds), which is the net of additional costs for providing services to new ALW beneficiaries offset by savings from transitioning individuals from skilled nursing facilities into a community placement under the ALW.

SF Community Living Services Benefit Transition Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$373,170
0890 – Federal Trust Fund	$-	$373,170
Total Funding Request:	**$-**	**$746,340**

Background. The SF CLSB waiver, administered by the city and county of San Francisco on behalf of DHCS, assists eligible individuals to move into available community settings and exercise increased control and independence over their lives. The waiver provides or coordinates services at community-based housing sites that enable beneficiaries to remain in the least restrictive, most home-like environment while receiving health-related services, including personal care and psychosocial services. Medi-Cal beneficiaries eligible to participate in the program must be:

1) 21 years of age and older.
2) A resident of San Francisco who would otherwise be homeless, living in shelters, or institutionalized.
3) Would be determined eligible for skilled nursing facility level of care.

The SF CLSB waiver is scheduled to expire on June 30, 2017. San Francisco has decided not to renew the waiver.

DHCS proposes to sunset the SF CLSB waiver effective July 1, 2017, and transition its 22 participants into the Medi-Cal Assisted Living Waiver (ALW). The ALW offers services in an assisted living or publicly subsidized housing setting to Medi-Cal beneficiaries who would likely otherwise receive care in a skilled nursing facility. Qualification for a skilled nursing level of care is determined by a care coordination agency utilizing an assessment tool to assess potential participants. According to DHCS, the goals of the ALW are to:

1) Facilitate a safe and timely transition of Medi-Cal beneficiaries from a nursing facility to a community home-like setting in a residential care facility, an adult residential care facility, or public subsidized housing, utilizing ALW services.
2) Offer eligible seniors and persons with disabilities, who reside in the community, but are at risk of being institutionalized, the option of utilizing ALW services to develop a program that will safely meet his or her care needs wlyhile continuing to reside in a residential care facililty, adult residential care facility, or public subsidized housing.

In addition to the trailer bill language to manage the transition, DHCS proposes to expand the ALW, which is currently operating in 14 counties, to serve the city and county of San Francisco. The ALW

expires February 28, 2019. According to DHCS, the services provided through the SF CLSB waiver are comparable and available under the ALW.

The department also expects the transition will result in 22 additional ALW enrollments from institutional providers within the city and county of San Francisco, in particular, from the highest cost skilled nursing facility in the state, Laguna Honda. DHCS expects these new transitions to community settings to result in General Fund savings based on reduced expenditures for institutional care. The budget includes savings of $746,340 ($373,170 General Fund and $373,170 federal funds), which is the net of additional costs for providing services to new ALW beneficiaries offset by savings from transitioning individuals from skilled nursing facilities into a community placement under the ALW.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Please describe the planned transition process for individuals currently receiving services under the SF CLSB waiver. How will this process be communicated to beneficiaries?

3. Please describe how the department intends to maintain continuity of care for beneficiaries transitioning from the SF CLSB to the ALW. Are there providers that serve SF CLSB participants that may not participate in the ALW?

Issue 13: Alternative Birthing Center Reimbursement

Budget Issue and Trailer Bill Language Proposal. DHCS proposes trailer bill language to allow reimbursement for deliveries in alternative birthing centers (ABCs) based on the equivalent, lowest acuity diagnosis-related group (DRG) reimbursement provided to general acute care hospitals. The budget includes $43,500 ($21,755 General Fund and $21,765 federal funds) for increased costs associated with higher reimbursement rates to ABCs upon approval of the proposed trailer bill language. The trailer bill language also makes technical changes to remove outdated reporting requirements and other statutory references.

Alternative Birthing Center Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$21,755
0890 – Federal Trust Fund	$-	$21,765
Total Funding Request:	**$-**	**$43,500**

Background. An ABC is a clinic that is not part of a hospital and provides comprehensive perinatal services and delivery care to pregnant women who remain in the facility for less than 24 hours. On average, there are approximately 200 births within an ABC each year. Along with providing pregnant mothers an alternative to traditional low-risk hospital births, ABCs provide cost-effective birthing services and help to reduce high overall medical costs as compared to low-risk hospital births.

