AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, FEBRUARY 25, 2019

2:30 P.M. - STATE CAPITOL ROOM 4202

ITEMS TO BE HEARD

NON-DISCUSSION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: STATE OF THE STATE'S PUBLIC HEALTH

PANEL

- **Karen Smith, M.D.,** State Public Health Officer and Director, Department of Public Health

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: OVERVIEW OF DEPARTMENT BUDGET AND MEDI-CAL ESTIMATE

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Ryan Miller**, Assistant Program Budget Manager, Department of Finance
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Ryan Woolsey,** Principal Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Senior Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 3: STRENGTHENING FISCAL ESTIMATES AND CASH FLOW MONITORING BUDGET CHANGE PROPOSAL AND MEDI-CAL DRUG REBATE FUND TRAILER BILL

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey,** Principal Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 4: AB 340 ADVISORY WORKING GROUP FINDINGS AND RECOMMENDATIONS

PANELISTS

- **John Bauters**, Director of Government Relations, Californians for Safety and Justice, and Chair of the AB 340 Advisory Working Group
- **Jennifer Kent**, Director, Department of Health Care Services

Public Comment

ISSUE 5: PROPOSITION 56 IN MEDI-CAL AND BUDGET CHANGE PROPOSAL

PANEL 1

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance

- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Senior Fiscal & Policy Analyst, Legislative Analyst's Office

PANEL 2

- **Debbie Toth,** Chief Executive Officer, Choice in Aging (ADHC/CBAS Provider)
- **Steve Horne,** President, California Medical Transportation Association
- **Michelle Nydam,** Administrator, Totally Kids Healthcare/Sun Valley (Stand-Alone, Pediatric, Subacute Facility)

PANEL 3

- **Kelli Boehm,** Legislative Advocate, California Medical Association
- **Brianna Pittman-Spencer,** Legislative Director, California Dental Association
- **Andrea San Miguel,** Policy Advocate, Planned Parenthood Affiliates of California
- **Mark Klaus,** President/CEO, Home of Guiding Hands (Intermediate Care Facility-Developmentally Disabled)

Public Comment

ITEMS TO BE HEARD

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: STATE OF THE STATE'S PUBLIC HEALTH

PANEL

- **Karen Smith, M.D.,** State Public Health Officer and Director, Department of Public Health

BACKGROUND

The Subcommittee has engaged with the Department about the Legislature's need to receive regular, up-to-date public health data on major causes of morbidity and mortality and trends associated with those health conditions. This information is critical to the Legislature's ability to make sound policy and fiscal choices that address the major causes of morbidity and mortality in California effectively. Ideally, the Subcommittee would like the Department to provide this information, in the form of a public presentation to the Subcommittee and in a written report, on an annual basis. This "State of the State's Public Health" would provide 3-5 year incidence, prevalence and trend analysis on key causes of illness, injury and death, such as the following (as examples):

- What are the rates of sexually transmitted diseases and what are the trends?
- How many cases of hepatitis A and how many deaths from hepatitis A have there been each year for the past 5 years?
- How many children drown and in what types of situations (i.e., backyard pools? ocean?)?
- How many people die of cancer and what are the leading types of cancer deaths, by age, gender, race, etc.?
- How many people die from heart disease?
- What are the vaccination rates and trends?
- How many people die from gun violence in California?

To this end, the 2018 Budget Act includes the following Supplemental Report Language (SRL):

ITEM 4265-001-0001—DEPARTMENT OF PUBLIC HEALTH

1. ***State of the State's Public Health.*** At its first budget subcommittee hearings of the 2019-20 budget process, the Department of Public Health shall report to the health and human services budget subcommittees of both houses of the Legislature a summary of key public health statistics in California. The briefing and related handout shall include excerpted information from the County Health Status Profiles report on key public health indicators, including available information about these indicators' trends, for issues that the Department considers major existing or emerging public health issues. The briefing

and related handout may, for example, provide statistics on issues such as opioid overdoses and naloxone treatments, the number of people infected with sexually transmitted diseases (STDs) and the geographic regions in which STD transmissions are highest, rates of diabetes and/or other chronic diseases among various subpopulations, or recent public health outbreaks.

This item in the agenda is for the purpose of the Department of Public Health providing the report requested above to the Subcommittee.

STAFF COMMENT AND QUESTIONS

What resources would the department need to provide annual oral and written reports to the legislature on the most up-to-date statistics on leading public health issues and concerns?

Staff Recommendation: Subcommittee staff recommends no action at this time as this is an informational item, but also recommends that the Legislature consider the value of providing resources to the department in order to institutionalize annual written and oral reports on key public health data.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: OVERVIEW OF DEPARTMENT BUDGET AND MEDI-CAL ESTIMATE

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Ryan Miller**, Assistant Program Budget Manager, Department of Finance
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- **Ryan Woolsey,** Principal Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson,** Senior Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED DHCS BUDGET

Department of Health Care Services (DHCS) Budget

For 2019-20, the Governor's budget proposes $104.2 billion for the support of DHCS programs (primarily Medi-Cal). Of this amount, approximately $744.1 million is budgeted for State Operations, while the remaining is for Local Assistance. The proposed budget reflects nearly a 2.1 percent ($2.1 billion) increase from the revised current year budget. The vast majority of DHCS's budget is for the Medi-Cal Program, for which the January budget proposes $100.7 billion ($22.9 billion General Fund). Given the size of the Medi-Cal program, the significant changes in the budget occur within the Medi-Cal estimate which is described in more detail below.

DEPARTMENT OF HEALTH CARE SERVICES (Dollars in Billions)					
Fund Source	**2017-18 Actual**	**2018-19 Revised**	**2019-20 Proposed**	**CYR to BY Change**	**% Change**
General Fund	**$20.4**	**$21.2**	**$23.4**	**$2.2**	**10.4%**
Federal Fund	$56.8	$63.7	$66.2	$2.5	3.9%
Special Funds/ Reimburse-ments	$15.9	$17.2	$14.6	-$2.6	-15.1%
Total Expenditures	**$93.1**	**$102.1**	**$104.2**	**$2.1**	**2.1%**
Positions	3,502.9	3,434.5	3,557.8	123.3	3.6%

BACKGROUND

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

- ***Medi-Cal.*** The Medi-Cal program is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 13.5 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, low-income people with specific diseases, and childless adults up to 138 percent of the federal poverty level.

- ***Children's Medical Services (CMS).*** CMS coordinates and directs the delivery of health services to low-income and seriously ill children and adults with specific genetic diseases; its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Newborn Hearing Screening Program.

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations through the following programs: Indian Health Program; Rural Health Services Development Program; Seasonal Agricultural and Migratory Workers Program; State Office of Rural Health; Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program; Small Rural Hospital Improvement Program; and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services***. DHCS oversees the delivery of community mental health and substance use disorder services.

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

MEDI-CAL ESTIMATE

Proposed local assistance funding for the Medi-Cal program is summarized in the table below and includes total funds of $100.7 billion ($22.9 billion General Fund). The proposed 2019-20 Medi-Cal local assistance budget is approximately 2.2 percent more than the estimated 2018-19 budget. Of significance is the significant decrease in current year General Fund from $23 billion in the 2018 Budget Act to $20.7 billion in the November estimate, as well as the 10.6 percent increase in General Fund from $20.7 billion in the current year estimate to $22 billion in the proposed 2019-20 budget. These significant swings in General Fund largely reflect: 1) the Administration's decision to not include a proposal to extend the Managed Care Organization (MCO) tax; and 2) the various complexities in estimating the Medi-Cal budget that are discussed in detail in the next item in this agenda.

Medi-Cal Funding Summary *(Dollars In Millions)*	2018-19 Budget	2018-19 Revised	2019-20 Proposed	CYR to BY $ Change	CY to BY % Change
General Fund	**$22,965.0**	**$20,679.3**	**$22,877.0**	**$2,197.7**	**10.6%**
Federal Funds	$67,298.9	$62,741.8	$65,359.4	$2,617.6	4.2%
Other Funds	$14,138.6	$15,084.7	$12,463.5	($2,621.2)	-17.4%
Total Local Assistance	**$104,402.4**	**$98,506.0**	**$100,699.9**	**$2,193.9**	**2.2%**
Medical Care Services	$99,506.8	$93,531.6	$96,027.5	$2,495.9	2.7%
County/Other Administration	$4,567.3	$4,606.6	$4,321.5	($285.1)	-6.2%
Fiscal Intermediary	$328.3	$367.7	$350.9	($16.8)	-4.6%

BACKGROUND

The Medi-Cal Program

Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 53-year-old joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, people with disabilities, and childless adults. Each state has discretion to structure benefits, eligibility, service delivery, and payment rates within requirements of federal law. State Medicaid spending is "matched" by the federal government, historically at a rate averaging about 57 percent for California, based largely on average per capita income in the State. California uses a combination of state and county funds augmented by a small amount of private provider tax funds as the state match for the federal funds.

