Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Holly J. Mitchell, Chair
Senator William W. Monning
Senator Jeff Stone

Thursday, May 5, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Michelle Baass

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VOTE ONLY

4260 DEPARTMENT OF HEALTH CARE SERVICES

The following issues were discussed at the March 17, 2015 Subcommittee No. 3 hearing.

Issue 1: Medi-Cal Eligibility Systems Workload (AB 1 X1, 2013)

Budget Issue. DHCS requests $3,683,000 ($1,788,000 General Fund) to support the ongoing policy and system initiatives required by AB 1 X1 (Pérez), Chapter 3, Statutes of 2013, the federal Affordable Care Act (ACA). This request includes three-year limited-term funding of $3,047,000, and four permanent positions.

Subcommittee Staff Recommendation—Approve.

Issue 2: Outreach and Enrollment Extension

Budget Issue. DHCS requests two-year limited-term special fund resources of $435,000 ($217,000 Special Deposit Fund and $218,000 federal funds) to address the workload performed by existing limited term positons that will expire on June 30, 2016. These resources are needed to support the implementation, maintenance and oversight of the Medi-Cal outreach, enrollment, and renewal assistance work that must be carried out to meet the requirements specified in AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, Sections 70 and 71, and SB 18 (Committee on Budget and Fiscal Review), Chapter 551, Statutes of 2014 and as extended by SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015.

Subcommittee Staff Recommendation—Approve.

Issue 3: Denti-Cal Oversight

Oversight and Budget Issue. DHCS requests four full-time permanent positions and $503,000 ($222,000 General Fund) to address current and anticipated increases in Denti-Cal workload due to ongoing efforts in connection with the findings and recommendations of the California State Auditor (CSA) and the federal Office of Inspector General audits regarding questionable billing for pediatric services.

Subcommittee Staff Recommendation—Approve.

Issue 4: AB 85 Health Realignment

Budget Issue. DHCS requests one permanent position and expenditure authority of $845,000 ($423,000 General Fund), of which $734,000 would be three-year limited-term, to address the ongoing administration of AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, as amended by SB 98 (Committee on Budget and Fiscal Review), Chapter 358, Statutes of 2013.

Subcommittee Staff Recommendation—Approve.

Issue 5: Federally Qualified Health Centers Pilot (SB 147, 2015)

Budget Issue. DHCS requests three-year, limited-term expenditure authority of $240,000, to support the implementation, administration, and evaluation of an alternative payment methodology (APM) pilot for select California Federally Qualified Health Centers (FQHCs), pursuant to the requirements of SB 147 (Hernandez), Chapter 760, Statutes of 2015. One-time contract authority of $300,000 is requested in 2017-18, to prepare an evaluation of the pilot. The contract will be funded 50 percent federal funds and 50 percent reimbursement from a foundation. For 2017-18, DHCS requests expenditure authority of $540,000 ($120,000 General Fund, $270,000 federal funds, $150,000 reimbursement).

Subcommittee Staff Recommendation—Approve.

Issue 6: Health Homes Activities

Budget Issue. DHCS requests three-year limited-term expenditure authority of $1,031,000 ($516,000 federal funds, $515,000 Special Deposit Fund), in support of the Health Homes Program (HHP), beginning July 1, 2016. Included in the request is three-year, limited-term contract funding for a total of $775,000 ($275,000 for year 1, $275,000 for year two, and $225,000 for year three).

Subcommittee Staff Recommendation—Approve.

Issue 7: Third Party Liability Recovery Workload

Budget Issue. DHCS requests $1,136,000 ($284,000 General Fund) and 10.0 permanent, full-time positions to address a growing workload and to increase savings. Federal and state laws and regulations mandate that Medi-Cal recover expenditures in personal injury cases involving liable third parties so that Medi-Cal is the payer of last resort. (The state received an enhanced federal participation rate of 75 percent.)

Subcommittee Staff Recommendation—Approve.

Issue 8: Eliminate Workers' Compensation Information Sunset - Trailer Bill Language

Budget Issue. DHCS proposes trailer bill language to eliminate the sunset provision and indefinitely extend the Department of Industrial Relations (DIR) authority to supply work-related injury or claim data from the Workers' Compensation Information System (WCIS) to the DHCS.

Subcommittee Staff Recommendation—Approve.

Issue 9: Supplemental Drug Rebates Cleanup Trailer Bill Language

Budget Issue. DHCS requests trailer bill language to make minor technical changes to Welfare and Institutions (W&I) Code §14105.436 and §14105.86 as amended by SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014. These technical changes will correct non-sequential lettering errors and inconsistent and erroneously omitted language in order to accurately preserve the intent and purpose of SB 870, to collect supplemental drug rebate revenues for certain prescription drugs based on drug utilization from all eligible Medi-Cal programs.

Subcommittee Staff Recommendation—Approve.

The following issues were discussed at the April 21, 2016 Subcommittee No. 3 hearing.

Issue 10: Foster Care: Psychotropic Medications (SB 238, 2015)

Budget Issue. DHCS requests one full-time permanent research program specialist II (RPS II) and $134,000 ($67,000 General Fund) in 2016-17 and $125,000 ($63,000 General Fund) ongoing, to implement the requirements of SB 238 (Mitchell) Chapter 534, Statutes of 2015.

Subcommittee Staff Recommendation—Approve.

Issue 11: Substance Use Disorders Health Care Reform Implementation

Budget Issue. DHCS requests $1,456,000 ($729,000 General Fund) to convert ten limited-term positions to permanent full-time positions and add one new permanent legal position. The ten two-year limited-term positions are set to expire on June 30, 2016. According to DHCS, the conversion of the positions to permanent full-time positions is necessary to continue to support the requirements set forth in the Affordable Care Act (ACA) and enacted in SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013, which enhanced Medi-Cal substance use disorder services. The additional legal position will address litigation workload associated with both SB 1 X1 and AB 848 (Stone), Chapter 744, Statutes of 2015, discussed later in this agenda. The legal position will be phased-in effective January 1, 2017.

Subcommittee Staff Recommendation—Approve.

Issue 12: Residential Treatment Facilities (AB 848, 2015)

Budget Issue. DHCS requests four permanent positions and expenditure authority of $478,000, from the Residential and Outpatient Program Licensing Fund (ROLF), to implement AB 848 (Stone), Chapter 744, Statutes of 2015. Of the four positions, one nurse consultant II position will be phased-in effective January 1, 2017, while the rest will be effective July 1, 2016.

Subcommittee Staff Recommendation—Approve.

4265 DEPARTMENT OF PUBLIC HEALTH

The following issues were discussed at the March 3, 2016 Subcommittee No. 3 hearing.

Issue 1: Richmond Laboratory: Viral Rickettsial Laboratory Enhanced Upgrade

Budget Issue. DPH requests to reappropriate $3.8 million from a capital outlay project approved in 2015-16 to upgrade the DPH's Bio-Safety Level 3 (BSL-3) certified Viral and Rickettsial Disease Laboratory. The upgrades were needed to ensure that DPH retains its BSL-3 Certification from the Federal Center for Disease Control and Prevention (CDC) and National Institutes of Health (NIH). According to DPH, the reappropriation is needed due to the project's delays that were beyond DPH or the Department of General Services' (DGS) control.

Subcommittee Staff Recommendation—Approve.

Issue 2: Timely Infectious Disease Outbreak Detection and Disease Prevention

Budget Issue. DPH requests $1.6 million General Fund in 2016-17, $2.1 million General Fund in 2017-18 and 2018-19, and 14 permanent positions, to provide ongoing support to protect California from infectious diseases through increased disease surveillance and laboratory capacity. The 14 positions will be phased-in.

Subcommittee Staff Recommendation—Approve.

Issue 3: Active Transportation Safety Program

Budget Issue. DPH requests $733,000 in reimbursement expenditure authority and an increase of 4.5 positions to implement the Active Transportation Safety Program with funds provided through an Interagency Agreement with the California Department of Transportation (Caltrans).
Subcommittee Staff Recommendation—Approve.

Issue 4: Protecting Children from the Effects of Lead Exposure

Budget Issue. DPH requests an increase of $8.2 million annually ($1.4 million in state operations and $6.8 million in local assistance) for four years from the Childhood Lead Poisoning Prevention Special Fund and to establish seven positions to extend services to children who have been exposed to lead as now defined by a lower blood lead level by the Centers for Disease Control and Prevention (CDC).

Subcommittee Staff Recommendation—Approve.

Issue 5: California Environmental Contaminant Biomonitoring Program

Budget Issue. DPH requests two permanent positions and $350,000 from the Toxic Substances Control Account for two years. The positions were established as limited-term positions and are set to expire on June 30, 2016.

Subcommittee Staff Recommendation—Approve.

Issue 6: End of Life Option Act (AB 15 X2, 2015)

Budget Issue. DPH requests $323,000 from the Health Statistics Special Fund in 2016-17, $245,000 in 2017-18 and annually thereafter, and two permanent positions to meet the new mandate to establish the End of Life Option Act program as specified in AB 15 X2 (Eggman), Chapter 1, Statutes of 2015, Second Extraordinary Session. This funding will enable DPH to create a secure database to implement and administer the program and provide staffing for the required confidential program management and reporting duties.

Subcommittee Staff Recommendation—Approve.

Issue 7: Collection of Data: Multi-Race or Multi-Ethnic Origin (AB 532, 2015)

Budget Issue. DPH requests $236,000 for fiscal year 2016-17 and $234,000 for fiscal year 2017-18 from the Health Statistics Special Fund to meet the new mandate to tabulate the data for both single and multiple race or ethnic designations in reports provided to other state departments as specified by AB 532 (McCarty), Chapter 433, Statutes of 2015.

Subcommittee Staff Recommendation—Approve.

Issue 8: Lesbian, Gay, Bisexual, & Transgender Disparities Reduction Act (AB 959, 2015)

Budget Issue. DPH requests one-time expenditure authority of $125,000 from the Health Statistics Special Fund to modify existing birth and fetal death registration systems and meet the new mandate to collect voluntary self-identification information pertaining to sexual orientation and gender identity as specified in the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act, AB 959 (Chiu), Chapter 565, Statutes of 2015.

Subcommittee Staff Recommendation—Approve.

Issue 9: Increase Access to HIV Pre-Exposure Prophylaxis (PrEP)

Budget Issue. DPH proposes to expend $2.6 million in federal funds ($1.4 million local assistance and $1.3 million state operations) in 2015-16 and $3.5 million ($1.8 million local assistance and $1.7 million state operations) in 2016-17, and requests the addition of five permanent positions, to implement a three-year Centers for Disease Control and Prevention (CDC) grant awarded to DPH on September 3, 2015.

A Section 28 budget letter, dated October 30, 2015, notified the Legislature of this grant and the related increase in current year federal fund authority.

Subcommittee Staff Recommendation—Approve.

Issue 10: Medical Marijuana (AB 243, AB 266, and SB 643 of 2015)

Budget Issue. DPH requests 37 positions and $12 million in funding from the Medical Marijuana Regulation and Safety Act Fund to be phased-in between fiscal years 2015-16 to 2018-19 to begin the implementation of the mandated provisions specified in AB 266 (Bonta), Chapter 689, Statutes of 2015, AB 243 (Wood), Chapter 688, Statutes of 2015, and SB 643 (McGuire), Chapter 719, Statutes of 2015. DPH requests to phase-in these positions, as follows: six positions and $457,000 in reimbursement authority for 2015-16; eight additional positions and $3,438,000 in 2016-17; two additional positions and $2,520,000 in 2017-18; and the final 21 additional positions and $5,658,000 in 2018-19.

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Trailer Bill Language. It is recommended to approve this proposal. It is also recommended to adopt placeholder trailer bill language to establish a public health surveillance system related to medical marijuana and use the Medical Marijuana Regulation and Safety Act Fund to support this system.

ITEMS FOR DISCUSSION

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Budget Overview

The Emergency Medical Services Authority (EMSA) develops and implements emergency medical services systems (EMS) throughout California and sets standards for the training and scope of practice of various levels of EMS personnel. The EMSA also has responsibility for promoting disaster medical preparedness throughout the state and, when required, managing the state's medical response to major disasters.

Budget Overview. The budget proposes expenditures of about $36.1 million ($8.7 General Fund and $6 million federal funds) and about 67 positions for EMSA.

Update on 2015-16 Funding for Medical Assistance Team. The 2015-16 budget included $500,000 General Fund and two permanent Senior Emergency Services Coordinators (SESC) positions beginning July 1, 2016. The additional resources are being utilized to respond to a moderate incident and for an initial response to a catastrophic incident. As of April 2016, both positions have been filled and the Southern California Medical Assistance Team (CAL-MAT) program has been reestablished.

To reestablish the southern California CAL-MAT, EMSA entered into a contract with California Disaster Medical Services Association (CDMSA), a non-profit organization. CDMSA is handling all administrative functions, including the recruitment and retention of volunteers, coordination of training activities, and mobilization and deployment of CAL-MAT for emergency response.

Both SESC positions are supporting California's CAL-MAT program by developing policies, procedures, and minimum standards of training for all CAL-MAT members. They also are coordinating administrative functions, exercise and trainings, assisting with the maintenance of the CAL-MAT caches, and serving as the direct liaison between CAL-MAT members and EMSA. They coordinate closely with California Department of Public Health in the continued development of policies and procedures including catastrophic planning for a flood event in the central valley, Emergency Response Teams, protocols to work in the joint Medical Health Coordination Center**,** and as a partner in revising the Public Health and Medical Emergency Operations Manual.

One of the SESC positions is supporting the AST Program by auditing the Disaster Medical Support Units (DMSU) which are placed with local providers. EMSA has completed 31 audits of 42 deployed DMSUs and EMSA has determined that the local providers are abiding by the state's memorandum of understanding resulting in a program that is robust in day-to-day response, as well as, being prepared to respond to an unexpected event.

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide a brief overview of EMSA's programs and budget.

4140 Office of Statewide Health Planning and Development

Issue 1: Budget Overview

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.

Major programs at OSHPD include:

- **Cal-Mortgage**: Provides loan insurance for non-profit healthcare facility development.
- **Facilities Development Division**: Reviews and inspects health facility construction projects.
- **Healthcare Information Division**: Collects data and distributes information on health and healthcare in California.
- **Healthcare Workforce Development Division**: Shortage designation, research, geographic information system, funding, loan repayments, internships, and pilot projects.
- **Health Professions Education Foundation**: Provides scholarships and loan repayments for healthcare professionals and students.

Budget Overview. The budget proposes expenditures of $160.8 million ($1.4 million federal fund and $159.4 million special funds and reimbursements) and 449 positions for OSHPD.

Subcommittee Staff Comment. This is an informational item.

Questions.

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: California Children's Services Program

Budget Issue. DHCS proposes trailer bill language (TBL) to implement the budget-related components of the California Children's Services Program (CCS) Whole Child Model. The TBL clarifies state, county, and Medi-Cal managed care health plan roles and responsibilities in counties where the DHCS implements the CCS Whole Child Model, with CCS services carved into managed care contracts. According to the Administration, the TBL is budget neutral.

The Whole Child Model is proposed to be implemented beginning in January 1, 2017, in some counties with County Organized Health Systems (COHS). The department indicates that it intends to seek additional statutory changes through a policy bill to implement the consumer protection and programmatic policy changes envisioned with the Whole Child Model.

CCS Budget and Caseload. See table below for CCS budget summary (excluding Medi-Cal costs) and caseload.