Existing state law requires DHCS to reimburse ABCs for facility-related delivery costs at a statewide, all-inclusive rate per delivery that cannot exceed 80 percent of the average Medi-Cal reimbursement to general acute care hospitals, as identified in the California Medical Assistance Commission (CMAC) annual legislative report. However, the contract between CMAC and DHCS has been dissolved and rate-setting responsibilities transferred to DHCS. The department currently utilizes a payment methodology that is based on DRGs, which pay similarly across hospitals for similar care for equivalent diagnoses.

DHCS proposes trailer bill language to implement an ABC reimbursement methodology based on the Medi-Cal DRG payment system, which replaced the CMAC system, and to align existing law to reflect an all-inclusive delivery rate-setting methodology. The proposed rate would be based on the DRG level-1 based general acute care hospital rate and would impose the following requirements: 1) ABC reimbursements may not exceed provider charges made to the general public; 2) federal approvals must be obtained before implementing the revised methodology; and 3) the application of the ten percent provider payment reduction, pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, would continue.

Additionally, DHCS proposes to: 1) remove certain provider and departmental reporting requirements that are not currently being administered and are no longer necessary; 2) add cross-references identifying other provider licensing and oversight provisions, as applicable; and 3) remove the annual legislative reporting requirements in regards to the ABC provider type assessing cost-effectiveness and quality of care. The budget includes $43,500 ($21,755 General Fund and $27,765 federal funds) for increased reimbursements to ABCs upon approval of the department's proposed trailer bill language.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 14: Ground Emergency Medical Transportation Supplemental Pmt. Program Audits

Budget Issue. DHCS requests three positions (conversion of limited-term to permanent) and expenditure authority of $393,000 ($197,000 federal funds and $196,000 reimbursements) annually. If approved, these resources would allow the department to continue auditing workload for its supplemental reimbursement program for ground emergency medical transportation (GEMT) providers.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$197,000
0995 – Reimbursements	$-	$196,000
Total Funding Request:	**$-**	**$393,000**
Total Positions Requested:	**3.0**	

Background. Federal Medicaid law authorizes states to claim certified public expenditures (CPEs), which are the certified actual costs of care provided by a governmental provider such as a public hospital or clinic, as the non-federal share of health care expenditures eligible to receive federal financial participation. To receive federal funding, the Centers for Medicare and Medicaid Services (CMS) requires providers to submit cost reports to accurately document the cost of providing the services.

AB 678 (Pan), Chapter 397, Statutes of 2011, authorizes state and local government entities to use CPEs to claim federal matching funds for the difference between the Medi-Cal reimbursement rate and the allowable cost for providing GEMT services. Public entities certify and submit CPEs for GEMT services and reimburse DHCS for the non-federal share of costs to administer the program. DHCS must audit cost reports submitted to claim CPE prior to submission to CMS for federal matching funds.

According to DHCS, approximately 100 local fire districts currently participate in the GEMT supplemental payment program. Participation has increased each year and is projected to be 120 in 2017-18. The department reports a backlog of approximately 428 cost reports caused by a delay in federal approval of audit requirements and expects an additional 120 cost reports requiring audit annually.

Limited-Term Resources Approved in 2014. The 2014 Budget Act approved seven positions, four permanent and three limited-term, for auditing workload related to implementation of the GEMT supplemental payment program. Three Health Program Auditor III positions will expire on June 30, 2017. DHCS proposes to convert these three positions from limited-term to permanent. These positions were approved as limited-term to clear an initial backlog of cost reports based on a retroactive implementation date for supplemental payments to 2010. According to DHCS, CMS auditing requirements have added to the complexity and resulting workload for each audit and, consequently, requests conversion of these limited-term positions to permanent to complete audits of provider cost reports timely.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. How does the department intend to clear its auditing backlog with the same level of resources?

Issue 15: AB 959 Clinic Supplemental Reimbursement Audits

Budget Issue. DHCS requests a two-year extension of expenditure authority of $1.4 million ($697,000 federal funds and $697,000 reimbursements). If approved, these resources would allow the department to implement supplemental Medi-Cal payments to state veterans homes and public clinics pursuant to AB 959 (Frommer), Chapter 162, Statutes of 2006.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$697,000
0995 – Reimbursements	$-	$697,000
Total Funding Request:	**$-**	**$1,394,000**
Total Positions Requested:	**0.0**	

Background. Federal Medicaid law authorizes states to claim certified public expenditures (CPEs), which are the certified actual costs of care provided by a governmental provider such as a public hospital or clinic, as the non-federal share of health care expenditures eligible to receive federal financial participation. To receive federal funding, the Centers for Medicare and Medicaid Services (CMS) requires providers to submit cost reports to accurately document the cost of providing the services.