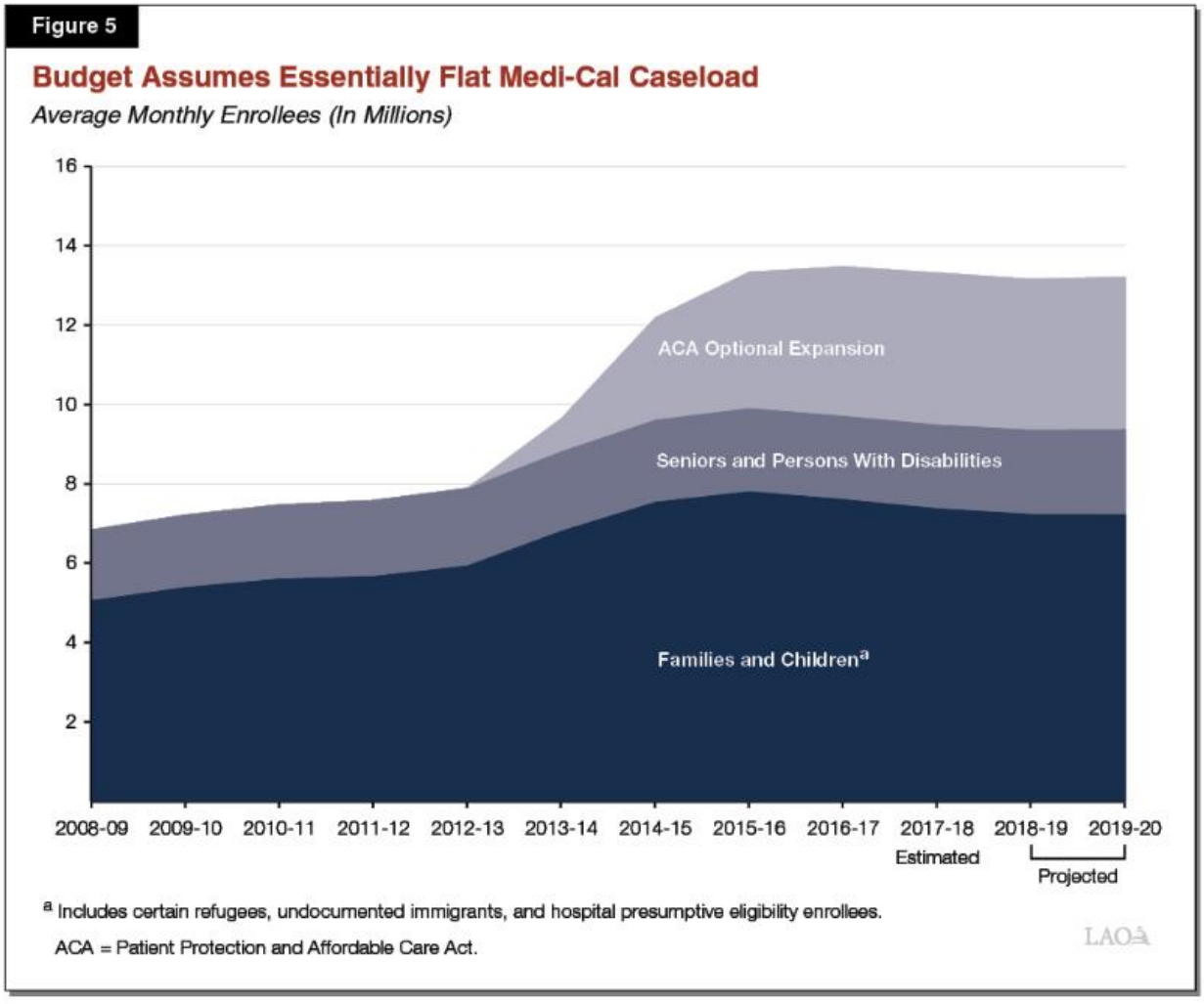
Medicaid is the single largest health care program in the United States. Approximately 37 percent of Californians are enrolled in Medi-Cal. The federal Affordable Care Act (ACA) brought the expansion of Medicaid coverage to non-elderly Americans and legal immigrants who have been in the United States at least five years and who have incomes below 138 percent of the Federal Poverty Level.

Medi-Cal Caseload

The Medi-Cal estimate assumes caseload to be approximately 13.2 million average monthly enrollees in 2019-20, as in the prior two years, reflecting the stabilization of the caseload followed by a slight, slow decline since 2016. DHCS states that the caseload decline reflects lower unemployment and a recovering economy.

	2017-18	2018-19	2019-20	CY to BY Change	CY to BY % Change
Medi-Cal Caseload	13,326,600	13,168,300	13,220,100	51,800	0.4%

The Legislative Analyst provided the following caseload chart in their *2019-20 Analysis of the Medi-Cal Budget*:



Significant Medi-Cal Estimate Adjustments

The most significant adjustments to the November 2018 Medi-Cal estimate include the following:

Current-Year (2018-19) Adjustments:

Savings of $2.3 billion General Fund as a result of the following:

- Successful resolution of federal CMS deferrals and a lower amount of projected deferrals (-$418 million)

- Long-Term Care Quality Assurance Fund offsets to the General Fund increase due to transfers of prior year withholds from providers who did not pay the fee (-$307 million)

- Hospital Quality Assurance Fee payments for children's health care increased due to a prior year adjustment and changes in timing (-$428 million)

- Drug Rebate projections increased based upon more recent data and drug rebate timing shifts (-$390 million)

- Base managed care projections decreased primarily because of reduced eligible projections (-$248 million)

Budget-Year (2019-20) Changes:

- Full-Scope Medi-Cal Expansion to Undocumented Young Adults ($194 million General Fund)

- Proposition 56 proposals ($1.05 billion in Proposition 56 funds)

- Whole Person Care Housing Services proposal ($100 million General Fund)

- No proposal to extend the Managed Care Organization (MCO) tax ($1.1 billion General Fund)

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the Medi-Cal estimate, highlighting the major policy and fiscal proposals and changes proposed for 2018-19 and 2019-20, and respond to the following:

1. For what reasons has the Administration not proposed to extend the MCO tax?

2. Does the Administration believe that the slight downturn in caseload not only reflects a stronger economy but also reflects a chilling effect of the recently-proposed changes to the Public Charge rule?

Staff Recommendation: Subcommittee staff recommends no action at this time.

ISSUE 3: STRENGTHENING FISCAL ESTIMATES AND CASH FLOW MONITORING BUDGET CHANGE PROPOSAL AND MEDI-CAL DRUG REBATE FUND TRAILER BILL

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey,** Principal Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

BACKGROUND

The Department's budget makes up a significant portion of the state's annual General Fund expenditures. In 2019-20, the Medi-Cal budget is estimated to be $100.7 billion ($22.9 billion General Fund). The Medi-Cal budget is on a cash basis, rather than an accrual basis, of accounting. This means that the timing of transactions can significantly disrupt fiscal year budgetary estimates. Accurate projections and cash management are critical to avoid interruptions in provider payments and services to the approximately 13.3 million Medi-Cal beneficiaries. Currently, DHCS' fiscal functions are performed by the Administration Division's Financial Management Branch (Budgets and Accounting functions) and the Fiscal Forecasting Division (FFD) (Medi-Cal and Family Health Estimates).

Welfare and Institutions Code (WIC) section 14100.5 requires DHCS to submit an Estimate of Medi-Cal expenditures twice a year - in November for the Governor's Budget, and in April for the May Revision. At the same time, DHCS prepares a twice-yearly Family Health Estimate for several non-federal programs. These two Estimates are highly detailed and forecast expenditures, caseload, and the impact of regulatory and state and federal policy changes in these programs. The Estimates include base program estimates, plus over 300 Policy Changes (PCs) that itemize specific programs or changes to the base. The Estimates are subject to the analysis of the Department of Finance, the Legislative Analyst's Office, the Legislature, and other stakeholders. FFD is the primary division responsible for preparing the Estimates, based on input from all other DHCS divisions.

During spring 2017 and spring 2018, DHCS found variances in excess of $500 million General Fund between the Estimates and actual expenditures. Monthly General Fund cash flow projections significantly fluctuated for FYs 2016-17 and 2017-18. DHCS, in partnership with Finance, initiated a comprehensive, ongoing effort to identify the major programs and factors contributing to the fluctuations in cash flow and Medi-Cal Estimate variances, and the solutions and associated resources needed to improve the accuracy of the Estimates and implement a monthly cash reconciliation process.