Table: CCS Summary

	2015-16	**2016-17**
Funding		
General Fund	$60,780,200	$73,441,100
Federal Funds	$18,515,600	$4,723,000
Total*	**$79,295,800**	**$78,164,100**
Caseload		
CCS-State Only	14,820	13,113
CCS-Medi-Cal/Targeted Low Income Program	169,387	172,114
Total	**184,207**	**185,227**

*Excludes Medi-Cal costs.

Background. The CCS program serves children and youth with special health care needs, primarily through a fee-for-service delivery system for services related to CCS-eligible health conditions, while the Medi-Cal managed care system provides for all other health care services such as primary care. In counties with populations of 200,000 or more, county CCS programs determine financial, residential, and medical eligibility, authorize CCS services, and provide care coordination. In smaller counties, DHCS performs some of the CCS eligibility and authorization services. Under longstanding realignment provisions, counties have a shared fiscal responsibility for some components of the CCS program. DHCS asserts that this complex system of care among fee-for-service providers, health plans, counties, and the state can be challenging for families to navigate and lacks incentives for coordinated, organized care. This is the basis for this proposal. Known as the CCS-carve-out, this arrangement has existed since Medi-Cal children have been mandatorily enrolled in managed care. The initial carve out was for three years. The CCS carve out has been extended repeatedly since then, usually for three or four year periods. The first extension allowed the COHS in the counties of San Mateo, Santa Barbara,

Solano, and Napa to include CCS services. Later extensions also allowed Yolo and Marin counties to include CCS services.

DHCS proposes to incrementally implement an integrated coordinated system of care for the CCS program and consolidate all care for the CCS-eligible child under one system. A CCS Whole Child model will be pursued within the existing COHS managed care model initially and will add the remainder of the COHS counties, except for Ventura. According to DHCS, this approach will continue to use CCS provider standards and provider network of pediatric specialty and subspecialty care providers. The implementation process will be gradual, with readiness and monitoring components that will enable continuity of care and continued access to specialty care.

The first phase of implementation of the Whole Child model is anticipated to begin no sooner than January 2017, into certain COHS counties contingent upon meeting readiness review requirements. DHCS is also proposing the Whole Child model be implemented in up to four counties in the Two-Plan Medi-Cal managed care model. The extension of the Whole Child model to these counties will begin no earlier than July 2017, and will also be subject to a readiness review by DHCS. Current state statute prevents CCS services from being delivered through managed care except in a small number of counties. This carve-out from managed care would have expired January 1, 2016. AB 187 (Bonta), Chapter 738, Statutes of 2015, extended the sunset date by one year for the carve-out of CCS from managed care, to January 1, 2017.

The proposed TBL would:

- Provide authority for the transition of CCS case management and care coordination along with the responsibility for fulfillment of the requirements of Sections 123855,123925, and 123960 of Health and Safety Code from a designated county department to a Medi-Cal managed care plan;
- Explicitly confirm that CCS eligibility determination remains the responsibility of the designated county department;
- Explicitly confirm that the CCS Medical Therapy Program (MTP) remains the responsible of the designated county department;
- Provide authority to implement the Whole Child model by all county letters, health plan letters, CCS numbered letters, plan or provider bulletins, or similar instructions;
- Change the language on treatment plans to be followed by the managed care plan from "treatment plans approved by the CCS Program" to "treatment plans developed in accordance with the requirements of DHCS;"
- Where practical, specify the reference to the CCS Program in the amended sections to either the State or county, so that no new responsibilities accrue to local CCS programs; and,
- Provide flexibility to the state to implement a single combined managed care rate for all health service needs of a CCS-eligible child.

Subcommittee Staff Comment and Recommendation—Reject Proposed Trailer Bill Language. It is not clear why the Administration is proposing pieces of this proposal through the budget process and pieces of the proposal through the policy process, particularly given that the Administration finds that there is no fiscal impact related to the TBL. Consequently, it is recommended to reject the TBL and defer to policy committee to discuss the entire proposal.

It is also recommended to hold the CCS budget open pending May Revision updates.

Questions.

1. Please provide an overview of this issue.

Issue 2: CA-MMIS System Reprocurement

Budget Issue. Through a Spring Finance Letter, DHCS requests one-year limited-term expenditure authority of $3,428,000 ($736,000 General Fund and $2,692,000 Federal Funds). The resources will fund the equivalent of 24 positions (which expire June 30, 2016) to complete the following activities within DHCS' California Medicaid Management Information System (CA-MMIS) Division:

1. Conduct close out activities for Xerox State Healthcare's (Xerox) portion of the CA-MMIS system replacement project (SRP), including determining the disposition of legacy System Development Notices (SDNs) that were deferred as part of the SRP, and identifying salvageable assets;
2. Procurement of new Fiscal Intermediary (FI) contracts to conduct business operations of the legacy CA-MMIS system; and
3. Re-evaluate the procurement approach to replace the legacy system under new system replacement efforts.

The resources requested are for the equivalent of 24 positions that will complete the activities outlined above as summarized in the table below.

Equivalent Positions by Division		Workload Supported
Administration (1.0)	• 1.0 Associate Administrative Analyst	This resource will support CA-MMIS Division in close out activities of the Xerox portion of SRP with a focus on financial aspects of the settlement agreement between DHCS and Xerox to include reimbursement of monies to Centers for Medicare and Medicaid Services.
CA-MMIS (16.0)	• 1.0 Data Processing Manager III • 2.0 Data Processing Manager IV • 1.0 Office Technician • 4.0 Senior. Information System Analyst • 2.0 Senior. Information Systems Analyst • 1.0 Staff Information Systems Analyst • 1.0 Staff Service Manager I • 1.0 Associate Administrative Analyst • 1.0 Associate Accounting Analyst • 2.0 Associate Government Program Analyst	These resources are significantly allocated to the close out activities for Xerox portion of SRP and in determining the disposition of legacy SDNs that were deferred as part of the SRP. As the close out activities wind down, they will focus on procurement of new contracts to conduct business operations of the CA-MMIS system.
Enterprise Innovation Technology Services (3.0)	• 1.0 Associate Information Systems Analyst • 1.0 Staff Information Systems Analyst • 1.0 System Software Specialist III	These resources will provide desktop, LAN, software support, and adherence to security policies and procedures as well as providing continuing support for staff involved in both the closeout activities of the Xerox portion of SRP and the procurement of the subsequent FI contract.
Office of Legal Services (3.0)	• 3.0 Attorney III	These resources will support CA-MMIS Division in legal aspects of close out activities of the Xerox portion of SRP and review proposed contract language for upcoming procurements.
Pharmacy Benefits Division (1.0)	• 1.0 Pharmacy Consultant II (Spec)	This resource will support CA-MMIS Division in close out activities of the Xerox portion of SRP and will transition to providing subject matter expertise for upcoming procurements.

Background. DHCS is the single state agency responsible for the administration of California's Medicaid program, known as Medi-Cal, which provides health care for more than 13 million members.

DHCS contracts with a FI to maintain and operate CA-MMIS, which is utilized by Medi-Cal to process approximately 230 million claims annually for payment of medical services provided to Medi-Cal members, resulting in over $23.66 billion a year in payments to health care providers.

In May 2010, DHCS awarded the contract to ACS State Healthcare, LLC (ACS), which was later acquired by Xerox State Healthcare, LLC (Xerox), to provide FI services and to replace the legacy system. The CA-MMIS Division is responsible for overseeing the fee-for-service (FFS) FI contract with Xerox and the ongoing maintenance and operation of CA-MMIS, as well the design, development, and implementation (DD&I) of a new system to replace CA-MMIS.

The Xerox FI contract was structured to provide:

1. Business operational services (including Medi-Cal call center, provider outreach and training, maintaining the Medi-Cal provider manual, etc.),
2. Maintenance and operations of the mainframe and related sub-systems (claims processing and utilization review),
3. Technical services to make system changes to the legacy mainframe system (i.e. systems groups), and
4. Planning for and implementing the system replacement project of the existing CA-MMIS.

The system replacement project was scheduled to be completed by June 30, 2016, which is when the existing limited-term positions are due to expire. However, a number of significant delays occurred in the delivery of the SRP. Eventually, Xerox determined it could not deliver a new system. On October 13, 2015, Xerox notified DHCS that it would not be completing the system replacement project. Subsequently, Xerox entered into negotiations with DHCS on terms and conditions of a settlement to terminate its contractual obligation to fully implement the SRP.

On March 21, 2016, Xerox and DHCS finalized a settlement agreement outlining the terms and conditions for Xerox to suspend all system replacement project activities, which include but are not limited to DD&I, project management, transition, integration, and testing. The settlement agreement (signed on April 8, 2016) includes compensation for the state costs incurred by the state for the system replacement project. Specifically, Xerox will pay DHCS $103.3 million in cash (60% by 4/22/16, 20% on 7/29/16, and 20% by 1/2/17), Xerox shall provide to DHCS $15 million in Xerox or IBM hardware and/or software, Xerox will withdraw and dismiss its claim related to the Provider Application and Validation for Enrollment System (PAVE), and DHCS and Xerox will terminate all other open claims, offsets, credits and refunds. DHCS will be reimbursed by Xerox for all costs related the system replacement project. Federal approval of the settlement agreement is anticipated to occur by April 2016. See table below for summary of state costs and the settlement agreement.

Column	Cost to Date (2/29/16)	Settlement Agreement
Xerox	($9,018,000)	$9,018,000
State (staff, overhead, and contractor)	($45,528,000)	$45,528,000
Settlement Agreement Payment Remainder		$68,757,571
Total	**($54,546,000)**	**$123,303,571**

Source: Department of Health Care Services

Xerox will continue to operate and maintain the current CA-MMIS System until September 30, 2019, or until DHCS has secured other FI services and support.

Per Centers for Medicare and Medicaid Services (CMS) guidance, DHCS will pursue a new, modular Replacement System procurement approach that will benefit from the most up-to-date technology and system design strategies available.

In order to move forward with the system replacement project closure, and initiate a new system replacement project DHCS must identify salvageable assets and re-evaluate the procurement approach to replace the legacy system. The CA-MMIS Division has developed plans to: close out the Xerox portion of the system replacement project; move forward with procurement of new contracts for FI business operations services; and re-evaluate the procurement approach to replace the legacy system.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

Issue 3: Medi-Cal: Coordinated Care Initiative

Oversight Issue. The 2012 budget authorized the Coordinated Care Initiative1 (CCI), which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits. Under the current memorandum of understanding with Centers for Medicare and Medicaid Services (CMS), Cal MediConnect ends on December 31, 2017. See table below for enrollment summary.

Cal MediConnect Enrollment Summary, as of March 1, 2016

County	Enrollment
Los Angeles	41,778
Orange	17,567
Riverside	13,671
San Bernardino	13,359
San Diego	15,595
San Mateo	9,503
Santa Clara	12,087
Total	**123,560**

In April, DHCS released a set of policy changes to CCI and noted that the goals of these changes are to:

- Strengthen the quality of care and care coordination in Cal MediConnect for beneficiaries;
- Ensure that beneficiary protections remain robust, beneficiary satisfaction remains high and increases, and the beneficiary is always at the center of the program;
- Generate sustainability for the program; and,
- Maintain transparency and stakeholder engagement.

These policy changes are:

1. **Strengthening Long-term Services and Supports (LTSS) Referrals & Care Coordination**
   DHCS is proposing to:
   a. Standardize Health Risk Assessment (HRA) referral questions for MSSP, IHSS, and CBAS to reflect the best practices developed over the early years of the program.
   b. Review plan policies and procedures regarding referrals to these programs to ensure that all beneficiaries who may benefit from them are being offered access to these supports.
   c. Review and expand data collection and reporting on interdisciplinary care teams, and individualized care plan completions, and CBAS, MSSP, and IHSS referrals.

2. **Sharing Best Practices & Lessons Learned**
   a. DHCS is proposing to convene Cal MediConnect plans in a series of meetings to share best practices and ensure all plans are performing to the highest standard.
   b. The kick-off meeting will be in May.

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

3. **Improving Continuity of Care**
Evaluation data shows that the beneficiary experience would be improved by reducing transition issues and allowing beneficiaries to see their current providers for longer periods of time. In response, DHCS is exploring:
   a. If CMS will extend the continuity of care period for Medicare services from 6 months to 12 months to match the Medi-Cal continuity of care period;
   b. Modifying continuity of care requirements requiring two visits with a specialist within the past 12 months to requiring just one visit as is the case with primary care physicians.

4. **Sustainable Enrollment**
To sustain the program, DHCS is proposing to expand enrollment, engagement and education efforts.
   a. **Annual Passive Enrollment into Cal MediConnect** – For 2016, for beneficiaries who are newly eligible, DHCS is proposing a two month passive enrollment period in September and October 2016. Beneficiaries newly eligible for Cal MediConnect are those new to Medi-Cal or new to Medicare or new to a CCI county in 2014 or 2015; and who did not participate in a prior CMC passive enrollment process. Beneficiaries will be cross walked from their MLTSS plan to the Cal MediConnect plan to ensure continuity of plans, MLTSS relationships, care management and plan relationships. DHCS will utilize Medicare claims data to assign Medi-Cal FFS members to Cal MediConnect plans.
   For 2017, an annual CMC passive process for the previous year's newly dually eligible population (beneficiaries who become eligible in 2016 would be enrolled in 2017).
   b. **Operationalizing Mandatory MLTSS Enrollment -** Begin monthly mandatory enrollment into MLTSS, with education about CMC option. Includes:
      - Initial month of implementation would include all duals who became newly eligible for MLTSS following the previous passive enrollment period.
      - Dual eligibles who had Medicare and are new to Medi-Cal, duals who move into a CCI county.
   c. **Exploring Potential Extension of Deeming Period**
      - Beneficiaries who temporarily lose their Medi-Cal eligibility are at risk of losing their enrollment in Cal MediConnect, causing beneficiary confusion and transition issues.
      - Based on stakeholder feedback, DHCS implemented a 30-day deeming period to make it easier for beneficiaries to stay enrolled in Cal MediConnect while the health plan helped the beneficiary reestablish their Medi-Cal eligibility.
      - While 30 days is an improvement, stakeholder and health plan feedback indicates that a longer period would help more beneficiaries maintain their Medi-Cal eligibility and enrollment in Cal MediConnect.
      - DHCS proposes to explore operationalizing a two month deeming period.

5. **Streamlined Enrollment -** Allow plans to facilitate enrollment into Cal MediConnect for beneficiaries enrolled in the plan's Medi-Cal MLTSS product. Includes beneficiaries currently enrolled in MLTSS plans and beneficiaries would only be able to use streamlined enrollment to enroll into the CMC plan connected to their MLTSS plan. This would occur through the following process:

a. Cal MediConnect health plans would collect the required information from beneficiaries and directly submit enrollment requests to HCO for processing on a daily basis.
b. HCO would process the request after ensuring the beneficiary was eligible for Cal MediConnect.
c. HCO will regularly share files with the plans to let them know which enrollment requests have been processed.

6. **Targeted Provider Outreach -** DHCS has conducted a detailed analysis of beneficiaries who opted out of Cal MediConnect and their most frequently seen providers. This data allows DHCS to identify providers (including physicians, hospitals, and medical groups) associated with large numbers of beneficiaries who have chosen not to participate in Cal MediConnect. DHCS intends to use these data to more effectively target provider education and outreach activities. These activities will both allow DHCS to engage with providers about their questions on the program, what they or their patients may want to know, and ensure that providers and beneficiaries have sufficient and accurate information about the program and its potential benefits.