AB 959 allows state veterans homes and public clinics to receive federal matching funds for services provided to Medi-Cal beneficiaries and claimed as CPEs. AB 959 requires an eligible veterans home or public clinic to reimburse DHCS for the cost of administering the supplemental reimbursement program as a condition of participation. The department developed an initial version of the required cost report template for providers to document CPEs, which was approved by CMS in June 2013. However, the department reports CMS has requested additional revisions to the report. Once the revised cost report is approved by CMS, the clinics will submit their completed cost reports, which will be audited by DHCS and submitted to CMS for federal matching funds. Because CMS has not yet approved the new cost report template, no cost reports have been submitted, no audits have been conducted, and no claims have been submitted to CMS.

Limited-Term Resources Approved in 2015. The 2015 Budget Act approved limited-term resources equivalent to approximately ten positions for implementation of the supplemental reimbursement program pursuant to AB 959. At the time, the department indicated it needed five Health Program Auditor III positions, two Health Program Auditor IV positions, one Health Program Audit Manager II, one Administrative Jaw Judge II, and equivalent of one Attorney. These positions were approved to manage workload related to the auditing of AB 959 clinic cost reports, conducting review of appealed cost report determinations, and litigating administrative appeals through the state hearing process. According to DHCS, in the absence of submitted cost reports these positions have been assisting with the development of the template, the audit program and procedures, and with provider training. DHCS also reports these positions have been assisting with audit workload for other programs. It is unclear how these positions were funded in the absence of reimbursement from AB 959 clinics, given no cost reports have been submitted.

DHCS proposes two-year extension of limited-term expenditure authority of $1.4 million ($697,000 federal funds and $697,000 reimbursements) to continue implementing the AB 959 program. These resources are equivalent to the ten positions in the previously approved request, except with two Health Program Auditor III positions replaced with one Attorney and one Legal Analyst. The department expects cost report auditing, appeal, and litigation workload once CMS approves the new cost report template.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Why has the implementation of this supplemental reimbursement program been delayed for more than 10 years?

3. What is the expected timeframe for CMS approval of the cost reports? When will the supplemental reimbursement program become operative?

4. How did the department fund the non-federal share of the previously approved positions if no cost reports, and therefore no clinic reimbursements, were received?

Issue 16: Third Party Liability Recovery – Fifty Percent Rule and Contracting Authority

Budget Issue and Trailer Bill Language Proposals. DHCS proposes trailer bill language to change the statutory amount it may recover from personal injury awards for services provided to Medi-Cal beneficiaries as a result of the injury. If approved, the budget includes $12.2 million General Fund savings to account for the increased recoveries the department expects to receive. DHCS also proposes trailer bill language to clarify and update its contracting requirements for third party liability recoveries consistent with other provisions of state contracting law.

Fifty Percent Rule Proposal Savings Estimate		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	($12,160,000)
Total Funding Request:	**$-**	**($12,160,000)**

Background. Federal and state law require DHCS to recover Medi-Cal costs from liable third parties, so that Medi-Cal is the payer of last resort. DHCS manages personal injury (PI) recovery cases in-house and uses a contractor to perform workers' compensation recovery activities. In 2015-16, the PI program recovered $60.4 million and the workers compensation program recovered $2.5 million.

Personal Injury Recoveries and the Fifty Percent Rule. DHCS' PI program reviews Medi-Cal expenditures paid for treating a member's injury and files a lien with the liable third party. The PI program may settle its lien directly with the liable third party or assert the lien against any settlement, judgment, or award resulting from a member's claim or action. However, state law requires DHCS to take no more than half of a settlement after all attorney's fees and legal costs are paid, a requirement known as the "Fifty Percent Rule." Federal Medicaid law, regulations, and guidance require the federal government's share of financing for injury-related services in a third party liability action to be fully reimbursed prior to the beneficiary receiving funds. Prior to the federal Affordable Care Act (ACA), most Medi-Cal beneficiaries had a federal matching percentage of 50 percent. When a lien was reduced under the Fifty Percent Rule for a beneficiary with a 50 percent federal match, DHCS reimbursed the federal government up to 100 percent of the amount recovered, with no funds remaining for state General Fund reimbursement. After the ACA expansion, the newly eligible group of beneficiaries has a federal matching percentage of 95 percent (100 percent prior to January 2017). For these members, DHCS reimburses CMS up to 200 percent of the amount recovered from the settlement, resulting in a loss to the state's General Fund.