The four program areas that are the primary drivers for major swings in the Estimate and cash reconciliation are:

1. Managed care capitation payments, which are developed and executed by CRDD, MCOD, OHC, and Accounting;

2. Supplemental payments (e.g., payments based upon Quality Assurance Fees), which are administered through several different DHCS programs/divisions, including CRDD, MCOD, OHC, Safety Net Financing Division, and TPLRD;

3. Drug rebates, which is managed by PBD for program policy development and administered collaboratively by PBD, Accounting, OHC, and the California Medicaid Management Information System (CA-MMIS) Division; and

4. Transfers and reimbursements from other state departments and funds, which are monitored and captured by FFD and the ADM Accounting Section.

In recent years, several new challenges have emerged in managing the Medi-Cal Estimates and associated budget items (the Medi-Cal budget) each year:

- The increased size of the Medi-Cal budget, due to the Affordable Care Act (ACA) Medicaid expansion, and increased use of Intergovernmental Transfers (IGTs), has increased the magnitude of current year adjustments. In Fiscal Year (FY) 2011-12 the Medi-Cal local assistance expenditures were estimated at $47 billion. The budget for FY 2019-20 is an estimated $100.7 billion. While the budget has more than doubled, there have been only minimal increases in staffing resources.

- The increase in IGTs and supplemental payments, as well as enhanced federal funds under the ACA, have resulted in increased complexity for accounting transactions and cash management, as well as more complex policy changes in the Medi-Cal budget.

- DHCS is dependent on external entities for a large volume of incoming funds such as IGT receipts, drug rebates, and managed care repayments, and DHCS does not control the timing of those receipts. Further, external entities also drive changes in timing for the implementation of policies, such as federal approvals of payment rates, contracts, information technology planning documents and enhanced federal funding requests, State Plan Amendments, and waivers.

- The shift to managed care as the primary Medi-Cal delivery system, with payments to managed care plans instead of Fee-for-Service (FFS) providers, results in significantly more funding concentrated in relatively fewer payments. In FY 2011-12, managed care was 26% of total expenditures and grew to 48% for FY 2018-19. Adjustments in managed care payment schedules, due to policy changes or operational needs, can result in large changes in current year expenditures. In addition, managed care encounter data is less robust than FFS, which adds uncertainty to the estimate process. Further, the methodologies for making certain payments to managed care plans, as well as supplemental payments, are often based on multi-year or other time periods that do not easily align to state fiscal years or semi-annual Estimate processes. Finally, managed care encounter data is more complex to reconcile for drug rebate reporting and accounting purposes, than fee-for-service pharmacy claims data.

- As Medicaid programs across the U.S. have increased participation in managed care models, the federal Centers for Medicare and Medicaid Services (CMS) has implemented a more complicated Medicaid rate review process. This process requires increased development and review time at the state and federal level and as a result, managed care rate packages may need to be implemented retroactively by several months or longer. These retroactive rate adjustments increase the complexity and uncertainty of budgeting/estimates and cash management for DHCS.

- Adding to the complexity, several other state departments and programs—such as In-Home Supportive Services, the Home and Community-Based Services Waiver for the Developmentally Disabled, and the Multipurpose Senior Services Program - affect the Medi-Cal budget, because they receive federal Medicaid funding through DHCS. DHCS must coordinate Medi-Cal budget amounts with the California Department of Social Services, the Department of Developmental Services, the Department of Aging, the California Department of Public Health, and the Office of Systems Integration, all of which rely on federal Medicaid funds through DHCS.

- Beginning in FY 2004-05, the Medi-Cal program has been budgeted on a cash basis, rather than an accrual basis like most state programs. While a cash accounting basis aligns with federal reporting, it causes complexity in managing year-end resources and budgeting for programs in other state departments that rely on federal Medicaid funding.

DHCS states that the proposed Budget Change Proposal and Trailer Bill (both described below) will address short-term workload to improve the quality of Medi-Cal fiscal planning and management. DHCS states that it is continuing to assess long-term solutions to redesign the Medi-Cal Estimate and increase responsiveness to ad hoc data and budget requests, using the most efficient approaches and systems.

Fiscal Estimates Budget Change Proposal:
DHCS requests 25.0 permanent positions and expenditure authority of $3,812,000 ($1,814,000 General Fund (GF); $1,998,000 Federal Fund (FF)) for fiscal year (FY) 2019-20 and $3,587,000 ($1,706,000 GF; $1,881,000 FF) for FY 2020-21 and ongoing to improve: 1) the Medi-Cal Local Assistance and Family Health Estimates; and 2) oversight and monitoring of cash flow. The additional staff will enhance monitoring of actual expenditures versus estimated expenditures, and use that information to provide more accurate projections of Medi-Cal expenditures.

Medi-Cal Drug Rebate Fund Trailer Bill Proposal:
DHCS proposes to establish a special fund for drug rebates to manage the impact on the GF when drug rebates are received and/or funding adjustments are calculated. GF offsets now occur when the rebates are received. Instead, the special fund would allow for a specific amount to be budgeted and transferred to offset GF expenditures. If additional rebates are received, the Department would be able to validate the rebates and have increased flexibility on the timing of the impact to the General Fund. As such, this proposal would reduce volatility in Medi-Cal GF spending. Specifically, this proposal would:

- Create the Medi-Cal Drug Rebate Fund in the State Treasury to hold the state share of federal and state supplemental drug rebates collected by DHCS, including all interest and dividends earned.
- Continuously appropriate the funds, without regard to fiscal year.
- Use the funds specifically for purposes of providing ongoing support towards health care services for beneficiaries in the Medi-Cal program.
- Authorize the State Controller to use the funds for cash flow loans to the GF, as specified.

Currently, when drug manufacturers provide rebates to DHCS, the rebates immediately offset the state General Fund (GF) and federal fund expenditures as they are received. However, there have been considerable variations in the amounts of rebates budgeted and received. The Rebate Accounting Information System (RAIS) determines the rebate amounts and identifies the appropriate funding split for the payments received. When rebates are first received, the funding split between the General Fund and the Federal Trust Fund is unknown. Accordingly, the initial funding is credited back at 50 percent GF and 50 percent Federal Trust Fund until the corrected adjustments are calculated by RAIS. The timing of these later adjustments have varied, and has shifted from one fiscal year to another. For example, funding adjustments in Fiscal Year 2016-2017 and Fiscal Year 2017-2018 were required due to changes in the RAIS to incorporate higher Federal Medical Assistance Percentage for the Affordable Care Act Optional Expansion pharmacy expenditures. This resulted in additional payments to the federal government and significant impact to the General Fund. Due to the uncertainty of when drug rebates are received and adjusted, fiscal management can be a challenge.

Legislative Analyst's Office Concerns and Recommendations
The LAO is supportive of both of the Administration's proposals (the Budget Change Proposal and trailer bill) to address the complexities of the Medi-Cal fiscal estimate, but also recommends the Administration prioritize increasing transparency for the Legislature and other external stakeholders. The LAO states: "There are many changes related to the presentation of Medi-Cal estimates and the availability of public information about

program operations that would increase the transparency of the Medi-Cal budget and allow for greater oversight by outside stakeholders." The LAO makes the following recommendations:

1. Approve of the requested resources (BCP) and the creation of the Drug Rebate Special Fund (trailer bill).

2. Require DHCS to share key information gained from improved monitoring with the Legislature, via regular updates on cash flows that compare actual spending to estimated budget amounts.

3. Require DHCS to report to the Legislature with a plan for longer-term structural and systems changes to promote sound estimates and budget transparency, focusing on IT system modernizations, the implications of moving Medi-Cal back to an accrual budget, and the use of special funds or reserves to smooth unanticipated fiscal swings in Medi-Cal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the complexity of the Medi-Cal estimate process and the causes of recent unanticipated sizable adjustments. The Subcommittee also requests DHCS to present the Budget Change Proposal and trailer bill, and respond to the following:

1. Does the Administration believe that it is possible to prevent significant unanticipated fiscal swings in the Medi-Cal budget?

2. Will approval of these two proposals ensure that there will not be $1-3 billion mid-year adjustments in the Medi-Cal budget?

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 4: AB 340 ADVISORY WORKING GROUP FINDINGS AND RECOMMENDATIONS

PANELISTS

- **John Bauters**, Director of Government Relations, Californians for Safety and Justice, and Chair of the AB 340 Advisory Working Group

- **Jennifer Kent**, Director, Department of Health Care Services

Public Comment

BACKGROUND

AB 340 (Arambula, Chapter 700, Statutes of 2017) requires DHCS, in consultation with the California Department of Social Services (CDSS) and others, to convene, by May 1, 2018, an advisory working group to update, amend, or develop, if appropriate, tools and protocols for screening children for trauma, as defined, within the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. AB 340 requires the working group to report its findings and recommendations to DHCS and to the Legislative Budget Subcommittees on health and human services no later than May 1, 2019.