Background. The 2012 budget authorized the Coordinated Care Initiative2 (CCI), which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits. Under the current memorandum of understanding with Centers for Medicare and Medicaid Services (CMS), Cal MediConnect ends on December 31, 2017. The Administration has indicated to CMS that it is interested in extending this date (as allowed by CMS) but has not committed to an extension. The CCI is being implemented in seven counties[3] (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).

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

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

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

  As of March 1, 2016, 123,560 individuals are enrolled in Cal MediConnect.

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

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

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

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

Requirements on Fiscal Solvency of CCI. SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013, requires the Department of Finance to annually determine if there are net General Fund savings for CCI. If CCI is not cost-effective, all components of CCI would cease operation. The January budget reflected a net General Fund savings of $191 million; however, the Administration indicates that it is still in the process of updating this calculation given the restructuring of the managed care tax. It is anticipated that more information on this will be forthcoming in the May Revision.

Multipurpose Senior Services Program and CCI. The 2015-16 budget included trailer bill language that extended the CCI MSSP transition to Medi-Cal managed care deadline to December 31, 2017; allowed for an earlier transition in a county or region when the MSSP sites and managed care plans mutually agree they are ready to transition and want to transition early; required that the MSSP sites and managed care plans demonstrate that they have met readiness criteria that is developed by DHCS, California Department of Aging (CDA), MSSP providers, managed care plans and stakeholders; and specified that if CCI is terminated MSSP will revert to a waiver benefit.

MSSP transitioned to a managed care benefit in San Mateo County on October 31, 2015. Reports indicate that this transition has gone smoothly.

DHCS notes that it has provided and utilized multiple communication forums and tools to track specific requirements the health plans must perform such as, the use of interdisciplinary care teams, individual care plans, health risk assessments, and care coordination requirements for the CCI counties, which also apply to MSSP participants and providers. One of these tools is the draft MSSP Site / Health Plan Contract template that has been distributed to stakeholders, which outlines the roles and responsibilities of both parties. DHCS, in partnership with CDA hold bi-weekly calls with MSSP sites and health plans. The MSSP sites and health plans are encouraged to discuss issues at the state facilitated bi-weekly teleconference calls.

DHCS recognizes that there will still be an MSSP population that will remain Fee-For-Service (FFS). The department, in collaboration with CDA, is developing a process that will ensure continuity of care for this population post transition. MSSP will remain a FFS benefit in the CCI counties for only those members that were MSSP participants and exempt from managed care enrollment at the time of transition. As documented in the preliminary CCI MSSP Transition Plan (submitted to the Legislature in May 2015), DHCS and CDA intends to actively request proposals and will contract with an entity (care management agency) or an MSSP provider that focuses solely in providing services to the entire FFS population in the CCI counties post transition. MSSP is not expected to transition until December

31, 2017, therefore it is unknown how many Medi-Cal members, who will also be MSSP participants residing in CCI counties, will be exempt from Medi-Cal managed care at the time of MSSP transition.

Subcommittee Staff Comment and Recommendation—Hold Open. The following issues should be considered in evaluating these proposed changes:

1. **Proposal to Strengthen LTSS Referrals Long Overdue.** DHCS's proposal to strengthen long-term services and supports referrals and care coordination is much needed and overdue. As has long been noted by this Subcommittee, a better understanding about referrals to LTSS services (e.g., MSSP, IHSS, and CBAS), the changes in utilization of these services as a result of CCI, and improved data collection regarding interdisciplinary care teams and completed individualized care plans is crucial to understanding if the CCI is changing health outcomes and consumer experiences.

2. **Concerns Raised with Passive Enrollment and Streamlined Enrollment Proposals.** DHCS has been utilizing a passive enrollment process that requires a person to "opt out" of they do not want to be enrolled in the plan and want to remain in fee-for-service Medicare. This process has resulted in a very high "opt out" rate in most counties. In March the rate ranged from ten percent in San Mateo to fifty-eight percent in Los Angeles. This has also resulted in a level of enrollment well below the expectations of the plans, CMS, and DHCS. In addition, consumer advocates and other organizations who assist this population report instances of confusion and discontinuity of care. For example, it has been reported that patients do not realize they have been enrolled in a plan and can no longer see their physician who does not contract with the plan. The following concerns have been raised by consumer advocates about the passive enrollment and streamlined enrollment proposals:

   a. **Passive Enrollment.** Consumer advocates argue that passive enrollment causes disruption and confusion for beneficiaries and have proposed an affirmative voluntary enrollment process as an alternative. Additionally, advocates note that the proposed timeline does not provide sufficient time to prepare and educate the community. They also find that health plans and Health Care Options do not have the capacity to handle another wave a passive enrollment in such a short timeframe, which will lead to confusion and frustrations with Cal MediConnect. Advocates also point out that the notices proposed to be used have similar deficiencies to those used the first time around and are not tailored to the specific populations.
   b. **Streamlined Enrollment.** Consumer advocates find that an enrollment broker, such as Health Care Options, provides an important and independent function in the Cal MediConnect enrollment process. This function is important because an independent enrollment broker ensures that consumers are not coerced into an enrollment decision about their health care coverage.

   These consumer advocates find that the state should develop a robust voluntary enrollment process that educates consumers clearly about the benefits of Cal MediConnect and that this ultimately will lead to more stable enrollment for this project.

3. **MSSP.** The MSSP Site Association requests to remove the MSSP transition deadline, restore MSSP payment and encounter data as a state responsibility, and initiate a dialogue with DHCS,

CDA, MSSP providers, and health plans to discuss an memorandum of understanding that defines all parties' roles in collaboration with all populations including clients in both Cal MediConnect and MLTSS.

Questions.

1. Please provide a brief update on CCI and an overview of the proposed changes to CCI.

2. How is DHCS working with stakeholders to obtain feedback on these proposals?

3. When does DHCS plan to make a decision on whether or not to implement these changes?

4. Is there a target enrollment number to ensure fiscal solvency of CCI?

5. Does DHCS intend to use the same notices regarding passive enrollment? Has DHCS made any changes to these notices?

Issue 4: Medi-Cal: Behavioral Health Treatment

Oversight and Budget Issue. The proposed budget includes $206.2 million ($90.5 million General Fund) to provide behavioral health treatment (BHT) services for children under the age of 21 with a diagnosis of autism spectrum disorder (ASD).

Background. SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014 requires DHCS to add behavioral health treatment (BHT) services, such as applied behavioral analysis (ABA), as a covered benefit in Medi-Cal to the extent required by federal law. Subsequent to the enactment of the 2014 budget, the federal government issued guidance indicating that BHT should be a covered Medicaid benefit for eligible children and adolescents with autism spectrum disorder (ASD). In response to the guidance, DHCS submitted State Plan Amendment (SPA) 14–026 to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2014 to seek the necessary approval to include BHT as a covered Medi-Cal service for individuals under 21 years of age with ASD. On January 21, 2016, CMS approved this SPA. BHT services are approved retroactively to July 2014.

On November 20, 2015, DHCS and Department of Developmental Services (DDS) jointly issued a transition plan that describes the transition of Behavioral Health Treatment (BHT) services from the regional centers to the Medi-Cal managed care and fee-for-service delivery systems. This transition began in February 2016 and will occur over a period of six months. Approximately, 5,000 individuals (of the estimated 13,000) have transitioned with 92 percent receiving automatic continuity of care with the same provider. The remaining eight percent have transitioned to a new provider.

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

BHT Grievances Filed with the Department of Managed Health Care. As of October 1, 2015 through April 25, 2016, the Department of Managed Health Care (DMHC) has received nine requests for Independent Medical Reviews (IMR) related to a health plan denial the BHT service. Of these, three grievances are pending, three times the health plan voluntarily reversed its original denial prior to the completion of the IMR, one health plan decision was overturned, one health plan decision was upheld, and one time the patient made the decision to withdraw from the IMR process.

For this same time period, DMHC received four complaints related to BHT coverage/benefit dispute. Of these, two plans were found in compliance (and the health plan provided the benefit as a courtesy to the enrollee), one was found out of compliance, and one was a case in which DMHC did not have jurisdiction.

For this same time period, DMHC received eight complaints related to BHT access. Of these, in six instances the health plan was found in compliance (and the health plan provided the benefit as a courtesy to the enrollee), one health plan was found in non-compliance, and one case is still pending.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised regarding waitlists for CDEs. DHCS indicates that it is not aware of any wait lists for CDEs for Medi-Cal beneficiaries. DHCS conducts monitoring of network adequacy through secret shopping; analysis of grievances and appeals, ombudsman calls, and monthly utilization data; stakeholder input; and regular check-ins with Medi-Cal managed care health plans.

No concerns have been raised to subcommittee staff regarding the transition of BHT services from the regional centers to the Medi-Cal managed care and fee-for-service delivery systems.

Questions.

1. Please provide a brief overview of this issue.

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

Issue 5: Medi-Cal: Full Scope Expansion for Undocumented Children

Budget Issue. The proposed budget includes $177.2 million ($142.8 million General Fund) in 2016-17 and $26.2 million ($20.4 million General Fund) in 2015-16 to expand full-scope Medi-Cal benefits to children under the age of 19 years, regardless of immigration status. This funding includes the costs for specialty mental health services provided by county mental health plans ($3.5 million General Fund in 2015-16 and $25.7 million General Fund in 2016-17).

Background. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015, extends Medi-Cal coverage to children who are otherwise eligible for Medi-Cal except for their immigration status, no sooner than May 1, 2016. DHCS expects to implement all necessary system changes on May 16, 2016. The eligibility effective date (when the system changes and transition plan are implemented) will be May 1, 2016. Medi-Cal is based on full month eligibility, so if an individual is eligible for one day of a given month, they are eligible for the entire month. There are two populations of children impacted by this change in Medi-Cal coverage.

- **New Enrollee Population:** Individuals under the age of 19 who meet all eligibility requirements for SB 75 but are not enrolled in the Medi-Cal program at the implementation of SB 75. These individuals will need to apply for Medi-Cal through the current application process. It is estimated that approximately 55,000 undocumented children under the age of 19 are currently eligible but not enrolled, DHCS estimates 50 percent will take up coverage over a 12-month period, once the program is operational.

- **Transition Population:** Individuals under the age of 19 who are currently enrolled in restricted scope Medi-Cal with unsatisfactory immigration status. The budget estimates that 114,981 children are currently enrolled in restricted-scope Medi-Cal, these children will automatically transition to full-scope Medi-Cal. On April 15, 2016, DHCS mailed an outreach letter to 123,340 beneficiaries under the age of 19 and in restricted aid codes.

Subcommittee Staff Comment and Recommendation—Hold Open. It is estimated that currently 64,000 undocumented children have comprehensive health coverage through a Kaiser Permanente program. SB 997 (Lara) requires that if these children transition to full-scope Medi-Cal under SB 75, they would be enrolled in Kaiser Medi-Cal, in order to maximize continuity of care and coverage. Under DHCS's proposed plan and current law, these children would have to apply to Medi-Cal and choose a health plan, and possibly be placed in fee-for service Medi-Cal pending plan enrollment. Consumer advocates request that SB 997 be included as part of the budget. However, it is not clear how this change could be implemented timely. It is also not clear how DHCS will identify these children, as they are currently in a non-Medi-Cal Kaiser plan.

Questions.

1. Please provide an overview of this issue.

2. Is DHCS on target to implement this change on May 16th? When will the state know if it is able to make the required system changes?

Issue 6: Medi-Cal: 1115 Waiver Renewal - "Medi-Cal 2020" Resources

Budget Issue. Through a Spring Finance Letter, DHCS requests a combination of two-year and five-year limited-term resources of $10,818,000 ($5,409,000 General Fund) to support the implementation of California's new 1115 waiver, "Medi-Cal 2020." Within the expenditure authority requested, $14,200,000 will be used for contractual services over the span of 5 years.

As California continues to be a leader in implementing the Affordable Care Act (ACA), operating the nation's largest Medicaid program, the Brown Administration and California's public hospital systems plan to use the Medi-Cal 2020 to build on the efforts of the previous 1115 waiver, "Bridge to Reform (BTR)," by expanding and sustaining the delivery of high quality, cost effective care over time. The renewal of the Medicaid waiver is a fundamental component to California's ability to continue to successfully implement the ACA beyond the primary step of coverage expansion.

According to DHCS, with the renewal of the 1115 waiver, the goal of the Medi-Cal program will be a transformation of the current health care delivery system and payment structure for the continued success and viability. The positions requested, which span over multiple divisions, will be utilized to help implement and administrate the several proposed programs of Medi-Cal 2020:

- Dental Transformation Initiative Program
- Public Hospital Redesign & Incentives in Medi-Cal Program (PRIME)
    - Alternative Payment Methodology (APM) Benchmark for PRIME Entities
- Whole Person Care Pilots
- Global Payment Program for the Remaining Uninsured
- Other requirements as set forth in the Special Terms and Conditions (STCs)

According to DHCS, these programs, as well as the resources allocated to them, are entirely new concepts that were not included in the BTR waiver and therefore have no existing DHCS employees assigned to them.