DHCS proposes trailer bill language to do the following:

1) Clarify the formula that defines the state's portion of litigation costs – State law allows for a reduction of the Medi-Cal PI lien so each party pays a proportionate share of litigation costs based on the amount they receive when an attorney facilitates the settlement. According to DHCS, state law and various case law creates situations where DHCS must reduce its lien by amounts greater than the actual litigation costs incurred by the member. The department's proposed language requires each party to pay a proportionate share of actual litigation costs based on the proportion of the settlement received.

2) Clarify right to recover when there are multiple settlements – According to DHCS, existing law does not explicitly address the department's right to recover the costs of treating a member's injury when there are multiple settlements, limiting the recovery to the amount derived from applying the lowest of three statutory reductions defined in statute. The department's proposed language:
   a. Clarifies the recovery is based on the aggregated amount of all settlements once the entire action has been resolved, not just a single settlement.
   b. Renames five references to the amount to be collected from "reasonable value of benefits so provided" to "amount of the director's lien as defined in subsection (d) of Section 14124.70".
   c. Requires the Medi-Cal member or DHCS, whoever initiates a claim with a carrier for a member's injury, to notify the other party, so both parties are protected in their rights to recover injury-related losses.
3) Revise Fifty Percent Rule - DHCS proposes to limit its recovery to no more than the settlement after deducting reasonable attorney's fees and litigation costs. According to DHCS, this approach conforms to federal law, stops General Fund losses, guarantees plaintiffs' attorneys receive their expected fees, and avoids making the member liable for attorney's fees or litigation costs.

The budget includes $12.2 million General Fund savings to account for increased recoveries the department expects to receive based on its proposed revision to the Fifty Percent Rule. This savings estimate assumes the state will no longer be required to pay approximately $4 million to the federal government for its share of ACA-related recoveries and will receive approximately $8.2 million from non-ACA-related recoveries that had previously been awarded to the beneficiary. The savings estimate does not account for changes to the number of beneficiaries filing personal injury claims if the beneficiary is no longer able to receive compensation.

The budget also includes no savings for the other two provisions of its proposal to clarify the formula to define the state's portion of litigation costs and to clarify the department's right to recover when there are multiple settlements.

Third Party Liability Contracting. In 1981, the state began a pilot program allowing contracting and outsourcing of some Medi-Cal third party liability recoveries. DHCS was required to enter into contracts with private entities to obtain missing information that was held by private companies on a contingency basis. Recent workers' compensation data provided by the Department of Industrial Relations eliminates the need to outsource discovery of missing information for workers' compensation claims. However, because many PI actions remain solely in private sector databases that are unreported to the state, the department reports it needs a contractor to gain information about these unreported PI cases. State law requires these contracts to be awarded based on a no cost, percentage of recovery formula not to exceed 25 percent of the gross recovery amount.

DHCS proposes trailer bill language to do the following:
1) Eliminate mandates for contracts for workers' compensation.
2) Eliminate mandates for regional contracts for northern and southern California. According to DHCS, both contracts have been awarded to the same contractor over five bidding cycles.
3) Provide a finite end to contracts consistent with state contracting policy.

4) Technical, clarifying amendments to statute to remove obsolete pilot-related provisions and align with current practice.
5) Allow DHCS to offer non-exclusive or non-competitive contracts to multiple contractors.
6) Repeals sections providing delegated authority of the DHCS Director to contractors for recovery. According to DHCS, contractor authority will be defined within future contracts to mitigate the risk of a contractor working inconsistent with state policy, ensure the state complies with federal law, and reduce susceptibility to lawsuits.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposals.

2. What additional recoveries does the department expect from the trailer bill language provisions clarifying the formula for the state's portion of litigation costs and clarifying the department's right to recover when there are multiple settlements?

3. If Medi-Cal beneficiaries will receive no compensation from filing a personal injury claim, why does the department expect such claims will continue to be filed?

Issue 17: Federally Qualified Health Ctrs. – Delayed Implementation of Payment Changes

Budget Issue and Trailer Bill Language Proposal. DHCS proposes budget actions and trailer bill language to delay implementation of two planned changes to reimbursements for federally qualified health centers (FQHCs).