The purpose of this item on the agenda is for the advisory working group to report its findings recommendations, as required by AB 340. The advisory working group recommends that Medi-Cal providers be given the following three options for screening pediatric populations (children and youth under the age of 21) for exposure to trauma:

1. Utilize the Bay Area Research Consortium on Toxic Stress and Health (BARC) screening tool, called PEARLS, alongside the existing state-required Staying Healthy Assessment (SHA), Bright Futures, or another state-approved Individual Health Education Behavior Assessment (IHEBA) to improve screening for trauma in children, and examine formal integration of this tool within the SHA.

2. Use the Whole Child Assessment (WCA), an existing state-approved IHEBA that incorporates screening for exposure to trauma along with required elements of the SHA.

3. Request approval from DHCS to use an alternative tool to screen for trauma that includes, at a minimum, all of the items contained in the PEARLS tool.

The workgroup proposes a two-step process for improving trauma screenings:

1. First, DHCS include the PEARLS tool as a complementary screening component along with the existing SHA, Bright Futures, or another approved IHEBA to improve trauma-screening practices immediately.

2. Second, DHCS explore if the SHA should be amended to incorporate the PEARLS tool questions into a single assessment tool.

The working group also recommends:

- If the PEARLS tool is incorporated into the SHA, any future version of the SHA include trauma-screening questions that have been evaluated for both biometric and psychometric properties.

- DHCS consider compliance monitoring through the use of a designated CPT code, coupled with provider training.

- To the extend the Whole Child Assessment remains an approved IHEBA, DHCS retain it as an available option for providers to use as an alternative to SHA + PEARLS.

Finally, the working group encourages the Legislature to explore systems that support trauma screening for adults in the future.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the panel to report on the findings and recommendations of the advisory working group and describe how these recommendations might guide the use of the funding for trauma screening included in the Governor's budget.

Staff Recommendation: Subcommittee staff recommends no action at this time as this is an informational item.

ISSUE 5: PROPOSITION 56 IN MEDI-CAL AND BUDGET CHANGE PROPOSAL

PANEL 1

The Subcommittee would like Panel 1 to present the Governor's budget proposals related to expenditures of Proposition 56 funds in Medi-Cal and health care programs, and to provide reflections on the impact thus far of Proposition 56 on access to, and quality of, health care. The Subcommittee also asks the LAO to provide a summary of its analysis of the Proposition 56 budget.

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Senior Fiscal & Policy Analyst, Legislative Analyst's Office

PANEL 2

Panel 2 consists of representatives of three types of Medi-Cal providers that have not received Proposition 56 supplemental payments (with the exception of $4 million one-time included in the 2018 budget for stand-alone, pediatric, sub-acute facilities), nor have they received relief from rate cuts in prior years or received rate increases in many years. The Subcommittee would like to hear about their experiences being providers with their current reimbursement rates, their knowledge of challenges for Medi-Cal beneficiaries to access these services, and rate proposals they are submitting this year.

- **Debbie Toth,** Chief Executive Officer, Choice in Aging (ADHC/CBAS Provider)
- **Steve Horne,** President, California Medical Transportation Association
- **Michelle Nydam,** Administrator, Totally Kids Healthcare/Sun Valley (Stand-Alone, Pediatric, Sub-acute Facility)

PANEL 3

The Subcommittee has asked the panelists on Panel 3 to share the experiences thus far of providers who have received Proposition 56 supplemental payments, their knowledge or impressions of the impact that Proposition 56 has had on access to care and quality of

care, and finally to share any proposals they have related to Proposition 56 expenditures in the 2019 budget.

- **Kelli Boehm,** Legislative Advocate, California Medical Association
- **Brianna Pittman-Spencer,** Legislative Director, California Dental Association
- **Andrea San Miguel,** Policy Advocate, Planned Parenthood Affiliates of California
- **Mark Klaus,** President/CEO, Home of Guiding Hands (Intermediate Care Facility-Developmentally Disabled)

Public Comment

PROPOSITION 56

Background

The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56), passed by the voters in November 2016, increased the excise tax rate on cigarettes and electronic cigarettes effective April 1, 2017, and other tobacco products effective July 1, 2017. Proposition 56 revenue is apportioned to several different state agencies, including to DHCS. The 2017 budget included $964 million in Proposition 56 funds for a combination of supplemental payments to Medi-Cal providers and an offset to General Fund spending on cost growth in Medi-Cal. The 2018 budget includes $1.3 billion for supplemental payments, Medi-Cal cost growth and provider educational loan repayments.

2019 Governor's Budget

The Governor's budget includes the following Proposition 56 proposals:

1. Makes most provider supplemental payments permanent and ongoing.
2. Eliminates the use of Proposition 56 as a General Fund offset for Medi-Cal cost growth ($218 million in 2018-19).
3. Extends $50 million in Proposition 56 supplemental payments to Medi-Cal family planning services, totaling $500 million given the 9-1 federal state matching payments.
4. Provides $30 million in Proposition 56 funds to incentivize the application of developmental screening of young children by physicians.
5. Provides $23 million in Proposition 56 funds for trauma screening of children and adults in Medi-Cal.
6. Creates a "Value-Based Payment Initiative" (VBP) and funds it with $180 million in Proposition 56 funds. The budget also proposes new state resources for DHCS to implement this VBP which are described below under "Budget Change Proposal."

The VBP is intended to provide incentive payments for managed care plans and their network physicians to reward those that meet predetermined performance benchmarks, i.e., to increase the quality of care on specified high-cost, high-prevalence types of medical care such as chronic disease management and behavioral health integration.

Proposition 56 Budget Change Proposal

DHCS requests 18.0 permanent positions and expenditure authority of $3,000,000 ($1,500,000 Healthcare Treatment Fund (HTF); $1,500,000 Federal Fund (FF)) for fiscal year (FY) 2019-20 and ongoing to support the implementation of the new Value-Based Payments (VBP) initiative. The positions will serve in four different divisions within DHCS and each position will address specified functions of the VBP initiative. The positions are grouped by division as follows:

Division	Requested positions
Managed Care Quality Monitoring Division (MCQMD)—8.0 positions	1.0 Staff Services Manager (SSM) III 4.0 Health Program Specialist (HPS) II 2.0 HPS I 1.0 Office Services Supervisor (OSS) I
Information Management Division (IMD)—2.0 positions	1.0 SSM II 1.0 HPS I
Capitated Rates Development Division (CRDD)—6.0 positions	1.0 SSM I 1.0 HPS I 4.0 Associate Governmental Program Analyst (AGPA)
Managed Care Operations Divisions (MCOD)—2.0 positions	1.0 HPS I 1.0 AGPA

The Governor's Budget proposes to use Proposition 56 funds to create directed payment programs that Medi-Cal managed care health plans (MCPs) would be required to implement to provide VBP payments to providers who meet necessary criteria. DHCS proposes to implement programs to incentivize providers to improve care for some of the State's most vulnerable residents. The Department intends to propose trailer bill language and the Governor's budget includes $360 million ($180 million Health Care Treatment Fund) for a program that encourages Medi-Cal managed care providers to meet certain goals in critical areas, such as 1) prenatal and postpartum care; 2) chronic disease management; and 3) behavioral health provider integration. Further program specifics will be outlined in the trailer bill legislation.

DHCS explains that the VBP initiative would implement a system that incentivizes the highest quality and most efficient providers. This is expected to lead to Medi-Cal beneficiaries being treated in a system that puts patients first and maximizes the impact of preventative care. DHCS' Strategic Plan includes the commitment to "hold ourselves and our providers, plans, and partners accountable for performance" and to be "prudent, responsible fiscal stewards of public resources."

LAO Concerns and Recommendations

The LAO raises a few concerns with the Governor's Proposition 56 proposals, as follows:

1. Proposed funding levels for provider payments may not be sustainable on an ongoing basis in light of the following: 1) tobacco tax revenue is a declining revenue source; and 2) scheduled changes in the federal share of cost for certain populations will increase the state's share of cost for Medi-Cal. The LAO projects annual shortfalls in Proposition 56 revenue.

2. Making Proposition 56 supplemental payments on a limited-term basis would provide more opportunity to assess their impact. The LAO points out that no analysis or evaluation has been done showing if Proposition 56 payments have been effective in increasing access to, or quality of, health care.

3. Additional detail is needed for the Legislature to assess the administration's new proposed supplemental payment programs.

Stakeholder Proposals

California Medical Association (CMA): The CMA is requesting the following modifications to the Governor's proposed Proposition 56 budget:

1. Make the supplemental payments permanent base rate increases.

2. Add four preventive visit codes for women over 40 years of age (CPT 99386, 99387, 99396, and 99397).

3. If new payment programs do not receive federal approvals in time to be implemented in the budget year, shift the funds proposed for these programs to the provider loan repayment program created and funded last year for an additional year of funding.