Along with these programs, Medi-Cal 2020 also requires several assessments, evaluations, and achievement of benchmarks which will require significant tracking and workload. These administrative requirements include:

- Independent Hospital Assessments (2016 and 2017)
- Independent Assessment of Access
- Global Payment Program Evaluations
- Hospital Redesign and Incentives in Medi-Cal Program (PRIME) Program Evaluations
- Other waiver component evaluations

The following chart identifies organizationally where the resources are located within DHCS, the equivalent of staffing and classifications requested, and the area of Medi-Cal 2020 they will be focusing on:

Organization	Resources Requested Equivalent to 31.0 Staffing (7/1/2016 – 6/30/2021)	Medi-Cal 2020 Program Activity
Office of the Medical Director	3.0 Limited Term Positions • Medical Consultant I • 2.0 - Associate Gov. Program Analyst	• Hospital Redesign and Incentives in Medi-Cal Program(PRIME) Program
Office of Legal Services	2.0 Limited Term Positions • 2.0 Attorney IV	• Overall legal support for any waiver related activities and intersections with the program at large, which including but is not limited to: o Federal/State and State/local and state negotiations o Draft/review/analyze of legislation, policy, guidance, contracts, etc. o Statutory and regulatory interpretation
Medi-Cal Dental Services Division	12.0 Limited Term Positions • 2.0 - Research Analyst II • 7.0 - Associate Gov. Program Analyst • Dental Hygienist Consultant Staff • 2.0 - Information Systems Analyst Specialist	• Dental Transformation Initiative Program
Managed Care Quality and Monitoring Division	9.0 Limited Term Positions • Staff Services Manager I • 2.0 - Research Program Specialist II • 4.0 - Associate Gov. Program Analyst • Research Analyst II • Health Program Specialist	• Whole Person Care Pilots o Increased Access to Housing and Supportive Services • Independent Assessment of Access • Integration and Care Coordination • Community-Based Adult Services (CBAS) fraud • Alternative Payment Methodologies
Safety Net Financing Division	2.0 Limited Term Positions • Research Analyst II • Research Program Specialist I	• Global Payment Program • Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME) payments
Administration Division	2.0 Limited Term Positions • Associate Personnel Analyst • Associate Accounting Analyst	• Administration – all programs
Research and Analytics Studies Division	1.0 Limited Term Position • Research Scientist III	• Statistical reporting • Analytic data file creation and hierarchical risk modeling • Institutional knowledge and context for all projects • Study design and analyses of health care outcomes, expenditures, and utilization

Background. California's 1115 Waiver Renewal, called Medi-Cal 2020, was approved by the Centers for Medicare and Medicaid Services on Dec. 30, 2015. Medi-Cal 2020 will guide the state through the next five years to transform the way Medi-Cal provides services to its 12.8 million members, and improve quality of care, access, and efficiency. Some of the key programmatic elements of Medi-Cal 2020 are:

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME). This program builds on the success of the state's Delivery System Reform Incentive Program (DSRIP), which was the first such transformation effort in the nation. Under PRIME, Designated Public Hospital (DPH) systems and District Municipal Public Hospitals (DMPHs) will be required to achieve greater outcomes in areas such as physical and behavioral health integration and outpatient primary and specialty care delivery. Additionally, PRIME requires DPHs to transition managed care payments to alternative payment methodologies, moving them further toward value-based payment structures over the course of the waiver. PRIME offers incentives for meeting certain performance measures for quality and efficiency. Over the course of the five-years, federal funding for PRIME for DPHs is $3.27 billion, and for DMPHs is $466.5 million.
- Global Payment Program (GPP). This is a new program aimed at improving the way care is delivered to California's remaining uninsured. GPP transforms traditional hospital funding for DPHs from a system that focuses on hospital-based services and cost-based reimbursement into a value-based payment structure. Under the GPP, DPHs are incentivized to provide ambulatory primary and preventive care to the remaining uninsured through a value-based payment structure that rewards the provision of care in more appropriate settings. This new approach to restructuring these traditional hospital-focused funds allows California to better target funding for the remaining uninsured and incentivize delivery system change, focusing on the provision of primary and preventive care, and shifting away from avoidable emergency room and hospital utilization.
- Dental Transformation Initiative (DTI). For the first time, California's Waiver also includes opportunities for improvements in the Medi-Cal Dental Program. The DTI provides incentive payments to Medi-Cal dental providers who meet certain requirements and benchmarks in critical focus areas such as preventive services and continuity of care. Over the course of the waiver, up to $750 million in annual funding is available under DTI.
- Whole Person Care (WPC) Pilots. Another component of Medi-Cal 2020 will allow for county-based pilots to target high-risk populations. The overarching goal of the WPC pilots is the integration of systems that provide physical health, behavioral health, and social services to improve members' overall health and well-being, with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC pilots may also choose to expand access to supportive housing options for these high-risk populations. The waiver renewal authorized up to $1.5 billion in federal funding over the five-years; WPC pilot lead entities will provide the non-federal share.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

Issue 7: Waiver Personal Care Services and Fair Labor Standards Act

Oversight Issue. On February 1, 2016, a new overtime rule under the federal Fair Labor Standards Act (FLSA) was implemented, requiring overtime pay for In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) providers when they work more than 40 hours in a workweek.

Providers exceeding the maximum number of hours allowed to work in a workweek for WPCS services will receive a violation up to monthly for instances of non-compliance. Initially, a three-month grace period from February 1, 2016, through April 30, 2016, was established to allow a transition period for providers to understand the requirements.

However, on April 27, 2016, DHCS extended this grade period for WPCS participants and their providers, who provide IHSS or WPCS or both, from May 1 to September 1, 2016. Providers will not receive any violations during this extended grace period. DHCS noted that additional time was needed to program information technology systems.

Background. On February 1, 2016 due to federal law, the FLSA, new overtime rule requires overtime pay for IHSS and WPCS providers when they work more than 40 hours in a workweek. Pursuant to state law, the maximum number of hours a provider is allowed to work in a workweek is 70-hours and 45-minutes.

However, WPCS has always been subject to a maximum work day of 12 hours, thus pursuant to new state law personal care services are not to exceed 70-hours and 45-minutes a workweek of IHSS and WPCS combined, or 66 hours a workweek if a provider is providing services to more than one participant. The waiver participant may be required to select one or more additional providers to ensure sufficient hours of care provided each day.

Exemptions. As of May 1, 2016, DHCS will allow some extra overtime hours up to the waiver limit (a 12-hour workday or 360 hours per month) for providers who meet one of the criteria listed in the exemption letter. The exemption criteria apply to WPCS participants who were enrolled in a waiver on January 31, 2016. DHCS will allow more overtime on a case-by-case basis, if:

1. The care provider lives in the same home as the waiver participant. They do not have to be a family member; or
2. The care provider is now giving care to the waiver participant and has done so for two or more years without a break; or
3. DHCS agrees that there are no other possible care providers near the waiver participant's home. The waiver participant must work closely with DHCS care managers to try to find more care providers.

DHCS estimates that 440 participants would likely be eligible for an exemption and 160 would pursue an exemption. (There are 1,800 WPCS participants.)

DHCS indicates that while completing the system requirements for automatic determination of violations in the WPCS programs, staff will be monitoring time cards manually. Providers are reminded that starting May 1, the following limits are in place and must be adhered to:

Providers who work for two or more participants:

- Can work up to 12-hours in a day, and up to a 66-hour work week.

Providers who work for one participant:

- Can work up to 12-hours in a day, and up to a 70-hour and 45-minute work week, not to exceed 283 hours worked in a month.

Waiver participants who have more than one provider working for them and their provider does not work for any other participants:

- Providers can work up to a 70-hour and 45-minute work week.
- The total hours worked by any one provider cannot be more than 283 hours in a month.

DHCS indicates that program staff will work with individual WPCS participants and their providers as necessary to correct inadvertent errors on a provider time card. In addition, DHCS states it will monitor timesheets closely to identify any egregious overtime violations. Should this occur, DHCS states it reserves the right to impose a manual violation on a provider.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. How is DHCS working with stakeholders on messaging this extension?

3. Did DHCS send letters to WPCS participants and providers specifying the process by which to request an exemption? Is the exemption process in effect?

Issue 8: Home and Community-Based Services (HCBS) Federal Requirements

Budget Issue. DHCS requests limited-term resources of $1,112,000 ($491,000 General Fund) to fund the following:

1. **HCBS Federal Requirements.** Three-year limited-term resources to comply with the Centers for Medicare and Medicaid Services (CMS) Federal Regulations (2249-F and 2296-F) on Home and Community-Based Settings Final Rule for existing Home and Community-Based Services (HCBS) providers and beneficiaries promulgated on March 17, 2014.

2. **Statewide Transition Plan (STP).** Four-year limited-term resources to work on the CMS approved Assisted Living Waiver (ALW) program, coordinate activities with the STP and ensure ongoing compliance of ALW providers with the HCBS final rule. Resources will also address continued work to meet existing Community-Based Adult Services (CBAS) workload, coordinate activities with the STP and ensure ongoing compliance of CBAS providers with the HCB Final Rule. The resources will address work done currently by limited-term positions that are set to expire 6/30/16.

Background. California's Medi-Cal Home and Community-Based Services (HCBS) programs are designed to offer safe and appropriate home and community-based care to individuals in lieu of long-term institutional placement. These programs serve about 500,000 individuals and are implemented by various state departments including the Department of Health Care Services (DHCS), the Department of Developmental Services (DDS), the California Department of Aging (CDA), and the California Department of Public Health (DPH). The state receives almost $7 billion annually in federal funds for these programs.

California's HCBS programs are implemented through the following:

- **1915(c) Waivers.** The federal government authorized the "Medicaid 1915(c) Home and Community-Based Services Waiver program" in 1981. The original intent of the HCBS Waiver program was to slow the growth of Medicaid (Medi-Cal in California) spending by providing services in less expensive settings. In order to contain costs, the federal legislation limited waiver services to individuals who would be institutionalized if the services were not provided. However, the costs of those waiver services cannot be higher than what they would cost in an institutional setting.

  The law permitted states to waive certain Medicaid program requirements and in doing so, deviate from Medicaid requirements, such as providing services only in certain geographic areas ("waive statewideness"). The HCBS Waiver program also allowed states flexibility to offer different types of services to individuals with chronic disabilities. Prior to this, with the origin of Medicaid in 1965, beneficiaries could only receive comprehensive long-term care in institutional settings.

  The waiver can be designed for a variety of targeted diagnosis-based groups including individuals who are elderly, and those who have physical, developmental, or mental health disabilities, or other chronic conditions such as Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). The waiver can be designed to offer a variety of services including case

management, personal attendant services, adult day health care services, habilitation services, day treatment services, psychosocial rehabilitation services, mental health services, and other services specifically requested by the state. 1915(c) HCBS waivers have subsequently become mechanisms for many states, including California, to provide Medicaid-funded community-based, long-term care services and supports to eligible beneficiaries.

California's 1915(c) HCBS wavier programs are:

- **Multipurpose Senior Services Program (MSSP) Waiver** (administered by CDA). The objective of this program is to provide opportunities for frail seniors age 65 or older to maintain their independence and dignity in community settings by preventing or delaying avoidable nursing facility placement. There are about 12,000 participants in this program.

- **HIV/AIDS Waiver** (administered by DPH). The purpose of this waiver is to allow persons of all age with mid- to late-stage HIV/AIDS to remain in their homes through a continuum of care designed to stabilize and maintain an optimal level of health, improve quality of life, and provide an alternative to institutional care in hospitals or nursing facilities. There are about 3,200 participants in this program.

- **Developmental Disabilities (DD) Waiver** (administered by DDS). The purpose of this waiver is to serve beneficiaries of all ages in their own homes and community settings as an alternative to placement in hospitals, nursing facilities or intermediate care facilities for persons with developmental disabilities (ICF-DDs). There are about 150,000 participants in this program.

- **Assisted Living Waiver (ALW)** (administered by DHCS). This waiver offers eligible seniors and persons with disabilities age 21 and over the choice of residing in either a licensed Residential Care Facility for the Elderly or an independent publicly subsidized housing with Home Health Agency services as alternatives to long-term institutional placement. There are about 4,000 participants in this program.

- **Nursing Facility/Acute Hospital (NF/AH) Waiver** (administered by DHCS). This waiver offers services in the home to Medi-Cal beneficiaries with long-term medical conditions, who meet the acute hospital, adult subacute, pediatric subacute, ICF-DD-continuous nursing, and nursing facility A/B levels of care with the option of returning and/or remaining in their home or home-like setting in the community in lieu of institutionalization. There are about 3,500 participants in this program.

- **In-Home Operations (IHO) Wavier** (DHCS). This waiver was originally developed for those individuals who had been continuously enrolled in a DHCS administered waiver prior to January 1, 2002 and who primarily receive direct services rendered by a licensed nurse. This waiver offers services to Medi-Cal beneficiaries with long-term medical conditions in their home or a home-like setting in the community in lieu of institutionalization. There are about 125 participants in this program.

- **San Francisco Community Living Support Benefit (SFCLSB) Waiver** (administered by San Francisco Department of Public Health). This waiver utilizes certified public expenditures for provision of waiver services to persons with disabilities age 21 and over who reside in the City

or County of San Francisco and who are either homeless, residing in a nursing facility, or are at imminent risk of entering a nursing facility. There are about 17 participants in this program.

- **Pediatric Palliative Care (PPC) Waiver** (administered by DHCS). This waiver offers children with life limiting conditions a range of home-based hospice-like services while they maintain the option of receiving curative treatment. There are about 1,800 participants in this program.

- **1115 Waiver - Community-Based Adult Services (CBAS).** CBAS offers center-based services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. There are about 32,000 participants in this program.

- **1915(i) State Plan Program.** Starting January 1, 2007, the Deficit Reduction Act of 2005 (DRA) gave states a new option to provide HCBS through their state plans. Once approved by CMS, state plans do not need to be renewed nor are they subject to some of the same requirements of waivers. Under this option, states set their own eligibility or needs-based criteria for providing HCBS. States are allowed to establish functional criteria in relation to certain services. The DRA provision eliminated the skilled need requirement and allowed states to cover Medicaid beneficiaries who have incomes no greater than 150 percent of the federal poverty level and who satisfy the needs-based criteria. The Patient Protection and Affordable Care Act of 2010 created several amendments including elimination of enrollment ceilings, a requirement that services must be provided statewide, and other enrollment changes.

  California currently has an approved 1915(i) State Plan program that allows the state to access federal financial participation for services provided to individuals with developmental disabilities who do not meet the institutional level-of-care criteria required for participation in the 1915(c) HCBS DD Waiver. There are about 32,000 participants in this program.

- **1915(k) Community First Choice (CFC) State Plan Program - IHSS.** This program provides IHSS services to individuals who meet a nursing facility level of care and allows an individual to live safely in his/her own home. CFC-IHSS services are provided in consumer-controlled homes. By being in the community and self-directing care, the individual is able to control their environment to the maximum extent consistent with their capabilities and needs. There are about 220,000 participants in this program.

New Home and Community-Based Setting Requirements. In January 2014, CMS announced it had finalized important rules that affect HCBS waiver programs and 1915(i) state plan programs provided through Medicaid/Medi-Cal, and subsequently published regulations in the Federal Register on January 16, 2014. The rules became effective 60 days from publication, or March 17, 2014. The state must fully comply with these rules by March 17, 2019. If the state does not comply with these rules it would be at risk of losing federal funds.

The purpose of the final rule is to ensure that individuals receive HCBS in settings that are integrated in and support full access to the greater community. The final rule also aims to ensure that individuals have a free choice of where they live and who provides services to them, and that individual rights and freedoms are not restricted, among other provisions.

Prior to the final rule, home and community-based (HCB) setting requirements were based on location, geography, or physical characteristics. The final rule defines HCB settings as more process and outcome-oriented, guided by the consumer's person-centered service plan by:

- Being integrated in and supporting full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

- Giving individuals the right to select from among various setting options, including non-disability specific settings and an option for a private unit in a residential setting.

- Ensuring individuals' rights of privacy, dignity and respect, and freedom from coercion and restraint.

- Optimizing autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact.

- Facilitating choice regarding services and supports, and who provides them.

For Medicaid/Medi-Cal provider-owned or controlled HCB residential settings, the provider must offer:

- A legally-enforceable agreement between the provider and the consumer that allows the consumer to own, rent or occupy the residence and provides protection against eviction.

- Privacy in units including lockable doors, choice of roommates and freedom to furnish and decorate units.

- Options for individuals to control their own schedules including access to food at any time.

- Individual's freedom to have visitors at any time.

- A physically-accessible setting.

DHCS Lead State Agency. DHCS acts as the Single State Medicaid Agency for the 1915(c) and 1115 waivers and 1915(i) and 1915(k) state plan programs. DHCS as the Single State Medicaid Agency is responsible for the funding and administration, monitoring and oversight for all of the HCBS programs. DHCS has taken the lead role to ensure all affected departments, programs, and their providers are aware of and collaborate with DHCS to come into compliance with the new federal HCBS setting final rule. On December 19, 2014 and again on August 14, 2015, DHCS submitted its "Statewide Transition Plan (STP) for Compliance with Home and Community Based Settings Rules" to CMS.

In the STP, DHCS highlights the various phases of implementation the state has taken and will take to achieve compliance with the HCB settings requirements:

- Education and Outreach. Information and education on the requirements of the HCB settings requirements and the regulations will be provided to state departments, consumers and families, regional centers, providers, advocacy groups, and other interested stakeholders on an ongoing basis.