According to its *2017-18 Governor's Budget Highlights*, DHCS plans to delay implementation until no sooner than July 1, 2018, a demonstration project to test an alternative payment methodology (APM) for FQHCs pursuant to SB 147 (Hernandez), Chapter 760, Statutes of 2015. Because SB 147 authorized implementation of the APM no sooner than July 1, 2016, the department does not require legislative approval for this delay.

DHCS also proposes trailer bill language to delay implementation of AB 1863 (Wood), Chapter 610, Statutes of 2016, which allows FQHCs to bill Medi-Cal for services provided by marriage and family therapists (MFTs) as a separate visit beginning July 1, 2017. If the department's trailer bill language proposal is approved, AB 1863 implementation would be delayed until July 1, 2018.

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

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

SB 147 Establishes an Alternative Payment Methodology Pilot for FQHCs. SB 147 authorizes an alternative payment methodology demonstration project designed to provide flexibility for clinics' delivery of health care services to Medi-Cal beneficiaries. The alternative methodology would pay clinics a monthly capitation rate for beneficiaries, which would allow clinics to receive payment for a beneficiary's care that is unrelated to the number of visits he or she makes to the clinic. This payment structure would be implemented no sooner than July 1, 2016, and would allow clinics to provide multiple provider services to beneficiaries on a single day.

AB 1863 Allows Separate Billing for MFTs. AB 1863 includes, beginning July 1, 2017, MFTs as a health care professional for which an FQHC may be reimbursed for a separate clinic visit. An FQHC that currently includes the cost of MFT services in its PPS rate must apply to the department for an adjustment to the rate if it chooses to bill these services as a separate visit. An FQHC that does not provide MFT services and elects to add these services to bill as a separate visit, must submit a request to the department for a change in its scope of service.

Prioritization of Department Workload. In its *2017-18 Governor's Budget Highlights*, DHCS reports that it must prioritize certain initiatives and delay others. In particular, the department plans to prioritize implementation of various resource-intensive federal regulations, such as the Medicaid managed care, Medicaid mental health parity, and home- and community-based services regulations. As a result, the department intends to delay several initiatives including the APM demonstration and MFT billing implementation for FQHCs, which would begin no sooner than July 1, 2018.

Proposed Amendment to Trailer Bill Language. The California Association of Marriage and Family Therapists (CAMFT) proposes to amend the department's trailer bill language to require implementation of FQHC billing for MFTs "no later than July 1, 2018". This language would allow the department to delay implementation for no more than one year from the original implementation date of July 1, 2017.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please describe the rationale for delaying implementation of the APM and billing for MFTs at clinics.

2. When does the department intend to implement these required reimbursement changes?

Issue 18: Family Health Estimate Overview

Budget Issue. The November 2016 Family Health Local Assistance Estimate includes $251 million ($175.2 million General Fund, $10.5 million federal funds, and $65.2 million special funds and reimbursements) for expenditures in 2016-17, and $266.9 million ($218.1 million General Fund, $4.5 million federal funds, and $44.3 million special funds and reimbursements) for expenditures in 2017-18.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2016-17**	**2017-18**	**BY to CY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$67,805,000	$73,877,000	$6,072,000
Federal Funds	$6,061,000	$-	($6,061,000)
Special Funds/Reimbursements	$4,723,000	$5,453,000	$730,000
County Funds [non-add]	[$78,685,000]	[$79,444,000]	[$759,000]
Total CCS Expenditures	**$78,589,000**	**$79,330,000**	**$741,000**
Child Health and Disability Prevention (CHDP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$32,000	$1,000	($31,000)
Total CHDP Expenditures	**$32,000**	**$1,000**	**($31,000)**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$106,186,000	$144,206,000	$38,020,000
Special Funds and Reimbursements	$36,425,000	$16,425,000	($20,000,000)
Total GHPP Expenditures	**$142,611,000**	**$160,631,000**	**$18,020,000**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$1,190,000	$-	($1,190,000)
Federal Funds	$4,509,000	$4,509,000	$-
Special Funds and Reimbursements	$24,083,000	$22,427,000	($1,656,000)
Total EWC Expenditures	**$29,782,000**	**$26,936,000**	**($2,846,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$175,213,000	$218,084,000	$42,871,000
Federal Funds	$10,570,000	$4,509,000	($6,061,000)
Special Funds and Reimbursements	$65,231,000	$44,305,000	($20,926,000)
County Funds [non-add]	[$78,685,000]	[$79,444,000]	[$759,000]
Total Family Health Expenditures	**$251,014,000**	**$266,898,000**	**$15,884,000**