4. Provide quarterly bonuses to hospital-based physicians when the threshold of Medi-Cal visits in that quarter exceeds a certain percentage, to be designed by DHCS with stakeholder input.

5. Allow DHCS, through trailer bill, to reassign/reassess codes affected by a code collapse proposed by the federal Center for Medicare and Medicaid Services (CMS) without triggering an access study.

California Dental Association (CDA): The CDA requests making the supplemental payments permanent base rate increases.

Sun Valley Specialty Healthcare: Sun Valley requests a rate increase and an updated, sustainable rate setting model and methodology for the four stand-alone pediatric sub-acute facilities.

California Medical Transportation Association (CMTA): The CMTA requests repeal of the 10 percent rate cut implemented through AB 97 (2011 budget trailer bill) for non-emergency medical transportation providers.

California Association for Adult Day Services (CAADS): CAADS requests elimination of the ten percent rate cut adopted by AB 97 (2011 budget trailer bill) and requests adoption of a 15 percent COLA for CBAS programs.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the three panels to present the information requested above and requests the administration to provide reactions to the information provided by the other two panels.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate on these administration and stakeholder proposals.

NON-DISCUSSION ITEMS

The Subcommittee does not plan to have a presentation of the items in this section of the agenda, unless a Member of the Subcommittee requests that an item be heard. Nevertheless, the Subcommittee will ask for public comment on these items.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 6: FAMILY HEALTH ESTIMATE

GENETICALLY HANDICAPPED PERSONS PROGRAM ESTIMATE

PROPOSAL

The proposed 2019-20 Genetically Handicapped Persons Program (GHPP) budget includes total funds of $126.9 million ($118.1 million General Fund), compared to the 2018-19 estimate of $123.7 million ($112.3 million General Fund). The $5.8 million General Fund increase from 2018-19 to 2019-20 is a result of a delay in processing GHPP enrollment applications that resulted in a temporary backlog of enrollment determinations, according to DHCS. The Administration states that the pending determinations have since been resolved, resulting in an increase in enrollment. The estimate shows no change in caseload from current year to budget year, at 780 individuals.

Genetically Handicapped Persons Program State-Only Estimate			
	2018-19 Estimate	2019-20 Proposed	CY to BY Change
General Fund	$112,314,600	$118,145,700	$5,831,100 (5.2%)
Enrollment Fees	$462,300	$462,300	$0
Rebates Special Fund	$11,000,000	$8,300,000	($2,700,000) (-24.5%)
TOTAL FUNDS	**$123,776,900**	**$126,908,000**	**$3,131,100 (2.5%)**

BACKGROUND

The goal of the GHPP program is to help individuals ages 21 and older with an eligible inherited condition achieve the highest level of health and functioning through early identification and enrollment into GHPP, prevention and treatment services from highly-skilled Specialty Care Center teams, and ongoing care in the home community provided by qualified physicians and other health team members. Hemophilia was the first medical condition covered by the GHPP and legislation over the years have added other medical conditions including Cystic Fibrosis, Sickle Cell Disease, Phenylketonuria, and Huntington's disease. The last genetic condition added to the GHPP was Von Hippel-Lindau Disease. Unlike other programs, GHPP covers services even when they are not directly related to the treatment of the GHPP eligible medical condition; the approval of these services is subject to individual review based on medical need. There is no income limit for GHPP, however, GHPP clients may be required to pay an annual enrollment fee based on the client's adjusted gross income.

CHILD HEALTH AND DISABILITY STATE-ONLY PROGRAM

PROPOSAL

The estimate for the Child Health and Disability Program (CHDP) (non-Medi-Cal, state-only funding) includes $0 General Fund for 2019-20, reflecting the move of minimal funding to the Medi-Cal estimate.

BACKGROUND

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

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

Caseload and expenditures have been close to eliminated as a result of the expansion of eligibility for full-scope Medi-Cal services to individuals under the age of 19, regardless of immigration status, that began in May 2016, pursuant to the provisions of SB 75 (Committee on Budget and Fiscal Review, Chapter 18, Statutes of 2015). Nearly all children who only had emergency Medi-Cal prior to the implementation of SB 75 now have full scope Medi-Cal, including the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. As such, DHCS states that CHDP state-only services are no longer needed as these services are now provided by Medi-Cal under the EPSDT benefit.

Caseload

The following table shows the dramatic decrease in utilization (caseload) over the past several years primarily reflecting implementation of the Affordable Care Act and SB 75:

.	TOTAL NUMBER OF CHDP SCREENS
2013-14	22,927
2014-15	15,923
2015-16	5,937
2016-17	494
2017-18	36
2018-19	22
2019-20	0

EVERY WOMAN COUNTS PROGRAM ESTIMATE

PROPOSAL

The proposed 2019-20 budget includes $44.4 million total funds ($16.7 million General Fund) for EWC, an $11.1 million (34%) increase from the 2018 Budget Act. As shown below, most of the funding for EWC is tobacco tax revenue. The $11 million increase reflects an increase in users (i.e., caseload), according to DHCS.

Every Woman Counts Estimate
(*Dollars in Millions*)

Funding	2018-19 Budget	2018-19 Estimate	2019-20 Proposed	CYB to BY Change
General Fund	$5.6	$16.1	$16.7	$11.1 (198%)
Proposition 99	$14.5	$14.5	$14.5	$0 (0%)
Breast Cancer Control Account	$8.0	$8.0	$8.0	$0 (0%)
Federal (CDC) Funds	$5.1	$5.1	$5.1	$0 (0%)
TOTAL FUNDS	**$33.2**	**$43.7**	**$44.4**	**$11.1 (34%)**

BACKGROUND

EWC provides breast and cervical cancer screenings to Californians who do not qualify for Medi-Cal or other comprehensive coverage, and is funded through a combination of tobacco tax revenue, General Fund, and federal Centers for Disease Control (CDC) grant. The CDC grant requires the program to monitor the quality of screening procedures, and therefore the program collects recipient enrollment and outcome data from enrolled primary care providers through a web-based data portal. This recipient data is then reported to CDC biannually and assessed for outcomes to determine if outcomes meet performance indicators, such as the number of women rarely or never screened for cervical cancer and length of time from screening to diagnosis to treatment. EWC was transferred to DHCS from the Department of Public Health in 2012.

EWC provides breast cancer screening and diagnostic services to California's uninsured and underinsured women age 40 and older whose incomes are at or below 200 percent of the Federal Poverty Level (FPL). Women age 21 and older may receive cervical cancer screening and diagnostic services. EWC also provides outreach and health education services to recruit and improve cancer screening and early cancer detection in underserved populations of African-American, Asian-Pacific Islander, American Indian, older, and rural women. EWC covered benefits and categories of service include office visits, screening, diagnostic mammograms, and diagnostic breast procedures, such as ultrasound, fine needle and core biopsy, pap test and HPV co-testing, colposcopy and other cervical cancer diagnostic procedures and case management.

EWC also serves as one of the main gateways for enrollment into the Breast and Cervical Cancer Treatment Program (BCCTP). BCCTP provides cancer treatment and services for eligible California residents diagnosed with breast and/or cervical cancer. BCCTP applicants are required to be screened and enrolled by CDC providers authorized to participate in EWC. State law allows non-EWC providers, such as non-Medi-Cal providers, to diagnose cancer and make referrals to an enrolled EWC provider for the purpose of enrollment into BCCTP. This process is known as a "courtesy enrollment." The individual seeking cancer treatment through BCCTP must provide the pathology/biopsy report to an EWC provider to confirm diagnosis and request enrollment into BCCTP.

Caseload

The following table shows the caseload estimates for the past several years. The dramatic decrease reflects the increase in comprehensive health care coverage resulting from implementation of the Affordable Care Act:

YEAR	EWC Caseload
2013-14	292,914
2014-15	275,219
2015-16	161,000
2016-17	25,030
2017-18	26,820
2018-19	26,963
2019-20	26,963

CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM ESTIMATE

PROPOSAL

Excluding Medi-Cal costs, the proposed 2019-20 CCS budget includes total funds of $85.7 million ($80.3 million General Fund), as compared to the current year (2018-19) estimate of $83.8 million total funds ($78.4 million General Fund).