- Systematic Assessment of Statutes, Regulations, Policies, and Other Requirements. DHCS and the other state departments have reviewed statutes, regulations, policies, and other requirements for residential and nonresidential HCB settings to determine the extent to which the state's standards comply with federal regulations. Stakeholders participated in and provided input to most aspects of this process.

- Compliance Determination Process for HCB Settings. An initial sample of on-site assessments will be completed as part of the existing monitoring and oversight processes and further on-site assessments will be conducted based on provider/beneficiary self-surveys. The final list of settings to have an on-site assessment will be completed and reported with timeframes for completion of on-site assessments and a plan for bringing sites into compliance as needed.

- Role of Person-Centered Planning. The impacted state departments will use a stakeholder process to evaluate the role of person-centered planning, as it relates to determining compliance with the federal regulations, assessing consumer satisfaction with the setting options, and other possible community integration issues.

- Appeal Process. The state will research existing appeals processes and determine the feasibility of incorporating the HCB setting appeal and complaint process into current structures.

- Compliance Monitoring. Each program will use self-surveys, on-site assessments, and/or other data collection methods to develop remedial strategies and monitor progress toward compliance with the federal regulations.

- Plan Updates and CMS Reporting. Progress on the STP will be continuously monitored and reported to CMS, as needed.

DHCS proposes the following timeline to comply with the new HCBS rules:

Timeline to Comply with New HCBS Rules

2014 THROUGH 2019	START	FINISH
CMS Rules Implemented	-----------	03/17/2014
STP Drafted and Reviewed by CMS	09/2014	03/2015
STP Revised with CMS Approval	03/2015	08/2015
Stakeholder & Public Meeting Input	09/2014	12/31/2018
Develop Review, Approval & Publication of On-Site Assessment	05/2014	08/2015
Develop Review, Approval & Publication of Provider self-Assessment Survey	07/2014	12/2016
Develop Review, Approval & Publication of Beneficiary Assessment Survey	09/2015	12/2015
Develop Review, Approval & Publication of Setting Analysis & Remedial Action Timeline	05/2015	12/2016
On-site Evaluations and Assessments	07/2015	12/2018
Assessment of Statutes, Regulations, Polices	07/2014	08/2015
Survey Team Training	06/2015	12/2015
Collect Assessment Data	01/2016	03/2018
Develop & Implement Tracking Database System	07/2015	02/2019
Enter data into tracking system	07/2015	12/2018
Provide Data Reports of Outcome	07/2017	12/2018
Develop, Review, Approve and Implement a Complaint and Appeals Process	06/2015	02/2019
Conduct Remedial & Action Strategies	01/2018	12/2018
Provide Final Report to CMS	09/2018	02/2019
Monitoring and Oversight of Compliance	03/2019	6/30/2019

Subcommittee Staff Comment and Recommendation—Hold Open. The following issues should be considered:

CMS Has Not Yet Approved State's Transition Plan. On November 16, 2015, CMS sent a letter to DHCS indicating that further information regarding, among other things, the settings impacted by the new HCBS rule, the timelines for many of the milestones outlined within the STP, and the state's plan for relocating beneficiaries, if needed. Additionally, CMS noted that:

> *The state has omitted from the STP several key details about the site-specific assessment process including: when provider self-surveys will be completed, how the state will ensure responses from providers, how beneficiary surveys will be matched to provider assessments, how beneficiary and provider surveys will be used to identify settings that require on-site assessment, an estimate of the number of on-site assessments, how the state will ensure coordination across on-site assessments, and how the on-site assessment tool would be used to categorize compliant and non-compliant settings.*

It will be important for DHCS to continue to engage with providers and consumers on defining the outstanding process details to address CMS's concerns and get approval of the STP.

DHCS indicates that it plans to finish discussions with CMS regarding outstanding issues related to the STP by the end of May. At that point, a 75-day clock (including a 30-day public comment period) starts and the state must re-submit the revised STP to CMS.

Coordinated Statewide Approach is Critical. The new federal rules are based on important principals that individuals have a free choice of where they live and who provides services to them, and that individual rights and freedoms are not restricted. It is critical that these principles are implemented consistently across the state's programs and agencies. It is DHCS's responsibility as the Single State Medicaid Agency to oversee this implementation and that it lead other departments in strategies to ensure compliance by 2019.

Early and Frequent Consumer and Provider Education is Essential. Concerns have been raised by providers that the state has not provided sufficient direction on how these new federal rules may impact the various types of providers. While the state is still awaiting direction from CMS, it is essential that state departments, under DHCS's direction, communicate as soon as possible what needs to change and the processes that will be developed to measure and ensure compliance with the new HCBS rule. Clear guidance on what is needed to come into compliance and the state's commitment of resources to support programs to move towards compliance is essential to successful implementation of this new rule.

Questions.

1. Please provide an overview of this issue.

2. When does DHCS plan to resubmit the STP? What outstanding questions/issues remain?

3. Is the state prioritizing its assessment of HCBS programs and settings? If so, what criteria is it using (e.g., maximization of federal financial participation)? Is there a plan to ensure sufficient resources for this process?

4. How is DHCS ensuring a coordinated and consistent statewide implementation of the HCBS rule?

5. How is DHCS sharing best practices on the implementation of this new rule across the impacted state agencies?

6. Has DHCS assessed whether or not some of these services will not comply with the HCBS rule before the March 2019 deadline? Will the state continue to fund these services?

7. Has DHCS reviewed Tennessee's Transition Plan? Is there anything the state can learn from this plan? (Tennessee was the first state to have their HCBS waiver transition plan approved by CMS.)

8. Is the state considering changes to licensing requirements for the facilities impacted by this new federal rule? How is DHCS working with the Department of Social Services on this?

Issue 9: California Community Transitions Demonstration Project

Budget Issue. DHCS requests five-year limited-term resources of $941,000 (federal funds) to continue work related to the federal Money Follows the Person (MFP) Rebalancing Demonstration, which was extended by the Centers for Medicare and Medicaid Services (CMS) for an additional five years through September 30, 2020. The MFP Rebalancing Demonstration is known as the California Community Transitions (CCT) Demonstration Project in the state. This request coincides with the grant period and close out reporting to CMS. The CCT Demonstration Project is 100 percent federally funded through the MFP grant.

The requested resources will address the workload performed by existing limited-term positions currently set to expire on June 30, 2016. Acording to DHCS, these resources are necessary to maintain the current program, meet MFP benchmarks, build the capacity of the Home and Community-Based Services (HCBS) delivery system and providers to sustain institution-to-community transitions beyond the expiration of the MFP grant, and to adequately implement MDS 3.0 Section Q to comply with the U.S. Supreme Court's Olmstead Decision. CCT currently draws down 87 percent Federal Medical Assistance Percentage (FMAP) as compared to 50 percent for standard Medi-Cal beneficiary assistance.

Background. In 2005, Congress authorized the MFP Rebalancing Demonstration and grant funding under the Deficit Reduction Act (P.L. No. 109-171); and in 2010, Congress extended MFP grants through September 30, 2016 under the Patient Protection and Affordable Care Act (P.L. 11-148). Current authorization of the MFP Demonstration is set to expire at the end of 2016; however, federal regulation allows MFP grantees to continue to spend grant funding through September 30, 2020 by way of supplemental budgets awarded in federal fiscal year 2016.

In order for a state to receive authorization to use remaining grant funding for the provision of MFP services, grantees were required to submit a sustainability plan that details projected methods for continuing the program and the steps necessary to continue to rebalance the long-term care system and increase transition activities during the final years of the Demonstration. California's approach to developing a Sustainability Plan was accepted on November 6, 2015. The official approval of the budget through September 30, 2020 will be issued by the CMS Office of Acquisition and Grants Management pending review of the final supplemental budget request submitted on October, 1, 2015.

The MFP Demonstration targets Medicaid beneficiaries of all ages who have nursing level-of-care need, and who have continuously resided in hospitals, nursing facilities (NFs), or intermediate care facilities for persons with developmental disabilities (ICF-DD) for three months or longer. CMS views the MFP Demonstration as part of a comprehensive, coordinated strategy to assist states, in collaboration with stakeholders, to make widespread changes to long-term care delivery systems across the nation.

According to DHCS, the five-year limited-term resources are necessary to ensure the CCT program is supported and run in an efficient manner through the remainder of the grant. The requested resources will address work related to overseeing the day to day operations of the program as well as the ongoing reporting requirements to CMS necessary to draw down grant funding. The workload will also include review of medical documentation and care plans for CCT participants to assess service needs, assess

treatment authorization requests, and determine appropriate waiver service eligibility for potential CCT participants. Additionally, the resources will support monitoring and oversight of the 30 contracted lead organizations responsible for transitioning frail, elderly and disabled beneficiaries out of NFs and will allow DHCS to provide guidance to those organizations when necessary.

According to DHCS, approval of this proposal will allow the state to:

1. Work to transition an additional 2,500 eligible individuals to the community setting of their choice who would otherwise have no option but to live in long-term care institutions.
2. Receive an additional 25 percent in enhanced FMAP for providing qualified HCBS to CCT Participants in their own homes for 365-days after discharge from an inpatient facility. By meeting grant benchmarks, the state can save approximately $100 million in payments to health care facilities in the next five years.
3. Reinvest General Fund savings to provide HCB LTSS to Medi-Cal beneficiaries who are not eligible for CCT, but who prefer to move out of long-term inpatient facilities. As a condition of receiving the federal MFP grant, California is committed to investing the savings it realized from the enhanced FMAP (approximately $27 million) into transitioning additional individuals out of inpatient care facilities.
4. Generate ongoing savings by providing services to individuals in the community instead of in Medi-Cal inpatient facilities. CCT will reduce Medi-Cal inpatient facility expenditures attributed to full scope inpatient facility care by an average of 40 percent by providing services to the same individuals in the community.

The request is for five-year limited-term resources to support the following expected outcomes:

- MFP will meet the benchmark of 2,500 transitions by September 30, 2020.
- Data reports to CMS will be submitted on time for inclusion in national data reporting.
- Nursing facilities will properly refer individuals to LCAs for options counseling.
- MFP will add eight lead organizations for a total of 40 to achieve statewide coverage.
- MFP will save the state $129,526,551 in funding by transitioning 2,500 beneficiaries from nursing facilities to the community (HCBS savings + enhanced FMAP).

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

2. How is the state reinvesting General Fund savings to provide HCB LTSS to Medi-Cal beneficiaries who are not eligible for CCT, but who prefer to move out of long-term inpatient facilities? (As a condition of receiving the federal MFP grant, California is committed to investing the savings it realized from the enhanced FMAP, approximately $27 million, into transitioning additional individuals out of inpatient care facilities.)

Issue 10: Medi-Cal: PACE Modernization

Budget Issue. DHCS proposes trailer bill language to enable modernization of the Program for All-Inclusive Care for the Elderly (PACE). The proposed legislative changes would:

- **Rate Setting**: Standardize rate-setting to DHCS to determine comparability of cost and experience between PACE and like population subsets served through Long-Term Services and Supports (LTSS) integration into managed care health plans under the Coordinated Care Initiative. Statutory change is necessary as DHCS is currently required to use a Fee-for-Service (FFS) equivalent cost/upper payment limit methodology to set capitation rates for PACE Organizations.
- **Remove Cap on the Number of PACE Organizations**: Remove existing statutory language that caps the number of PACE Organizations with which DHCS can contract.
- **Remove Not-for-Profit Requirement**: Remove existing statutory language to align with updated PACE federal rules and regulations.
- **PACE Flexibilities**: Add new statutory language enabling DHCS to seek flexibility from the Centers for Medicare and Medicaid Services (CMS) on several issues including the composition of the PACE interdisciplinary team (IDT), the frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and development of a streamlined PACE waiver process.

Background. PACE enrollment in the state is voluntary for Medi-Cal beneficiaries. Federal regulations (Title 42, Code of Federal Regulations, Section 460.162) specify that a PACE participant may voluntarily disenroll from the program without cause at any time. Participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. The PACE program becomes the sole source of Medicare and Medi-Cal services for PACE participants.

The PACE model of care provides a comprehensive medical/social service delivery system using an IDT approach that provides and coordinates all needed preventive, primary, acute and LTSS. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model affords eligible individuals to remain independent and in their homes for as long as possible. The PACE plan receives a monthly Medicaid and/or Medicare capitation payment for each enrolled participant and retains full risk for the cost of all Medicare and Medi-Cal services as well as any additional services determined necessary by the PACE IDT.

The PACE population is comprised predominantly of beneficiaries dually eligible for Medicare and Medi-Cal, and the seniors and persons with disabilities (SPD) Medi-Cal only population. These populations have been transitioned to the Medi-Cal managed care delivery system over the past five years under California's Bridge to Reform Section 1115 Medicaid Waiver. As a result, the enrollment base for PACE Organizations has changed from a majority FFS population to a managed care population over the last four years.

Rate Setting: The PACE FFS rate methodology does not take into account plan-specific experience and utilization when setting PACE rates. Pursuant to subdivision (e)(1) of Welfare and Institution (W&I) Code Section 14593, DHCS is required to "establish capitation rates paid to each PACE organization at no less than 95 percent of the FFS equivalent cost, including DHCS's cost of administration, that DHCS estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries." However, there is an erosion of FFS data as Medi-Cal transitions to a managed care delivery system creating a fundamental issue with the current FFS equivalent PACE rate methodology DHCS is required to use to set rates. In December 2015, CMS issued guidance updating rate setting criteria for PACE Medicaid capitation rates. As part of this guidance, CMS has stated that new managed care rates must be based on data no older than three years. The current rate methodology needs to change to address any future data credibility issue(s) regardless of what type of new methodology is established.

Consequently, legislation is required to move away from the traditional FFS equivalent rate methodology to set capitation rates for the PACE organizations and instead implement actuarially sound rates based on plan-specific cost, service utilization, quality and performance based measures utilized for other managed care health plan models contracting with DHCS. The FFS equivalent rate methodology specified in state statute is not in alignment with the plan-specific cost and experience-based rate methodology that is utilized for other managed care health plans contracting with DHCS. The scope of the rate methodology utilized for managed care health plans is defined in W&I Code Section 14301.1. A change to the current rate calculation methodology is necessary and alignment of rate methodologies between PACE and managed care health plans is appropriate. Standardizing rate-setting will allow DHCS to determine comparability of cost and experience between PACE and like population subsets served through managed care health plans that provide care to similar populations.

Cap on the Number of PACE Organizations: Removal of the existing cap on the number of PACE organizations with which DHCS can contract, as proposed, will promote better alignment with DHCS's Strategic Plan initiative 2.1 to support integrated linkages between systems of care. Removing the PACE organization cap will allow continuing expansion of PACE in California, which aligns with ongoing DHCS efforts to transition to a statewide managed care delivery system. Currently, there are eleven PACE organizations that are in operation with three additional interested applicants.

To achieve this goal, a statutory change is necessary as DHCS is currently limited by subdivision (a)(2) of W&I Code Section 14593 to contracting with no more than 15 PACE organizations (language removing the cap will be contingent upon federal approval of the experience-based rate methodology).

Not-for-Profit Requirement: Removal of the existing specification that DHCS enter into contracts only with nonprofit organizations for the purpose of implementing PACE aligns with recently released federal guidance permitting for-profit entities to apply as PACE organizations. Removal of the nonprofit specification will also align with ongoing DHCS efforts to transition to a statewide managed care delivery system by further enabling continuing expansion of PACE in California.