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

The programs included in the Family Health Estimate are:

- **California Children's Services (CCS)**: The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care.
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 174,178 in 2016-17, an increase of 60 or 0.03 percent, compared to the 2016 Budget Act. The budget estimates Medi-Cal CCS caseload of 177,396 in 2017-18, an increase of 3,218 or 1.8 percent, compared to the revised 2016-17 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 12,803 in 2016-17, an increase of 701 or 5.8 percent, compared to the 2016 Budget Act. The budget estimates state-only CCS caseload of 12,557 in 2017-18, a decrease of 246 or 1.9 percent, compared to the revised 2016-17 estimate.
- **Child Health and Disability Prevention (CHDP):** The CHDP program, established in 1973, provides complete health assessments and immunizations for children at or under 18 years of age whose family income is at or below 200 percent of the federal poverty level and who are not enrolled in Medi-Cal. This program also administers the Early and Periodic Screening, Diagnosis, and Treatment benefit for fee-for-service Medi-Cal beneficiaries.
  Caseload Estimate: The budget estimates state-only CHDP caseload of 509 in 2016-17, a decrease of 1,284 or 71.6 percent, compared to the 2016 Budget Act. The budget estimates state-only CHDP caseload of zero in 2017-18, a decrease of 509 or 100 percent, compared to the revised 2016-17 estimate. According to DHCS, these significant caseload reductions are primarily due to the eligibility of all children, regardless of immigration status, for full-scope Medi-Cal pursuant to SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015. (See *Issue 21: Elimination of State-Only Child Health and Disability Prevention Program*)
- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington's, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal.
  Caseload Estimate: The budget estimates state-only GHPP caseload of 931 in 2016-17, an increase of 44 or 5 percent, compared to the 2016 Budget Act. The budget estimates state-only GHPP caseload of 936 in 2017-18, an increase of 5 or 0.5 percent, compared to the revised 2016-17 estimate.
- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. In prior Family Health Estimates, program benefits and administrative costs were budgeted on an accrual basis, while other programs in the Family

Health Estimate are budgeted on a cash basis. Beginning in 2017-18, the EWC program will transition from an accrual basis to budgeting on a cash basis. (See *Issue 22: Every Woman Counts Accrual to Cash Budgeting*)

Caseload Estimate: The budget estimates EWC caseload of 161,000 in 2016-17, unchanged compared to the 2016 Budget Act. The budget estimates EWC caseload of 25,000 in 2017-18, a decrease of 136,000 or 84.5 percent, compared to the revised 2016-17 estimate. The significant decrease in 2017-18 caseload is due to the proposed transition from an accrual basis to budgeting on a cash basis.

Delay of CCS Whole Child Model Implementation. SB 586 (Hernandez), Chapter 625, Statutes of 2016, authorizes DHCS to establish the Whole Child Model program in designated County Organized Health System (COHS) or Regional Health Authority counties. The program would transition services currently provided to CCS beneficiaries on a fee-for-service basis into a Medi-Cal managed care plan contract. After stakeholder discussions, DHCS has proposed implementation of the Whole Child Model program in 21 counties with 5 health plans to improve care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.

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

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

The budget assumes the Whole Child Model will begin implementation in three COHS counties beginning July 1, 2017. However, the department's *2017-18 Governor's Budget Highlights* indicates it intends to delay implementation of the Whole Child Model until July 1, 2018. This would result in shifting of the currently budgeted costs into 2018-19, with a one-time savings in 2017-18 of $45.1 million ($21.1 million General Fund and $23.9 million federal funds).

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please describe the status of implementation of the Whole Child Model program.

Issue 19: Elimination of State-Only Child Health and Disability Prevention Program

Trailer Bill Language Proposal. DHCS proposes to repeal the statutory provisions granting eligibility for the state-only Child Health and Disability Prevention (CHDP) program. If approved, this language would eliminate access to CDHP's health screening and immunization services for children not enrolled in Medi-Cal.