CCS Budget
(Non-Medi-Cal)

	2018-19 Estimate	2019-20 Proposed	CY to BY Change
General Fund	$78,356,200	$80,318,000	$1,961,800 (2.5%)
Federal Fund	$5,453,000	$5,453,000	$0
TOTAL FUNDS	**$83,809,200**	**$85,771,000**	**$1,961,800 (2.3%)**

BACKGROUND

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

Historically, the CCS program has served children who fit into three categories: 1) children in Medi-Cal; 2) Children in Healthy Families; and 3) "State-only" children who are not eligible for either Healthy Families or Medi-Cal. The Family Health Estimate includes CCS costs only for children who are not in Medi-Cal. The largest category of children in CCS are in Medi-Cal, however these costs are contained separately, in the Medi-Cal estimate. State-only children, who are not eligible for Medi-Cal, qualify for CCS by being in a family for which their estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

The CCS program is administered as a partnership between county health departments and DHCS. For CCS-eligible children in Medi-Cal, their care is paid for with state-federal matching Medicaid funds. The cost of care for CCS-Only children is funded equally between the State and counties. The cost of care for CCS children who had been in the Healthy Families program was, and continues to be, funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds, despite the fact that these children have transitioned into Medi-Cal.

Whole Child Model

SB 586 (Hernández, Chapter 625, Statutes of 2016) authorizes DHCS to establish a "Whole Child Model" (WCM) for children enrolled in both Medi-Cal and CCS in 21 counties served by four county organized health systems, instead of the existing arrangement in

most counties where CCS services are "carved out" from the Medi-Cal managed care plan. The bill continues the CCS carve-out in the remaining 37 counties until January 1, 2022.

The WCM is being implemented in the following 21 counties served by four COHS plans: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo.

This bill contains a number of provisions to ensure the expertise and quality of care in CCS is preserved as part of the transition to the WCM, including requirements for plan readiness, time-limited continuity of care, ensuring CCS benefits are provided according to CCS program standards; requiring Medi-Cal managed care plans to facilitate timely access to services by CCS providers and facilities with clinical expertise in treating the enrollee's specific CCS condition; requiring DHCS to pay plans participating in the WCM a new actuarially sound rate specifically for CCS children and youth; requiring a "rate floor" for CCS providers; and requiring an independent evaluation that compares CCS services in WCM counties before and after CCS services are carved into the plan, and that compares the WCM counties to other counties where CCS is not carved into the plan.

Caseload

After several years of dramatic decreases with increases in CCS-Medi-Cal reflecting the Medi-Cal expansion to cover all eligible children regardless of immigration status, adopted through SB 75 (2015 budget trailer bill), caseload is expected to be stable in the state-only CCS program, at approximately 15,000 children in both 2018-19 and 2019-20.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with the Family Health estimate at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 7: DENTAL MEDICAID MANAGEMENT INFORMATION SYSTEM CONTRACT MANAGEMENT STAFFING BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS requests the conversion of 4.0 limited-term (LT) positions to permanent positions and expenditure authority of $701,000 ($175,000 General Fund (GF)/$526,000 Federal Fund (FF)) in fiscal year (FY) 2019-20 and ongoing. The requested positions, for Medi-Cal Dental Services Division (MDSD), Enterprise Innovation and Technology Services (EITS), and Office of Legal Services (OLS), will continue to support ongoing workload associated with the transition from one Fiscal Intermediary (FI) contract to two separate contracts, an FI and an Administrative Service Organization (ASO) contract. DHCS states that the two contracts are needed to support ongoing workload in policy and system initiatives.

BACKGROUND

In 2011, Delta Dental was 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 Centers 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 Medicaid Management Information System (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 federal financial participation (FFP) enhanced funding for MMIS activities. In order to address CMS' concerns and with DHCS currently evaluating alternatives for the eventual migration to a single MMIS, DHCS released two competitive Request For Proposals (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 California Dental Medicaid Management Information System (CD-MMIS).

The selected FI contractor (DXC Technology) is responsible for the turnover, operation, and takeover of the CD-MMIS. The FI operates the existing CD-MMIS 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 (Delta Dental) operates with the dental FI Contractor using the existing CD-MMIS. The ASO contractor is 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.

In 2016, a DHCS BCP authorized 4.0 LT positions for EITS, 2.0 LT positions for MDSD, and 1.0 LT position for OLS. These positions supported increased workload which included reviewing, assessing, analyzing, tracking, and reporting on the existing and additional contract requirements and related oversight of both the Fl and ASO contracts. The transition from one contract to two contracts required an unanticipated, significant increase in the processes, procedures and policies specific to and in compliance with the terms and conditions of both contracts. This essentially doubled the workload necessary to perform the required administration and oversight of the two contractors as part of MDSDs contract management responsibilities. DHCS states that this workload will not decrease over time and cannot be absorbed by other EITS, MDSD or OLS resources.

The permanent resources are needed to continue the transition of the ASO and Fl functions and complete the contract turnover-takeover process. These resources will continue to provide oversight and make certain there is collaboration between the two vendors. The management and oversight of the two separate vendors has essentially doubled the workload of the existing MDSD, EITS, and OLS staff. The Administration states that without these resources, DHCS will be unable to perform the administration and oversight needed. This could result in a loss of enhanced federal funding.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 8: CHILDHOOD LEAD POISONING PREVENTION (SB 1041) BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS, Information Management Division (IMD), requests 1.0 permanent position and expenditure authority of $144,000 ($72,000 GF; $72,000 FF) in 2019-20 and ongoing to implement the requirements of SB 1041 (Leyva, Chapter 690, Statutes of 2018). SB 1041 requires DHCS to collaborate with the California Department of Public Health (CDPH) to collect and analyze data on blood lead level (BLL) screening tests for children enrolled in Medi-Cal. The data will be used to monitor appropriate case management efforts, to advance lead testing of children enrolled in Medi-Cal, and for public reporting.

BACKGROUND

CDPH oversees the Childhood Lead Poisoning Prevention (CLPP) Program and is responsible for determining the requirements for BLL screenings, consistent with guidelines issued by the federal Centers for Disease Control and Prevention. DHCS maintains an interagency agreement (lA) with CDPH to reimburse federal financial participation (FFP) for BLL screenings and case management services for Medi-Cal FFS children with elevated BLL. CDPH contracts with counties and cities to provide BLL case management services for children who screen positive for BLL. Under this agreement, CDPH must provide BLL screenings to eligible FFS children in accordance with all state and federal requirements in order to be eligible to receive Title XIX FFP from DHCS. As part of this lA, CDPH is responsible for collecting and retaining supporting data and documentation, which is available to DHCS upon request. CDPH currently publicly reports statewide data, by county or zip code.

Medi-Cal provides BLL screening tests in accordance with American Academy of Pediatrics' Bright Futures periodicity schedule, Title 17 of the California Code of Regulations (CCR), and federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service requirements. EPSDT services offer a broader definition of medical necessity for children and allow for more comprehensive screenings and treatment services that meet and exceed standards. As a result, BLL screening tests may be provided on an inter-periodic basis whenever a practitioner determines "the existence of a suspected illness or condition or change or complication in a condition..." according to Title 22, CCR Section 51184(a)(3) and when otherwise determined medically necessary.

SB 1041 requires CDPH to amend its existing regulations to make it a goal of the state that all children at risk of lead exposure receive blood lead level screening tests. Towards this goal, SB 1041:

- Requires CDPH to collect and analyze data on blood lead level screening tests for children enrolled in Medi-Cal.

- Requires DHCS to provide CDPH with Medi-Cal eligibility data so that it can be linked with the existing data system.

- Requires CDPH to notify health care providers who perform periodic health assessments for children about:
  - The risks and effects of childhood lead exposure;
  - The blood lead testing requirements for children enrolled in Medi-Cal; and
  - The blood lead testing requirements for children not enrolled in Medi-Cal but with a high risk of exposure.

- Requires CDPH to revise an existing biennial report describing the effectiveness of appropriate case management efforts to include: 1) the number of Medi-Cal-enrolled children, by age and county, who have and have not received a BLL screening test; and 2) the number of children not enrolled in Medi-Cal who have received a BLL screening test.

Although this bill places the administrative responsibility for implementation on CDPH, DHCS will provide data to CDPH on children enrolled in Medi-Cal who have or may have received BLL screening tests for use in the mandated report and for ongoing internal analysis of performance in meeting BLL screening goals. DHCS will draw the necessary data from its Management Information System/Decision Support System (MIS/DSS). The MIS/DSS contains Medi-Cal fee-for-service claim and Managed Care encounter records from October 1, 2004, including associated eligibility, and provider data from the Medi-Cal Eligibility Data System (MEDS).

While the report specifically referenced in SB 1041 is to be published biennially, the analysis of data for BLL testing would be continuous. To achieve this, DHCS and CDPH will need to produce data consistently, even in non-reporting years, to improve data quality and monitor performance in meeting BLL testing requirements for children enrolled in Medi-Cal.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 9: CYBERSECURITY PROGRAM AUGMENTATION BUDGET CHANGE PROPOSAL

PROPOSAL

The DHCS, Enterprise Innovation & Technology Services requests 3.0 permanent positions and expenditure authority of $1,182,000 ($591,000 General Fund (GF); $591,000 Federal Fund (FF)) in fiscal year (FY) 2019-20 and $1,155,000 ($578,000 GF; $577,000 FF) in FY 2020-21 and ongoing. Within the expenditure authority requested, $575,000 ($288,000 GF; $287,000 FF) will be used to cover the recurring annual costs of additional enterprise security infrastructure tools. These resources are needed to address the remaining cybersecurity risks identified by two independent security assessments conducted by the State of California Military Department's Cyber Network Defense and California Office of Health Information Integrity in 2017.