To achieve this goal, a statutory change is necessary as DHCS is currently limited by subdivision (a)(1) of W&I Code Section 14593 to contracting with public or private "nonprofit" organizations for implementation of the PACE program. A related change in W&I Code Section 14592 that would modify the reference to federal law is intended to assure that an outdated federal regulation will not be a barrier to this clarification.

PACE Flexibilities: PACE continues to grow at a rate much faster than anticipated, expanding and evolving with the advent of newer health care delivery practices and methods, much unlike the rules governing PACE. Federal PACE regulations do not provide any flexibility in requirements of the composition of the PACE IDT and frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and the PACE waiver process. The lack of flexibility in the PACE regulations hinders PACE organizations from keeping up with current best practices and as a result disservices California participants that may benefit from newer methods. Enabling DHCS to seek flexibility in the federal PACE regulations allows for continued modernization of the program in addition to assisting PACE organizations in their efforts to provide the highest quality of care to Californians.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. Please describe how the new methodology is likely to impact existing rates?

3. What criteria does DHCS use to evaluate new PACE provider application? Who does DHCS consultant with on this evaluation?

Issue 11: Every Women Counts Program

Budget Issue. DHCS requests three-year, limited-term federal funds authority of $399,000 to perform programming, data analysis, and data management functions for the Every Woman Counts (EWC) program.

The proposed budget includes $32.2 million (special fund and federal fund) for EWC, a $5.7 million decrease from the 2015-16 estimate of $37.9 million, which primarily reflects a decrease in caseload as a result of the federal Affordable Care Act and the transition of EWC caseload to Covered California or Medi-Cal.

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

On January 30, 2015, the CDC issued a policy requiring EWC to implement a Patient Navigation/Case Management system and track outcomes for all women's breast and cervical cancer screenings, regardless of health coverage payer source. To meet the CDC grant requirement to monitor the quality of screening procedures, EWC collects recipient enrollment and outcome data from enrolled primary care providers through a web-based data portal known as DETEC. Recipient data is reported to CDC biannually and assessed for outcomes per CDC prescribed Core Program Performance Indicators (CPPI). Specific outcomes indicators include number of women rarely or never screened for cervical cancer and length of time from screening to diagnosis to treatment.

This proposal seeks to continue to provide the necessary resources to meet statutory mandates set forth by state and federal legislation. The CDC grant requires EWC to monitor the quality of screening procedures, collect recipient enrollment and outcome data from enrolled primary care providers. Recipient data is reported to the CDC biannually and assessed for outcomes per CDC prescribed Core Program Performance Indicators. Specific outcome indicators include the number of women who are rarely or never screened for cervical cancer and length of time form screening to diagnosis to treatment. Additionally, state law requires annual reports on the number of women served by EWC by race/ethnicity/geography, number diagnosed with cancer, number of women referred to treatment service and to project quarterly and annual expenditure reports and caseload data.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

Issue 12: Office of Family Planning Contract Conversion

Budget Issue. DHCS requests ten permanent, full-time state civil service positions and $1,458,000 ($637,000 General Fund) for 2016-17 and $1,368,000 ($596,000 General Fund) on-going to replace existing contracted staff. The requested positions will ensure adequate staffing levels to meet state Office of Family Planning (OFP) requirements and comply with Government Code Section 19130, which prohibits contracting out for services that can be performed by state civil servants.

The current contract funding is built within the Medi-Cal Local Assistance Estimate. DHCS proposes to discontinue the policy change in order to build the expenditure authority in the state operations budget. The current contract is annually budgeted at $2,861,000 ($1,430,000 General Fund). With the contract conversion to state civil service positions, there is an anticipated cost savings of approximately $1,403,000 ($793,000 General Fund) in year one and $1,493,000 ($834,000 General Fund) in year two and on-going.

Background. The OFP is established by Welfare and Institutions (W&I) Code §14500-14512. OFP is charged "to make available to all citizens of the state, who are of childbearing age, comprehensive medical knowledge, assistance, and services relating to the planning of families". The Family Planning, Access, Care and Treatment (Family PACT) program is administered by OFP and has been operating since 1997 to provide family planning and reproductive health services at no cost to California's low-income residents of reproductive age. Family PACT serves 1.8 million income-eligible men and women of childbearing age through a network of 2,300 public and private providers. Pursuant W&I Code §14501, other OFP functions and duties charged by the California Legislature include, but are not limited to:

- Establishing goals and priorities for all state agencies providing or administering family planning services.
- Coordinating all family planning services and related programs conducted or administered by state agencies with the federal government so as to maximize the availability of these services by utilizing all available federal funds.
- Evaluating existing programs and establishing in each county a viable program for the dispensation of family planning.
- Developing and administering evaluation of existing and new family planning and birth control techniques.

W&I Code §14501 requires OFP to conduct ongoing monitoring and evaluation of family planning services. OFP has historically used a personal services contract to hire staff to meet this mandate and to assist with the administration of the Family PACT program. Family PACT was previously operated under the authority of a Section 1115 demonstration waiver with a requirement to have an independent evaluation of the waiver's impact on reproductive health outcomes, utilization and costs, and access. The Centers for Medicare and Medicaid Services (CMS) required the waiver's impact to be monitored and evaluated to measure the program's goals. State Plan Amendment 10-014, approved by CMS in 2011 transitioned the Family PACT program into the Medicaid State Plan. The transition from a waiver program to a program under the Medicaid State Plan eliminated the requirements to have an independent evaluator provide monitoring and evaluation of the program's goals. However, the W&I

Code §14501 mandate remains, which requires OFP to conduct ongoing monitoring and evaluation of family planning services.

Since 1997, the Bixby Center for Global Reproductive Health at the University of California, San Francisco (UCSF) has had business agreements with OFP to provide data for policy and programmatic decisions through a multi-method approach that includes analysis of administrative data; assessment of provider and client perspectives; and medical record reviews. The UCSF business agreement includes a medical consultant who advises OFP regarding evidenced-based and clinical practice guidelines published by professional organizations with respect to reproductive health services.

The 2012 Budget Act transferred OFP/Family PACT from the California Department of Public Health (CDPH) to DHCS, effective July 1, 2012. In response to OFP's transition from the CDPH to DHCS, OFP and UCSF executed a contract amendment that changed the scope of services for years four and five of the UCSF 2010-2015 business agreement. The scope of services was expanded from evaluation and monitoring of Family PACT to the evaluation and monitoring of Medi-Cal family planning services. OFP has a longstanding commitment to evidence-driven policies and to quality improvement/utilization management (QI/UM) activities with respect to family planning and family planning-related services. Recently, OFP renewed its business agreement with UCSF for three years (Fiscal Years 2015-2016 through 2017-2018) to continue to perform on-going assistance in monitoring and evaluating the State's family planning programs to fulfill OFP's statutory requirement.

According to DHCS, the existing personal services contract does not meet the Government Code Section 19130 exemption requirements.

Below, lists the requested ten permanent positions, which are requested to perform critical functions for OFP, such as data programming, data collection and management activities to monitor the State's family planning programs:

- Medical Consultant I
- Pharmacy Consultant I
- Staff Services Manager II (Managerial)
- Research Scientist Supervisor I
- Research Scientist III
- Research Scientist II
- Staff Programmer Analyst
- Research Analyst II
- Research Analyst I (Demography)
- Research Analyst I (Geographic Information Systems)

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. How will the state ensure that the evaluation remains objective?

Issue 13: Medi-Cal: Dental Fiscal Intermediary Turnover-Takeover

Budget Issue. Through a Spring Finance Letter, DHCS requests three-year expenditure authority of $2,052,000 ($514,000 General Fund) to support the equivalent of seven three-year limited-term positions and contractual services to address workload related to the conversion of the current Medi-Cal Dental Fiscal Intermediary. DHCS is presently securing two contracts, one for the dental Administrative Services Organization (ASO) and one for the dental California Dental Medicaid Management Information System (CD-MMIS) Fiscal Intermediary (FI) services. These resources are necessary to perform the turnover-takeover efforts of the FI and ASO from the current vendor.

Included in this request is $500,000 for an independent verification and validation consultant to provide oversight of this turnover-takeover and $500,000 for a project manager contract to assess the project's status, performance trends, milestones, and project completion.

Background. From 1966 to 1972, all claims for dental health care services rendered to Medi-Cal recipients were paid by a single FI and the state assumed full responsibility for costs. In 1973, with passage of the Waxman-Duffy Act, the State Legislature provided the opportunity for the State of California to explore the possibility of delivering dental care on a prepaid, at-risk basis (for services and administrative cost).

Under the provisions of the Waxman-Duffy Act, which became effective January 1, 1974, the state entered into a four year pilot project with California Dental Services, a.k.a. Delta Dental Plan of California, to provide dental care services on a prepaid, at-risk basis. Legislative action allowed the state to extend the pilot project leading to the first of several competitively bid contracts, under a prepaid, at-risk model. Since awarding the first contract to Delta Dental, it has subsequently prevailed as the incumbent contractor.

In 2011, Delta Dental was again selected as the awardee for the dental fee-for-service (FFS) contract which included both FI and ASO responsibilities on an at-risk basis. However, the Center for Medicare and Medicaid Services (CMS), upon review of the contract, determined the contract did not meet certain regulatory criteria and conditions under 45 Code of Federal Regulation (C.F.R.) Part 95 and 42 C.F.R. Part 433 as a MMIS related acquisition. CMS expressed significant concerns with the procurement of the 2011 contract structure and asked DHCS to modify the contracting delivery model or risk losing 75/25 federal financial participation (FFP) enhanced funding for MMIS activities. The main concerns identified by CMS are as follows:

- Non-compliance with Management Information System (MMIS) requirements.
- Use of an underwriting shared risk.
- Non-enforcement of Knox-Keene licensure requirements; and
- Use of a hybrid model of MMIS and administration within one (1) contract with underwriting risk sharing.

DHCS notified Delta Dental the 2011 contract award would not be approved by CMS and a re-procurement would be required. The current contract in place (which is an extension of the last fully executed contract from 2004 as approved by CMS) between DHCS and Delta Dental is set to expire on June 30, 2016.

DHCS is currently requesting approval for an additional extension of the current contract with Delta Dental to ensure a smooth one-year transition to the new ASO and FI contractors, and to allow enhanced FFP for MMIS activities during the re-procurement period leading up to the implementation of the new contracts on July 1, 2017. DHCS is also seeking federal approval of the Planning Advanced Planning Document (PAPD) for enhanced funding to procure the two new Contracts for the CD-MMIS FI services and the dental ASO. DHCS anticipates announcing the successful awardees in May 2016.

The selected FI contractor will be responsible for the turnover, operation, and eventual takeover of the California Dental Medicaid Management Information System (CD-MMIS), and for effective and efficient auto adjudication of claims and related documents. The selected contractor will take over the existing CD-MMIS and operate it to the satisfaction of State and federal regulations and requirements for FI services for Medi-Cal and other state health programs that provide dental services. Programs that currently utilize CD-MMIS for dental claims, Treatment Authorization Requests (TARs) processing and other dental related services include Medi-Cal, California Children's Services Program (CCS), the Genetically Handicapped Persons Program (GHPP) and Regional Center consumers.

The selected ASO Contractor will operate with the dental FI Contractor using the existing CD-MMIS. The ASO contractor will be responsible for the administrative functions that consist of monitoring and maintaining systems related to the operations portion of providing services to Medi-Cal beneficiaries. Those responsibilities include TAR and Adjudicated Claim Service Lines (ACSL) processing, maintaining the Telephone Service Center (TSC), and providing outreach efforts to both maintain and increase utilization.

The turnover and takeover of the existing FI and ASO responsibilities, managing two separate contracts for FI and ASO functions once the new contracts have been awarded, and overseeing the relationship between the existing and new FI and ASO vendors so that collaboration is achieved to best support the dental program is new workload that cannot be absorbed within existing resources. The requested resources will be located within the MDSD, Office of Legal Services (OLS), and Enterprise, Innovation, and Technology Services (EITS) – via managed resources.

CMS recently expressed concerns with certain elements of the current Dental FI Contract, including the fact that California operates two Medicaid Management Information Systems. In order to address CMS' concerns and with DHCS currently evaluating alternatives for the eventual migration to a single MMIS, DHCS released two competitive RFPs. One RFP solicited bids to provide administrative services for the Medi-Cal Dental Program and the other RFP was to obtain an FI that will support the CD-MMIS. This proposal requests the resources necessary to transition the ASO and FI functions and complete the turnover-takeover process. This is the first time DHCS is procuring for these functions separately, providing oversight, and making certain of collaboration between two vendors. Existing staff cannot perform or absorb the magnitude of management and administration required for a successful turnover-takeover process. These positions will provide the necessary resources to perform the required oversight throughout the turnover-takeover process. Without these resources, the department will be unable to perform the administration and oversight needed, and could result in a loss of enhanced federal funding.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

2. What improvements will this bring to the Denti-Cal program such as, improved access and utilization, expedited provider enrollment and beneficiary outreach?

Issue 14: Robert F. Kennedy Farm Workers Medical Plan (SB 145, 2015)

Budget Issue. DHCS requests five-year limited-term funding of $220,000 General Fund to implement provisions of SB 145 (Pan), Chapter 712, Statutes of 2015 and $100,000 General Fund is requested for a one-time system upgrade.

SB 145 requires DHCS to reimburse the Robert F. Kennedy Farm Workers (RFK) Medical Plan up to $3,000,000 annually for claim payments that exceed $70,000 on behalf of an eligible employee or dependent for a single episode of care, until January 1, 2021.

Background. RFK Medical Plan is a non-governmental, self-funded, self-insured health plan that is subject to collective bargaining agreements between the United Farm Workers (UFW) and multiple agricultural employers. The Affordable Care Act (ACA) bans annual and lifetime limits to plan coverage. The ACA allows for multi-employer plans with collective bargaining agreements to maintain a "grandfathered" status for some provisions, but not the annual and lifetime limits. Due to these prohibitions, RFK Medical Plan has stated that it will not be financially viable to continue without a subsidy. SB 145 requires DHCS to review claims submitted by RFK Medical Plan and reimburse the plan.

DHCS's Special Collection and Process Innovation Section is responsible for consultative and analytical work for a wide variety of Medicaid recovery and collections programs. The section is responsible for requesting and analyzing eligibility and service data to determine claim amounts, supporting litigation and collection activities, responding to customer inquiries, and developing new collection processes. DHCS is proposing to implement SB 145 requirements within this section.

In 2016-17, the requested resources will allow the department to make the following technical changes and procedural developments including:

- Develop regulations and departmental policies
- Develop standardized correspondence and departmental procedures
- Process and review incoming correspondence
- Make recommendations to help develop and implement technical infrastructure to house and pay claims received
- Respond to inquiries via phone and e-mail from the RFK Medical Plan, stakeholders, and members
- Prepare data releases for exchange of Protected Health Information (PHI) in accordance with Health Insurance Portability and Accountability Act (HIPAA) guidelines

In 2017-18, the department will shift from implementation related work to support and oversight, including:

- Continue to develop standardized correspondence and departmental procedures as needed
- Process and review incoming correspondence
- Review and analyze individual claims for 11,000 members (ongoing caseload), relating to a single episode
- Calculate reimbursements
- Track and monitor fund balance

- Create and route claims and invoices for payment
- Facilitate compliance with statutory timeframes
- Advise and provide recommendations to management
- Monthly meetings of internal technical group to meet ongoing program requirements

Also, according to DHCS, in 2016-17, the case management system will require a one-time system design notice at a cost of $100,000 to store claims data, create invoices, and provide necessary analytics/reports.