Background. The state-only CHDP program, established in 1973, provides complete child health assessments and immunizations to children under 21 years of age enrolled in Medi-Cal, and non-Medi-Cal children under 19 years of age whose family income is at or below 200 percent of the federal poverty level (FPL). Children from families with incomes at or below 200 percent of the FPL can pre-enroll in fee-for-service Medi-Cal under the presumptive eligibility for children provisions of the Medicaid program. This pre-enrollment takes place electronically at CHDP provider offices at the time children receive health assessments. This process is known as the CHDP Gateway to Medi-Cal.

The CHDP program is responsible for the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit of the Medi-Cal program. The health assessments, immunizations, and laboratory screening procedures provided for eligible children not enrolled in full-scope Medi-Cal are funded with 100 percent General Fund.

Child Health and Disability Prevention Program (State-Only) – *Funding and Caseload Estimate*			
Fund Source	**2016-17**	**2016-17**	**2017-18**
	2016 Budget	***Revised***	***Proposed***
0001 – General Fund	$115,000	$32,000	$1,000
Estimated Caseload (State-Only Screens):	**1,794**	**509**	**0**

Full-Scope Medi-Cal for Children Regardless of Immigration Status. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015, expands eligibility for full-scope Medi-Cal to all income-eligible children under age 19, regardless of immigration status. Undocumented children were previously eligible for restricted-scope Medi-Cal coverage, which includes emergency and pregnancy related services only. Services provided under restricted-scope Medi-Cal receive a 50 percent federal match, while the additional non-emergency services provided under the full-scope expansion are funded entirely by state General Fund. DHCS estimates there are 250,000 undocumented children under age 19 covered under the expansion of eligibility and, according to latest department data, 182,531 have enrolled as of March 2017.

According to DHCS, pursuant to the provisions of SB 75 all children who previously were only eligible for limited-scope services are now eligible for full-scope Medi-Cal, including the EPSDT benefit. Because EPSDT provides screening services to full-scope Medi-Cal beneficiaries that are currently provided to limited-scope beneficiaries under the state-only CHDP program, DHCS believes the program is no longer necessary. The department reports that it has received no claims for state-only CHDP since November 2016 and, as noted above, the CHDP local assistance estimate assumes no state-only screens will be performed in 2017-18.

Immigration Enforcement Concerns from Beneficiaries. Various stakeholders have reported an increase in inquiries from parents of undocumented children considering disenrollment from Medi-Cal, citing concerns about immigration enforcement actions by the new federal administration. The department does not capture information on the reasons for disenrollment, but has observed a slowdown in enrollment in recent months. These stakeholders have raised concerns about elimination of the state-only CHDP program's screening services at a time when significant uncertainty regarding federal immigration is driving anxiety about enrollment in public health and human services programs.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending further information about caseload assumptions for this program in the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 20: Every Woman Counts Accrual to Cash Budgeting

Trailer Bill Language Proposal. DHCS proposes trailer bill language to change the Every Woman Counts (EWC) program budget from an accrual to a cash basis beginning in 2017-18 and reduce the frequency of program reporting requirements from quarterly to biannually.

Background. The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured individuals who reside in California, with income at or below 200 percent of the federal poverty level. Breast cancer screening is available for individuals age 40 and older and individuals of any age who are symptomatic. Cervical cancer screening is covered for individuals age 21 and older. EWC covered benefits and categories of service include office visits, screening, diagnostic mammograms, and diagnostic breast procedures, such as ultrasound, fine needle and core biopsy, pap test and HPV co-testing, colposcopy and other cervical cancer diagnostic procedures and case management.

Medi-Cal has been on a cash basis for budgeting and accounting since 2004-05. On a cash basis, expenditures are accounted for based on the fiscal year in which payments are made, regardless of when the services are provided. On an accrual basis, expenditures are accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. The EWC program, since transferring from the California Department of Public Health in 2012, has continued to be budgeted on an accrual basis despite the prevalence of cash basis budgeting for other DHCS programs. The proposed trailer bill language would convert the EWC program budget from an accrual to a cash basis beginning in 2017-18. In addition, the 2010 Budget Act requires quarterly reporting to the Legislature on caseload, estimated expenditures, and related program monitoring data and activities of the EWC program. The proposed trailer bill language would instead require biannual reporting of this information. According to DHCS, this timeframe would allow for incorporation of additional claims information to make caseload and expenditure projections.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.