BACKGROUND

In accordance with the State Administrative Manual (SAM) section 5305, Information Security Program, the DHCS' Chief Information Security Officer (CISC) is responsible for creating, maintaining, and enforcing information security policies and standards. This proposal is consistent with the ISO's responsibility for the management and oversight of DHCS' Information Security Program. Approval of this proposal will provide the required protection of DHCS' information assets and state information security policies, standards, and procedures as outlined in the State Information Management Manual (SIMM) 5305-A.

Cyberattacks have been on the rise every year and DHCS has seen a dramatic increase in the sophistication and volume of attacks. International cybercriminal organizations and nation states have access to state-of-the-art tools and experts that work 24/7 to attack organizations with large amounts of data. Currently, DHCS averages between one and four million attacks per month against its firewall, and these are only the attacks that get past the State data center's firewall and their own sophisticated intrusion prevention system. Should an attack be successful and get past the firewall, there is a significant chance it could result in a data breach of PHI. As of June 2018, there have not been any significant breaches of the DHCS firewall; however, industry breaches at major organizations have shown they can go undetected for months or even years.

California Military Assessment

As required by California State Government Code section 11549.3, the State of California Military Department's CND Team performed an Independent Security Assessment (ISA) of DHCS in 2017. The assessment criteria was based upon agreed standards set forth by the California Information Security Office (CISC). The ISA identified areas with low maturity in cybersecurity.

CalOHII Assessment

CalOHII has statutory authority over all Health Insurance Portability and Accountability Act (HIPAA) impacted state entities within the Executive Branch and implements statewide policy [California Health and Safety Code §130300 et seq.]. CalOHII completed a compliance review of DHCS in 2017 based upon its requirements under the Statewide Health Information Policy Manual (SHIPM).

Based upon the state mandates listed above and ongoing state investment in security assessments by the California CND, it is clear the Governor's Office and executive state leadership desire to improve cyber security capabilities. Additionally, at the California Health and Human Services Agency (Agency) and Department level, there is a desire to increase compliance with HIPAA based upon CalOHII assessments. DHCS supports both Agency and state level goals to identify areas that need further investment into the necessary funding. Given the Department's responsibility to protect the confidential health records of 13.3 million beneficiaries, it is vital to increase the level of security and address areas of weakness identified by the security assessments. This request carefully targets the specific areas that need improvement, which will prevent data breaches and federal non-compliance fines.

In June 2018, the OIS identified DHCS as being a high-risk department based upon new state criteria. Criteria included the high criticality of its systems, the confidentiality of its data, the importance of the health services business function, the large size of DHCS, and the compliance results from past assessments. Due to this determination, OIS notified CHHS that DHCS will be included in a security audit in FY 2018-19.

The CND report dated January 10, 2018, identified 14 findings requiring remediation. DHCS will be able to partially remediate some of these findings using existing resources, however additional permanent staff and software tools are required for complete and ongoing remediation. CND will re-assess DHCS every two years, so temporary remediation is not sufficient.

The CalOHII compliance assessment dated April 7, 2017, identified 26 areas of non-compliance with SHIPM. This included 16 high risk, eight medium risk, and two low risk. DHCS has identified three of the CalOHII findings (two high risk, one medium risk) as requiring additional resources to remediate. Similar to the CND findings, complete and ongoing remediation requires additional permanent staff and software tools. In total, this request is intended to address 17 of 40 total findings between the two assessments which are resource constrained, with work prioritized by risk level. The other 23 findings are being remediated using existing DHCS staff and tools.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal**.**

ISSUE 10: PRIVATE HOSPITAL DIRECTED PAYMENT AND QUALITY INCENTIVE POOL BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS requests 4.0 permanent positions and five-year limited-term (LT) resources equivalent to 8.0 positions. The resources are needed to implement the Hospital Quality Assurance Fee (HQAF) directed payment model, known as the Private Hospital Directed Payment (PHDP) program, and the new workload for the Quality Incentive Pool (QIP) program as defined by Title 42, Code of Federal Regulations (CFR), part 438.6(c).

Fiscal Year	Total Funds	General Fund	Federal Fund	Hospital Quality Assurance Revenue Fund
2019-20	**$1,729,000**	**$595,000**	**$864,000**	**$270,000**
PHDP Program	$540,000	$0	$270,000	$270,000
QIP Program	$1,189,000	$595,000	$594,000	$0
2020-21	**$1,639,000**	**$568,000**	**$819,000**	**$252,000**
PHDP Program	$504,000	$0	$252,000	$252,000
QIP Program	$1,135,000	$568,000	$567,000	$0

The following chart identifies the positions requested with the corresponding activity.

Division	Request	Activity
Capitated Rates Development	4.0 permanent positions • 4.0 Associate Governmental Program Analysts (AGPAs)	• PHDP Program
	1.0 five-year LT resource (extension) • 1.0 Research Data Specialist I	• QIP Program
Office of Medical Director	6.0 five-year LT resources • 1.0 Nurse Consultant III (Specialist) • 1.0 Staff Services Manager I • 1.0 Health Program Specialist II • 1.0 Health Program Specialist I • 2.0 AGPAs	• QIP Program
	1.0 five-year LT resource (extension) • 1.0 AGPA	• QIP Program

BACKGROUND

PHPD Program

The HQAF program was established on April 1, 2009 by Assembly Bill 1383 (Chapter 627, Statutes of 2009) and was subsequently extended by Senate Bill (SB) 90 (Chapter 19, Statutes of 2011), SB 335 (Chapter 286, Statutes of 2011), and SB 239 (Chapter 657, Statutes of 2013). In November 2016, the voters of California passed Proposition 52, which permanently extended the HQAF program. The HQAF program collects fees from private hospitals and uses these funds, matched with federal funds, to provide supplemental payments to managed care plans (Plans) in order to enhance reimbursement for hospital services and provide funding for health care coverage for

children in the Medi-Cal program. The program supports hospital services for Medi-Cal beneficiaries by providing Medi-Cal managed care supplemental payments of approximately $4 billion annually for Medi-Cal hospital services as well as over $850 million annually in children's health care funding. In 2015, a BCP authorized 9.5 LT positions and contract funding effective from January 1, 2016 to December 31, 2018.

On May 6, 2016, the federal Centers for Medicare & Medicaid Services (CMS) issued a final rule that amends and expands the requirements of Title 42, CFR, Part 438 (42 CFR 438) pertaining to Medicaid managed care. Pursuant to 42 CFR 438.6, HQAF program payments in managed care constitute unallowable direction of payment, and must be discontinued, phased down over a 10-year period, or converted into an allowable directed payment model. To continue providing critical funding for hospital services and minimize risks related to CMS approval of future capitation rates, including HQAF program payments, and in consultation with CMS and the private hospital stakeholder community, DHCS is converting the majority of HQAF program payments into an allowable directed payment model, the PHDP program.

The PHDP program implements a uniform dollar increase in reimbursement to private hospitals that provide designated services under their contracts with plans. In order to comply with CMS' requirements regarding this type of directed payment model, DHCS must seek annual approval to continue the PHDP program, and develop interim adjustments to the Medi-Cal managed care capitation rates to reflect the anticipated amount of PHDP program payments for each rating cell (i.e. for each unique combination of plan, county or rating region, aid category, and rating period). Final PHDP program payment amount are calculated by reweighting the interim adjustments based on the actual utilization of inpatient and outpatient hospital services. Payments are structured utilizing a pool approach that caps statewide payments to a maximum amount each year. The PHDP program pool amount is $2.1 billion in 2017-18, and will be reevaluated annually. CMS approved the concept for the 2017-18 PHDP program on March 6, 2018, with the caveat that final review and approval of the actuarial reasonableness of the program will occur during CMS' review of California's capitation rates for the 2017-18 contract period.

CRDD is the lead division within DHCS responsible for implementing the PHDP program in collaboration with plans and private hospitals. CRDD's overall functions include developing and implementing Medi-Cal managed care capitation rates and financing policies. CRDD's function also includes performing financial oversight of plans and providing managed care fiscal estimates for the bi-annual Medi-Cal Local Assistance Estimate (Estimate), proposed legislation and regulations, benefit changes, and advocate/stakeholder proposals.