Maintaining these resources until 2021-22 will allow DHCS to process the final year of data which occurs beyond the sunset date of January 1, 2021, to provide reimbursement to the RFK Medical Plan.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

Issue 15: Hospital Quality Assurance Fee Extension

Issue. The California Hospital Association (CHA) requests that the Subcommittee consider trailer bill language to extend the sunset date of the hospital quality assurance fee (QAF); the current QAF sunsets January 1, 2017. CHA requests the sunset date be extended one year to January 1, 2018.

The existing hospital QAF is estimated to provide, annually, approximately $800 million in savings to the General Fund, with a certain portion of the fee revenue offsetting General Fund costs for providing children's health care coverage.

The budget assumes that the QAF sunsets and; consequently, only includes about $150 million in General Fund savings.

Background. Beginning in 2009, the Legislature has imposed a quality assurance fee on private hospitals in California. The current fee program was established through SB 239 (Hernandez/Steinberg), Chapter 657, Statutes of 2013. During that time the QAF has resulted in nearly $10 billion in new federal funding for Medi-Cal patients that seek care in hospitals for inpatient and outpatient traditional and managed care services as well as specialty care including trauma, high acuity, inpatient psychiatric, subacute care, and transplant services. SB 239 also established an alignment between hospitals and the state to ensure the maximum amount of federal funds are received for hospital care for Medi-Cal patients, including seniors, persons with disabilities, and children enrolled in the Medi-Cal program. The state has been receiving 24 percent of the net increase in payments for hospital services created by the fee program which is used to pay for health care coverage for children.

The current hospital fee sunsets on January 1, 2017. CHA is sponsoring a November 2016 ballot initiative to make the QAF permanent, if passed by the voters. CHA proposes that the sunset of the current fee be extended by one year in the unlikely event that the initiative does not pass in November. With the sunset date moving forward, the fee program will be able to continue into 2017.

Legislative Analyst's Office (LAO). The LAO recommends the Legislature extend the hospital QAF in this legislative session because it is both a benefit to the General Fund and the hospital industry.

Subcommittee Staff Comment and Recommendation—Hold Open. Even if the QAF was extended a year through trailer bill language, a full year of savings would not occur in the budget year given the anticipated time it would take to get the extension approved by the federal Centers for Medicare and Medicaid Services. However, these accrued savings would be realized in future years.

Questions.

1. Please provide an overview of this issue.

2. Does the Administration have any concerns with extending the QAF for one year?

Issue 16: Medi-Cal Payment Reductions, Rates, and Access

Budget Issue. The budget continues the AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, Medi-Cal payment reductions. Total fund savings from AB 97 with the changes implemented in AB 1 X2 (Thurmond), Chapter 3, Statutes of 2016 (special session legislation related to the managed care tax and developmental services) is $433 million (about $216 million General Fund). See table below for a summary of the savings.

Table 1: AB 97 Medi-Cal Provider Payment Reduction Summary in January Budget and Special Session Legislation (AB 1 X2 (Thurmond), Chapter 3, Statutes of 2016)*

AB 97 Payment Reductions
(Total Fund)

(dollars in thousands)

Provider Type	Retroactive Savings Period	Total Retroactive Savings	On-Going Annual Savings	FY 2015-16		FY 2016-17	
				On Going	Retro	On Going	Retro
Nursing Facilities - Level A	6/1/11-6/30/12	$246	$254	$254	$0	$254	$0
ICF/DDs				$8,340	$0	$0	$0
ICF/DD-Habilitative							
ICF/DD-Nursing							
FS Pediatric Subacute	Exempt						
AB 1629 Facilities (3)	N/A						
DP/NF-B							
Phase 1 Providers (4)	6/1/11-12/20/11	$14,458	$29,175	$29,175	$0	$29,175	$0
Physician 21 yrs+		$0	$49,746	$49,746	$0	$49,746	$0
Medical Transportation		$0	$14,461	$14,461	$0	$14,461	$0
Medical Supplies and DME	6/1/11-10/23/13	$39,428	$17,394	$17,394	$1,878	$17,394	$7,510
Dental (5)		$0	$0	$0	$0	$0	$0
Clinics		$0	$18,512	$18,512	$0	$18,512	$0
Pharmacy (6)	6/1/11-2/6/14	$80,576	$30,891	$30,891	$20,144	$30,891	$26,859
Phase 3 Providers		$0	$2,414	$2,414	$0	$2,414	$0
Managed Care(w/ ACA)		$0	$235,797	$184,306	$0	$235,797	$0
Grand Total		**$134,708**	**$398,644**	**$355,493**	**$22,022**	**$398,644**	**$34,369**

Note:

(1) Data Source: Nov 2015 Estimate and AB1 X2 (Thurmond), Chapter 3, Statutes of 2016

(2) AB 97 injunctions were lifted on 6/25/2013.

(3) AB 1629 facilities includes Freestanding (FS) NF-B and FS Adult Subacute facilities. Implementation of payment reduction began May 1, 2012 and ended July 31, 2012. The Department paid back the 10% payment reduction to this facility type in December 2012.

(4) Phase I includes all subject providers, including the Pediatric Day Health Care (PDHC) and Audiology Program, except for the enjoined providers and the Child Health and Disability Prevention (CHDP) program.

(5) SB 75 (2015): Effective July 1, 2015, dental providers were exempt from the 10% payment reduction.

(6) The pharmacy retro recoupment implementation date and schedule has been updated. Implementation date shifted from from 4/2016 to 10/2015, and recoupment schedule is now estimated to take place over 36 months instead of 66 months.

*Please note these numbers will be updated at the May Revision.

Background. As a result of the state's fiscal crisis, AB 97 required DHCS to implement a ten percent Medi-Cal provider payment reduction, starting June 1, 2011. This ten percent rate reduction applies to all providers with certain exemptions and variations. Certain exemptions were specified in AB 97 and

some are a result of an access and utilization assessment. AB 97 provides DHCS the ability to exempt services and providers if there are concerns about access. DHCS has formally established a process for pharmacy providers to seek exemption from the provider payment reductions.

On October 27, 2011, the federal Centers for Medicare and Medicaid (CMS) approved California's proposal to reduce Medi-Cal provider reimbursement rates. As part of this approval, CMS required DHCS to (1) provide data and metrics that demonstrated that beneficiary access to these services would not be impacted, and (2) develop and implement an ongoing healthcare access monitoring system.

DHCS had been prevented from implementing many of these reductions due to a court injunction. On June 14, 2013, the United States Court of Appeals for the Ninth Circuit denied the plaintiffs' motion for a stay of mandate in this case, allowing the implementation of all of the AB 97 Medi-Cal provider ten percent payment reductions. For the enjoined providers, DHCS began implementation of the retrospective payment reductions on a staggered basis, by provider type, starting in September 2013.

About 80 percent of Medi-Cal enrollees are enrolled in Medi-Cal managed care. The remaining 20 percent receive Medi-Cal through fee-for-service. Generally, those in FFS are persons with limited-scope aid codes, dual eligibles in the non-Coordinated Care Initiative counties, and persons who are exempt from managed care because of a medical exemption request.

The 2015-16 budget eliminated the AB 97 reduction related to dental providers effective July 1, 2015.

AB 1 X2 eliminated the AB 97 reduction for intermediate care facilities for the developmentally disabled and eliminated the recoupment of reductions related to the AB 97 payment reductions and rate freezes for skilled nursing facilities that are distinct parts of general acute care hospitals, referred to as distinct part nursing facilities, for dates of service on or after June 1, 2011, and on or before September 30, 2013.

Recoupment of Retroactive Savings. DHCS has begun the recoupment of retroactive savings for all affected providers except durable medical equipment, it is anticipated that this recoupment will begin in August.

Managed Care and Actuarial Soundness of Rates. Managed care rates can only be reduced by AB 97 on an actuarial basis and must support the required services. Consequently, as more and more individuals shift into Medi-Cal managed care, the negative impact of these reductions to access of Medi-Cal services is reduced. This is because health plans must meet access standards and a health plan's rate must be actuarially sound (i.e., generally, the rate cannot be reduced to a level that does not support the required services).

In the Governor's budget, the AB 97 reductions to managed care plans as a percentage of their base rates are 0.54 percent in 2015-16 and 0.74 percent in 2016-17. If the reductions applicable to the elimination of the primary care physician rate increase are considered, then the reductions as a percentage of health plan base rates are 0.54 percent in 2015-16 and 0.81 percent in 2016-17.

New Federal Rule on Fee-For-Service Access Monitoring. In November 2015, CMS released a rule describing a process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with Section 1902(a)(30)(A) of the Social Security Act (the Act) and to address issues raised by that process. This rule became effective January 4, 2016. DHCS has begun implementation of the rule, related to the requirement that beginning October 1, 2016, state agencies are required to develop an access monitoring review plan. (This access plan was originally due July 1, 2016, but was delayed by CMS.)

At a high level, the rule requires the state to develop an access monitoring plan and update the plan annually. The rule also requires DHCS to submit a detailed analysis of providers and services every three years. Such analyses must include primary care physicians, specialists, behavioral health, pre-and-post natal obstetrics, and home health providers. Additionally, the rule requires for any state plan amendment submitted that changes, through reduction or restructuring, provider payments, a new monitoring plan must be submitted. When submitted, it must include an analysis of access for the prior 12 months, the anticipated effect of the proposed change on access, and input from beneficiaries, providers, and other stakeholders on the proposed changes. In addition to the established monitoring procedures, it must create additional procedures to monitor the effects of the changes. Finally, the rule states to implement ongoing mechanisms for beneficiary and provider input on access to care and states will need to promptly respond to input citing specific access problems with an appropriate investigation, analysis and response.

To address the minimum, ongoing requirements of the rule, the department must redesign its current access monitoring plan. The rule requires DHCS to significantly increase the number of providers it monitors, as well as associated metrics, such as geographic location of those providers. DHCS must also expand current monitoring efforts to include rate comparisons of Medi-Cal payments to those of other payers (both public and private). DHCS will be required to solicit input from providers and beneficiaries and publish the proposed monitoring plan for public feedback prior to final submission by October 1, 2016. Additionally, should DHCS propose provider rate reductions or restructuring, the rule requires additional monitoring mechanisms, public input, and more periodic analyses (at least annually).

Stakeholder Concerns. Consumer advocates, providers, provider associations, and other stakeholders are concerned that the existing Medi-Cal rates, payment reductions, and rate freezes directly impact an enrollee's ability to access Medi-Cal services. These stakeholders find that the existing payments do not cover the costs to provide services to Medi-Cal enrollees and are not sufficient enough to sustain their operations.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as updated information will be received at the May Revision and discussions continue on this topic.

Questions.

1. How does DHCS proactively evaluate the impact of the AB 97 reductions to each specific provider type to ensure that access is not compromised? Please explain what data sources and other information the department uses to evaluate access.

2. Please provide an update DHCS's development of an access monitoring review plan per the new federal rule.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Women, Infants, and Children Program

Budget Issue. DPH proposes total expenditures of $1.4 billion in 2016-17, a $20.5 million (1.5 percent) increase over the revised estimate for 2015-16, and a $46.5 million (3.3 percent) decrease from the 2015 Budget Act for the Women, Infants, and Children (WIC) Program. DPH estimates that 1,258,598 average monthly WIC participants in 2015-16 and 1,230,676 in 2016-17.

Table: WIC Expenditure Summary

	2015 Budget Act	2015-16 Estimate	2016-17 Proposed
Local Assistance (Federal Funds)	$1,126,206,368	$1,075,229,926	$1,094,093,548
Local Assistance (Rebate Funds)	$237,437,089	$221,369,550	$216,739,700
State Operations	$55,140,136	$55,140,136	$61,429,198
Total Expenditures	**$1,418,783,593**	**$1,351,739,612**	**$1,372,262,446**

In addition, the budget requests the following:

a. **Increase Enrollment of Children.** Four permanent positions and $513,000 in federal fund expenditure authority to WIC Division's outreach activities and improve data-sharing with the California Department of Social Services' (CDSS) CalFresh Program to increase child enrollment in both programs.

b. **eWIC.** To redirect three permanent positions to the Office of Systems Integration (OSI) and increase federal fund expenditure authority by $5.78 million for fiscal year 2016-17 to replace WIC paper checks with an electronic debit card, and replace the current WIC Management Information System (WIC MIS) with a United States Department of Agriculture (USDA) approved, Electronic Benefits Transfer (EBT)-ready Management Information System (MIS). The total request for the project is $39 million ($7.9 million for EBT and $31.1 million for the MIS) over five years. (This issue was also discussed at the March 3, 2016 Subcommittee No. 3 hearing under the Office of Systems Integration.)

Background: WIC. The WIC program is a federal supplemental nutrition program that provides supplemental food benefits to WIC participants. The food benefits are redeemed as vouchers at WIC authorized food vendors. These vendors provide an economic stimulus in local economies, as well as provide nutritional benefits during critical phases in a child's development. In the long term, the breastfeeding education and supplemental foods address child hunger. Children who are fed adequate and nutritious foods have improved development and have fewer health issues.

The WIC Division at DPH operates a $1.3 billion program serving approximately 1.3 million of California's economically and nutritionally-vulnerable residents. The WIC program is not an entitlement program; rather it is fully funded by an annual grant from the U.S. Department of Agriculture. WIC provides nutrition services and food assistance to low-to-moderate income families for pregnant and postpartum women, infants, and children up to their fifth birthday. In addition to the

categorical eligibility requirement, participants must be at or below 185 percent of the federal poverty level, and have a nutritional risk. Applicants are deemed eligible due to participation in other programs such as Medi-Cal, CalFresh, and California Work Opportunity and Responsibility to Kids (CalWORKS). The WIC program assists families by providing nutrition education, breast feeding support, vouchers to purchase healthy supplemental foods, and referrals to healthcare and other community services.

Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:

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

Background: WIC Enrollment. According to the National Center for Children in Poverty, about 48 percent of California's young children under the age of six live in low-income households. Of the total amount of young children, 23 percent live in households with incomes that are between 100-200 percent of the federal poverty level. Food insecurity, defined as a lack of consistent access to adequate food, has been rising among California households with children. In 2001-2002, 11.7 percent of households reported food insecurity, which rose to 15.6 percent of households in 2010-2012. Statistically significant findings related to health and food insecurity in children include: lower bone mineral content in adolescent boys, iron deficiency anemia among children, less mental proficiency in toddlers, higher rates of developmental risk, more frequent minor complaints like stomach aches, headaches, and colds, higher hospitalization rates, increased behavioral problems, poorer psychosocial functioning, higher rates of depression and anxiety, lower math achievement and reading gains, and increased risk of repeating a grade level.

While California is more successful than any other state in reaching individuals eligible for the WIC program (82 percent in 2012 compared to the national average of 63 percent), California's coverage rates vary across participant categories, namely pregnant women, postpartum women, infants, and children. The most recent 2011 California-specific data indicates that while the largest participation category served is children, the child coverage rate is the lowest at 73 percent; coverage for postpartum women is the highest at 91.2 percent, followed by infants at 90.7 percent, and pregnant women at 83.4 percent. Applying this 73 percent coverage estimate to the current number of children served results in an estimated 270,000 California children (age 1 year to under 5) eligible for, yet not enrolled in, the WIC program. To date, WIC has been unable to close the gap between those who are eligible for services and do not apply, as well as those who have been certified but do not actively receive benefits. WIC data analyses suggest a smaller decline in WIC participants if they were also enrolled in CDSS/CalFresh and/or Medi-Cal. This proposal seeks to increase participation rates by researching and developing data and program linkages.

WIC and CDSS/CalFresh have made a commitment to work together to increase enrollment of children in these programs. The goal is to increase California's coverage rate of eligible children participating in WIC by five percent, or 48,000 children, and to assist CDSS with increasing their enrollment of children in CalFresh by 400,000 by June 30, 2018.

According to DPH, the permanent positions requested in this proposal will be a team of professionals dedicated to work with counties to improve outreach to child populations, and to improve county WIC administrative processes to lower barriers to application and household retention in the WIC program. By having resources to address participation rates, DPH finds that the WIC program will be able to identify families that have enrolled in either CalFresh or WIC, but not the other; identify families that are enrolled in WIC but no longer actively participate in the program; and, identify barriers that will lead to effective strategies to improve participation.

Linking WIC program data to CalFresh and Medi-Cal data allows WIC to identify children enrolled in CalFresh and Medi-Cal, but not in the WIC program. Once eligible but unserved children are identified through the data matches, data analytics and Geographical Information System (GIS) mapping can identify hot spots of unserved geographical areas for targeted outreach activities. By using GIS to map the location of children in California, WIC plans to target outreach efforts to increase participation in hot spots (for example, areas with a high concentration of eligible but unenrolled children) and identify best-practices from cold spots (for example, areas with low concentration of eligible but unenrolled children).

Working collaboratively with CDSS will allow WIC to focus on the following key areas to improve participation rates:

a. County-level analysis of CalFresh and WIC program dual-enrollment and retention rates;

b. County-level analysis of inter-program referrals and "warm" hand-off models, both WIC ↔ SNAP and Medi-Cal ↔ WIC, and including connections between each of the program's management information systems; and

c. Targeted outreach and promotion efforts aimed at identified gaps in enrollment (such as pre-schoolers age 2 and up until the 5th birthday).

Background: eWIC. The United States Department of Agriculture's Special Supplemental Nutrition Program for WIC is a federally-funded nutrition education and supplemental food program established in 1972 under Public Law 92-433. DPH administers the WIC Program in California, contracting with 84 local agencies throughout California (in all 58 counties) to provide WIC services at over 650 sites, with approximately 1.4 million participants served on a monthly basis.

The federal Healthy, Hunger-Free Kids Act of 2010 requires all states to migrate from a WIC paper-based food benefits delivery system to an EBT system by 2020. Without an EBT system automating WIC benefits by October 1, 2020, California will not be in compliance with federal law, which may jeopardize millions of dollars in federal funding for the California WIC Program. DPH performed a detailed analysis that revealed the current WIC MIS was outdated and not EBT-compliant; therefore,

DPH received both federal and state approvals to begin the procurement to solicit bids and contract for the services of a design, development, and implementation systems integrator. DPH also contracted with the OSI (via an interagency agreement) to leverage the new California EBT Services contract to automate the issuance of WIC food benefits via the California EBT system.

The new eWIC MIS must be fully operational in California before WIC food benefits can be issued via EBT. In its June 2015 eWIC MIS Project Status Report, the California Department of Technology (CDT) gave the project an overall rating of "Yellow" (which indicates a project is slipping). This report also identified other possible delays that will likely cause the project to slip even further behind schedule. With the approaching federal deadline of October 1, 2020, DPH decided to leverage OSI's experience and have OSI manage the project. This would include the OSI assuming responsibility for completing the procurement; entering into a contract with the successful system integrator; managing design, development, testing, pilot, and statewide implementation activities; being responsible for contract and financial management; and providing other needed services.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these items open pending the May Revision updates.

Questions.

1. Please provide an overview of the WIC budget and these proposals.

2. How does the WIC program work with stakeholder community? Is there an ongoing standardized process for this engagement?

Issue 2: Genetic Disease Screening Program

Budget Issue. DPH proposes $92.2 million, a $7 million increase (8.2 percent) over the current year (2015-16) budget of $84.1 million for the Genetic Disease Screening Program (GDSP). Of the proposed $92.2 million, $13.4 million is for state operations while $78.8 million is proposed for local assistance. The 8.2 percent increase in the program budget primarily reflects the implementation of screening for adrenoleukodystrophy (ALD), required through AB 1559 (Pan), Chapter 565, Statutes of 2014. According to DPH, the decrease in expenditures between the 2015 Budget Act and the current year November estimate reflects changing caseload estimates.

Genetic Disease Screening Program Budget

	2015 Budget Act	**2015-16 Estimate**	**2016-17 Proposed**
PNS Local Assistance	$39,975,652	$35,724,295	$36,002,304
NBS Local Assistance	$36,357,366	$36,039,031	$42,769,479
State Operations	$13,379,000	$13,379,000	$13,379,000
TOTAL	**$89,712,018**	**$85,142,327**	**$92,150,783**

Background. GDSP consists of two programs - the Prenatal Screening Program and the Newborn Screening Program. Both screening programs provide public education, and laboratory and diagnostic clinical services through contracts with private vendors meeting state standards. Authorized follow-up services are also provided to patients. The programs are self-supporting on fees collected from screening participants through the hospital of birth, third party payers, or private parties using a special fund - Genetic Disease Testing Fund.

Prenatal Screening Program (PNS). This program screens pregnant women who consent to screening for serious birth defects. The fee paid for this screening is about $207. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. There are three types of screening tests for pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester. Women who are at high-risk based on the screening test results are referred for follow-up services at state-approved “Prenatal Diagnosis Centers.” Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

Newborn Screening Program (NBS). This program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is $111.70 (and is proposed to be increased to $122.70 in the budget, as described below). Where applicable, this fee is paid by prepaid health plans and insurance companies. Medi-Cal also covers the fee for its enrollees. The NBS screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment that mitigates more severe health problems. Informational materials are provided to parents, hospitals and other health care entities regarding the program and the relevant conditions, and referral information is provided where applicable.

AB 1559 Newborn Screening 2015 Budget Change Proposal. The 2015-16 budget included an augmentation of one permanent position and $1.975 million Genetic Disease Testing Fund. Of this request, $1.825 million is one-time funding to upgrade the computer system and $150,000 is ongoing. DPH requested these resources to comply with AB 1559 which expands the NBS program to include screening for adrenoleukodystrophy (ALD) as soon as ALD is added to the federal Recommended Uniform Screening Panel (RUSP), which occurred earlier this year.

The NBS is fully supported by fees, paid by insurance or individual patients, and therefore DPH proposes to raise the fee in order to cover the costs of this proposal. DPH proposes to raise the fee by $11.00 for a total fee of $122.70 beginning July 2016. DPH states that the new funding will cover the costs of: upgrading the Screening Information System, processing blood specimens, performing blood screens, testing chemicals, equipment and supplies used to assay results, and follow-up costs for screen positive cases, including case management, diagnostic work-up, confirmatory processing, provider and family education, and informative result mailers.

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

Questions.

1. Please provide an overview of the Genetic Disease Screening Program and the fee increase proposed in the budget.

Issue 3: California Personal Responsibility Education Program

Budget Issue. DPH requests $6.4 million ($700,000 in state operations and $5.7 million in local assistance) in federal fund expenditure authority, and the conversion of five limited-term positions to permanent positions, to continue the California Personal Responsibility Education Program (CA PREP), which is administered through the Maternal, Child and Adolescent Health Program.

Background. The Patient Protection and Affordable Care Act (ACA) of 2010 amended Title V of the Social Security Act (42 U.S.C. 701 et. seq.) to include a new formula grant program entitled the Personal Responsibility Education Program (PREP). The purpose of PREP funding is to reduce birthrates and sexually transmitted infections among high-need adolescents through evidence-based sexual health education.

The adolescent birth rate in the United States decreased significantly over the past 30 years, reaching a record low of 26.5 live births per 1,000 female youth aged 15 to 19 in 2013. In California, the decline has been even more substantial, from an adolescent birth rate of 70.9 per 1,000 in 1991 to 23.2 per 1,000 in 2013. While great progress has been made, there are still substantial disparities in rates of adolescent childbearing and sexually transmitted infections based on race, ethnicity, geography, and other social and demographic characteristics. Notably, in California nearly three out of four adolescent births are to Hispanic mothers, although Hispanic females account for only one-half of the adolescent population. Other vulnerable populations include youth in the foster care and juvenile justice systems, homeless/runaway youth, female adolescents with major mental illnesses, and male and female youth who identify as lesbian, gay or bisexual. These populations tend to have higher rates of early pregnancy, childbearing and/or sexually transmitted infections including the Human Immunodeficiency Virus when compared to other adolescents. Thus, these vulnerable adolescents are in substantial need of targeted sexual health education and support services.

CA PREP has received five years of continuous funding. This funding was extended through federal fiscal year 2017. California will receive $6.4 million of this national allocation in federal fiscal year 2016, which began October 1, 2015. Given that CA PREP is part of the ACA, DPH anticipates annual funding to continue beyond the current federal fiscal year 2017 extension, based on strong federal interest in and support for evidence-based adolescent pregnancy prevention.

CA PREP is designed to reduce rates of adolescent births and sexually transmitted infections through evidence-based sexual health education. CA PREP provides medically accurate, age-appropriate information about sexual and reproductive health that many youth do not receive from any other source. The curricula used are evidence-based; initial CA PREP program knowledge outcomes strongly support the effectiveness of the curricula.

There are currently 22 local entities participating in CA PREP, consisting of six county government agencies and 16 non-profit community-based organizations in 20 counties. Only California counties with a high need for adolescent sexual health education and services are eligible to participate in the program. CA PREP agencies are required to: 1) educate California's highest-need and most vulnerable adolescents on both abstinence and contraception through implementing evidence-based program models; 2) address at least three adulthood preparation subjects such as Adolescent Development,

Healthy Life Skills, and Parent Child Communication; 3) create family planning clinical linkages; and 4) maintain a community coalition of stakeholders to engage community members in actions that change social norms. The goals of these activities are to: decrease adolescent pregnancies and sexually transmitted infections; support meaningful opportunities to increase resiliency and self-efficacy to avoid harmful behaviors; ensure access to youth-friendly reproductive health services; and increase community support of healthy youth development and reduction of risky sexual behaviors. Since program implementation began in 2012, over 35,723 youth have been served.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this proposal.

Issue 4: Office of Health Equity

Oversight Issue. The 2012 budget provided DPH with $60 million in Proposition 63 funding to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities in the public mental health system. DPH has just recently awarded some of these funds. While DPH has been complimented by various stakeholders on conducting an inclusive and thoughtful process regarding the California Reducing Disparities Project, the delay in awarding these funds has postponed the ability of these funds to make any impact on the improvement of the public mental health system.

Background. AB 1467 (Committee on Budget), Chapter 23, Statues of 2013 created the Office of Health Equity (OHE) at DPH. The OHE was created by consolidating the Office of Multicultural Health at DPH, the Office of Women's Health at the Department of Health Care Services (DHCS), the Office of Multicultural Services at the Department of Mental Health (this department was eliminated in 2012), the Health in All Policies Task Force at DPH, and the Healthy Places Team at DPH.

OHE was tasked to accomplish all of the following (1) achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically-isolated communities; (2) work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health; (3) advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically-competent health and mental health care and services; and (4) improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.

Office of Health Equity - Budget by Fund Source [1]

Fund	2014-15	2015-16	2016-17
General Fund	$362,000	$362,000	$426,000
Air Pollution Control Fund [2]	$111,000	$112,000	$0
Unallocated Account, Cigarette and Tobacco Surtax Fund	$222,000	$221,000	$236,000
Federal Trust Fund	$315,000	$191,000	$595,000
Mental Health Services Fund	$18,557,000	$50,072,000	$18,068,000
Cost of Implementation Account, Air Pollution [2]	$211,000	$210,000	$389,000
Grand Total	**$19,776,000**	**$51,167,000**	**$19,714,000**

[1] Numbers may not add or match to other statements due to rounding of budget details. Dollars rounded to the nearest thousands.

[2] This transfer of budget allotment is a technical adjustment because Fund 0115 appropriations support activities from the Center of Chronic Disease Prevention & Health Promotion and Fund 3237 appropriations support the CDPH's Climate Action Team activities.

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

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

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

Solicitation/Contract	Original Timeline to Award Contract	Current Timeline to Award Contract	Amount (over six years)
Statewide Evaluator	August 2015	Awarded in February 2016 to Loyola Marymount University	~$4 million
Five Technical Assistance Provider (TAP) Contracts*	August 2015	Awarded in February 2016 to the following:	
		ONTRACK Program Resources, Inc. – African American TAP	~$2.4 million
		Special Services for Groups – Asian/Pacific Islander TAP	~$2.4 million
		Regents of the University of California, UC Davis (Center for Reducing Health Disparities) – Latino TAP	~$2.4 million
		Center for Applied Research Solutions – LGBTQ TAP	~$2.4 million
Fifteen Capacity Building Pilot Projects	September 2015	Intent to award announced on May 2, 2016, see below for more details.	
Twenty Implementation Pilot Projects	September 2015	May 2016	
Education, Outreach and Awareness	Fall 2016	Fall 2016	

*The TAP for the Native American population was reissued on February 24, 2016, due to CDPH's need to request additional information and specificity related to the proposer's organization and their work with California Native American populations. The proposal submission date for this solicitation is April 22, 2016.

On May 2, 2016, DPH announced the awards for the Implementation Pilot Projects. Responsibilities for the Implementation Pilot Projects include addressing culturally and linguistically appropriate mental health services within communities of their respective target population. The primary goal of these projects is to validate community-defined evidence-based practices through rigorous evaluation. The awards were to:

African American:
1. Catholic Charities of the East Bay – Alameda County
2. Safe Passages – Alameda County
3. The Village Project, Inc. – Monterey County
4. West Fresno Health Care Coalition – Fresno County

Asian and Pacific Islander *:
1. Asian Community Mental Health Services – Alameda County
2. Cambodian Association of America – Los Angeles County
3. East Bay Asian Youth Center – Alameda County
4. HealthRIGHT 360 – San Mateo County
5. Korean Community Services – Orange County

*Five awardees were selected as there were only two Capacity Building Pilot Project applications submitted.

Latino:
1. Health Education Council – Yolo County
2. La Clínica de la Raza, Inc. – Alameda County
3. La Familia Counseling Center, Inc. – Sacramento County
4. Mixteco/Indígena Community Organizing Project – Ventura County

LGBTQ:
1. Asian & Pacific Islander Wellness Center – City and County of San Francisco
2. Gender Spectrum – Alameda County
3. On The Move – Napa County
4. Openhouse – City and County of San Francisco

Native American **:
1. Friendship House Association of American Indians, Inc. – City and County of San Francisco
2. Indian Health Center of Santa Clara Valley – Santa Clara County
3. Indian Health Council, Inc. – San Diego County
4. Native American Health Center – Alameda County
5. United American Indian Involvement, Inc. – Los Angeles County

**Five awardees were selected as there were no Capacity Building Pilot Project applications submitted and these organizations met or exceeded the minimum scoring requirements.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide a status update on the CRDP and contract awards.

2. When will the Capacity Building Pilot Project awards be announced?

3. How much is expected to be awarded for the Capacity Building Pilot Projects and Implementation Pilot Projects?