Additional resources are required to successfully implement the PHDP program. Pursuant to 42 CFR 438.6(c) and the PHDP program proposal approved by CMS, DHCS may make directed payments only for contract services. The original request for three-year LT resources equivalent to 7.5 positions in BCP 4260-013-BCP-2018-GB "Hospital Quality Assurance Fee" did not account for the full extent (unknown at the time) of the workload associated with identifying the subset of hospital utilization that meets the requirements for a contract service.

QIP Program

DHCS developed several managed care directed payment programs (in accordance with Title 42 CFR 438.6(c)) to align, augment, and support the quality improvement initiatives promulgated through the managed care delivery systems and the Medi-Cal 2020 Demonstration. While each of these directed payment programs focus on a distinct health care delivery sector, they all have been designed to promote and maintain access to care and will each concentrate efforts on the department-wide priority of delivering effective, efficient, affordable care to Medi-Cal beneficiaries. CMS has reviewed and approved California's submission of the QIP proposal for Designated Public Hospital (DPH) systems defined by WIC 14184.10(f)(1) for delivery system and provider payment initiatives under Medicaid managed care plan contracts. Implementation of this directed payment program is a fundamental component to California's ability to continue successfully implement the progress made through the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program and other programs of the 1115 waiver, Medi-Cal 2020.

Pursuant to WIC 14197.4, effective in the 2017-18 rate year, the State will direct plans to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. This program will support the State's quality strategy by promoting access and value-based payment, increasing the amount of funding tied to quality outcomes, while at the same time further aligning state, plan, and hospital system goals. This payment arrangement, worth $640 million for FY 2017-18 (future years' amounts will be determined on an annual basis), moves California towards value-based alternative payment models. It integrates historical supplemental payments to come into compliance with the managed care rule by linking payments to the utilization and delivery of services under the plan contracts.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal**.**

ISSUE 11: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY EXPANSION BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS, Integrated Systems of Care Division (ISCD), requests 2.0 permanent positions and expenditure authority of $279,000 ($140,000 General Fund (GF) and $139,000 Federal Fund (FF)) in fiscal year (FY) 2019-20 and $261,000 ($131,000 GF and $130,000 FF) in FY 2020-21 and ongoing. The resources will allow the Program of All-Inclusive Care for the Elderly (PACE) to continue to operate effectively and efficiently under federal and state regulations as the program expands. This will also enable ISCD to conduct timely review and execution of contracts and contract amendments. ISCD will also be able to maintain compliance functions pursuant to PACE contracts, which includes federally mandated annual onsite audits for the first three years for new PACE Plans, and biennial audits for established PACE Plans.

BACKGROUND

Pursuant to Welfare and Institutions Code 14591-14594, the PACE program is designed to provide care for California's frail population as an alternative to institutionalization. The PACE program serves eligible beneficiaries by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care services. This all-inclusive care model allows the beneficiaries to receive all of their services through the PACE Plan, as a one-stop shop, while still residing in their home and/or community.

In 2016, the PACE Modernization Act Trailer Bill (Section 31-36 of SB 833, Chapter 30, Statutes of 2016) promoted new flexibilities and growth of the PACE program. This included the removal of a cap on the total number of PACE Organizations (POs) that operate in the state (previously capped at 15), implementation of an experience-based rate methodology, and the allowance of for-profit entities to participate in the PACE program. This has allowed for the PACE program to grow at an accelerated rate that requires additional staffing to meet the demands of the growing program

DHCS has experienced an increase in PACE interest as well as continued expansion requests from existing POs. There are currently 11 POs in place. At this time, the PACE Policy Unit is facilitating the implementation of one new PO in FY 2018-19, eight new POs in FY 2019-20, and three new POs in FY 2020-21. Based upon this implementation schedule, the DHCS is expected to have 23 active POs by July 1, 2020 (FY 2020-21).

DHCS anticipates additional applications, in FY 2018-19, from parties who expressed interest in expanding existing POs within existing service areas and into new markets. Currently, there are four existing POs with plans to open a new PACE center in the next calendar year. Since 2017, DHCS has received one or more expansion applications from ten out of the 11 existing POs. On average, each PACE center serves around 235 participants. At this expansion rate, the State can expect new PACE enrollment to

increase statewide by 2,360 participants over the next two years. With the addition of the new PACE centers, federal regulations dictate that an onsite audit be conducted for the first three years to make it compliant with Federal and State statutes, and biennially thereafter.

Additionally, ISCD is working with the California Department of Public Health (CDPH) on licensure review, licensure approval, and exemption processes for PACE licensures for Adult Day Health Care (ADHC) and Primary Care Clinic, as required for operation of PACE centers. The additional workload includes licensure exemption review through development and implementation of an extensive review tool, desk and administrative reviews of policies and operating procedures, and onsite certification of compliance with State and Federal readiness standards for both new facilities and annual audits.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal**.**

ISSUE 12: EXTENSION OF HEALTH HOME PROGRAM FUNDING TRAILER BILL

PROPOSAL

This trailer bill proposal would extend the appropriated expenditure/encumbrance authority for the Health Home Program Account Special Deposit Fund from June 30, 2020 to June 30, 2023.

BACKGROUND

AB 361 (Mitchell, Chapter 642, Statutes of 2013) authorizes DHCS to implement the Health Home Program (HHP), with specific conditions on populations to be served and limits on State General Fund impact. HHP services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social supports. The HHP is designed to serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers of services and who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports needed by eligible beneficiaries.

SB 75 (Committee on Budget and Fiscal Review, Chapter 18, Statutes of 2015), uncodified section (SEC.) 51, established the Health Home Program Account in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds to be used for the HHP implementation. SEC. 52 authorized the sum of fifty million dollars ($50,000,000) to be appropriated from the Health Home Program Account to DHCS for the purposes of implementing the HHP. This appropriation is currently available for encumbrance or expenditure by DHCS for the implementation of the HHP until June 30, 2020.

In an effort to successfully implement the HHP, DHCS delayed program implementation from 2016 to 2018. HHP is currently in the process of being implemented in four waves over six-month intervals. The first phase of implementation began on July 1, 2018 and the last implementation phase is set to begin January 1, 2020. Given the delay in HHP implementation, DHCS proposes to extend the sunset date that governs the HHP's ability to utilize funds from June 30, 2020 to June 30, 2023. This will allow the funds to be available for the duration of the program, in accordance with updated HHP implementation timelines, as well as to facilitate the completion of the HHP evaluation required pursuant to Welfare and Institutions Code Section 14127.5.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 13: MEDI-CAL FISCAL INTERMEDIARY CHECKWRITE CONTINGENCY PAYMENTS TRAILER BILL

PROPOSAL

This trailer bill proposal would authorize DHCS to make contingency payments to healthcare providers to mitigate risk of a disruption to the Medi-Cal Checkwrite process and ensure continuity of access to healthcare services for beneficiaries in its unlikely event. Contingency payments would be determined based on the previous claims history of the provider held by the department, and would be trued up once the Checkwrite disruption has ceased.

BACKGROUND

CA-MMIS processes payments to providers of medical care to Medi-Cal certified eligible beneficiaries, via the Medi-Cal Checkwrite. The FI provides other related services including, but not limited to, the operation of a telephone service center and provider relations functions; system operations, updates and enhancements; processing eligibility inquiry transactions, treatment authorization requests, and service authority requests. In Fiscal Year (FY) 2017-18, the weekly Medi-Cal Checkwrite averaged $345,048,851; the total amount paid during FY 2017-18 equaled $17,942,540,252.

In order to mitigate the risk of a possible Medi-Cal Checkwrite disruption caused by the implementation of new system functionality, emergencies, or other unplanned interruptions, the FI contract required the FI to develop an automated contingency payment process to ensure payments to providers would be able to continue uninterrupted. The medical FI contract was approved by the Centers for Medicare and Medicaid Services (CMS) which disperses federal Medicaid funding. DHCS has not recently experienced a Checkwrite delay but relies on aging information technology systems and is taking responsible precautions.

The process developed pursuant to the FI contract: (1) calculates contingency payment amounts based on the provider's payment history for the past twelve months (or all months if fewer than twelve) and a percentage set by DHCS which may vary by provider type; (2) validates that the provider is in good standing; and (3) allows DHCS to determine which providers receive contingency payments for which service dates. Once the Medi-Cal Checkwrite disruption ends, the process reconciles the contingency payments against adjudicated claims for that time period and adjusts future payments accordingly.

Although DHCS has the technical ability to calculate contingency payments to providers when there is a disruption to the Medi-Cal Checkwrite process, pursuant to the federally-approved contingency process contained in the medical FI contract, the State Controller's Office requires statutory authority to process such contingency payments.

Therefore, DHCS is seeking statutory authority to make contingency payments to providers for claims if there is a disruption to the Medi-Cal Checkwrite process upon approval of the Department of Finance.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.