AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

TUESDAY, MAY 16, 2017

9:30 A.M. - STATE CAPITOL ROOM 4202

ITEMS TO BE HEARD

ITEMS TO BE HEARD

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

ISSUE 1: SB 82 GRANTS ADJUSTMENTS

PANELISTS

- **California Health Facilities Financing Authority**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

It is requested that Item 0977-495 be amended to reflect a decreased amount of funding to be reverted in Item 0977-101-0001, Budget Act of 2013. The adjustment reflects a revised level of forfeitures from Chapter 34, Statutes of 2013 (SB 82) grants to various counties.

Detail:
"0977-495—Reversion, California Health Facilities Financing Authority. As of June 30, 2017, the balances specified below, of the appropriations provided in the following citations shall revert to the balances in the funds from which the appropriations were made.

0001—General Fund

1) Item 0977-001-0001, Budget Act of 2016 (Ch. 23, Stats. 2016). $1,952,000 appropriated in Program 0890-Mental Health Wellness Grants.

2) Item 0977-101-0001, Budget Act of 2016 (Ch. 23, Stats. 2016). $75,548,000 appropriated in Program 0890-Mental Health Wellness Grants.

3) Item 0977-101-0001, Budget Act of 2013 (Ch. 20 and 354, Stats. 2013), as reappropriated by Item 0977-490, Budget Act of 2016 (Ch. 23, Stats. 2016). $7,039,000 $6,717,000 appropriated in Program 50-Mental Health Wellness Grants."

BACKGROUND

SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, provided $142.5 million in one-time General Fund, $4 million in ongoing Mental Health Services Act (MHSA) funding, and $2.8 million in federal matching funds (reimbursements) to provide grants for community-based mental health crisis support.

Known as the Investment in Mental Health Wellness Act of 2013, SB 82 authorized CHFFA to disburse funds to California counties or their nonprofit or public agency designates to develop mental health crisis support programs. The one-time General Fund grants support capital projects to increase capacity for crisis intervention, crisis stabilization, crisis residential treatment, and rehabilitative mental health services. The MHSA and federal funds grants support personnel costs associated with operation of mobile crisis support teams. The grants support capital improvement, expansion and limited start-up costs.

CHFFA conducted five funding rounds for competitive grant awards between November 2013, and May 2016. After completion of all five rounds, the program approved a total of 56 grants for the benefit of 41 counties. Approximately $136.5 million of capital funding (General Fund) and $4 million of MHSA funding for mobile crisis support team personnel has been encumbered. As of June 30, 2016, $37.9 million of total funding has been disbursed to 22 counties. Once projects are completed, these grants will add the following mental health crisis support resources:

- 76 mobile crisis vehicles
  - Status (Sept 2016): 61 purchased; additional 15 expected by the end of 2017
- 58.25 mobile crisis personnel
  - Status (Sept 2016): 55.65 individuals hired
- 1,185 crisis stabilization and crisis residential treatment beds
  - Status (Sept 2016):
    - 63 crisis stabilization beds added; additional 228 expected by the end of 2017
    - 56 crisis residential treatment beds added; additional 838 expected by the end of 2017
- 18 peer respite beds
  - Status (Sept 2016): None added; 18 expected by the end of 2017
    Approximately 41 beds will be dedicated to youth individuals.

After the fifth and final funding round, $7 million of General Fund capital funding remained to revert back to the General Fund. The 2016 Budget Act reappropriated these funds and authorized a total augmentation of $31 million ($17 million General Fund, $14 million MHSA funds) in 2016-17 for additional expansion of community-based mental health crisis support specifically for children and youth under 21 years of age. The January budget includes a current year reversion of the $17 million General Fund allocated in 2016 for this purpose, while preserving availability of the MHSA funding. The Subcommittee heard and denied this proposed reduction on ***April 3, 2017***.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration present and explain these May Revise adjustments.

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

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 2: DISTRIBUTED ADMINISTRATION TECHNICAL ADJUSTMENTS (ISSUES 403 AND 404)

PANELISTS

- **Office of Statewide Health Planning and Development**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

It is requested that expenditures, reimbursements, and 96.4 positions scheduled in Programs 9900100-Administration and 9900200-Distributed Administration be eliminated from Items 4140-001-0121 and 4140-001-0143. It is also requested that the distributed administrative expenditures, reimbursements, and positions in Programs 3835-Health Care Workforce, 3840-Facilities Development, and 3855-Health Care Information and Quality Analysis be scheduled under the newly established Program 3860-Administration within the following items:

- $7,800,000 in Item 4140-001-0121
- $8,285,000, -$151,000 Reimbursements, and 96.4 positions in Item 4140-001-0143
- $57,000 in Item 4140-001-0181
- $31,000 in Item 4140-001-3064
- $16,000 in Item 4140-001-3068
- $298,000 in Item 4140-001-3085
- $126,000 in Item 4140-017-0143

The changes requested reflect a net-zero shift in funds to facilitate the accounting and budgeting of administrative expenditures.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration to present and explain these May Revise adjustments.

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

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 3: AIDS DRUG ASSISTANCE PROGRAM (ADAP) MAY ESTIMATE ADJUSTMENTS (ISSUE 401) AND TRAILER BILL

PANELISTS

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This issue covers May Revise changes and adjustments to the ADAP Estimate, originally proposed as part of the January budget and heard by this Subcommittee on ***March 20, 2017.***

It is requested that Item 4265-111-0890 be decreased by $6 million and the ADAP Rebate Fund be increased by $19,467,000.

These adjustments reflect:

- a shift in the distribution of expenditures between federal and rebate funds;
- a reduction in the number of clients expected to transition from medication-only to private insurance as a result of a shortened Covered California open enrollment period;
- an increase in caseload and medication prices;
- termination and replacement of the Enrollment Benefit Manger contract with A.J. Boggs; and
- a delay in implementation of the Pre-Exposure Prophylaxis (PrEP) Assistance Program.

Trailer bill language is also requested to separate the PrEP Assistance Program from ADAP and clarify that the PrEP Assistance Program will cover uninsured clients.

This Subcommittee heard a stakeholder proposal on ***March 20, 2017*** to adopt trailer bill to clarify that the PrEP Assistance Program will cover uninsured clients, consistent with this Administration proposal.

The ADAP Estimate for the 2017 May Revision provides a revised projection of Current Year [Fiscal Year (FY) 2016-17] and Budget Year (FY 2017-18) local assistance costs for the medication and health insurance programs for ADAP.

- For FY 2016-17, CDPH estimates that ADAP expenditures will be $365.1 million, which is a $2.6 million increase compared to the 2017-18 Governor's Budget. The increase in expenditures is mainly due to an increase in medication-only clients and continuing increases in medication prices.

- For FY 2017-18, CDPH estimates that ADAP expenditures will be $395.7 million, which is a $13.5 million increase compared to the 2017-18 Governor's Budget. OA estimates fewer clients transitioning from medication-only to private insurance associated with the proposed implementation of ADAP case management services.

- For FY 2016-17, CDPH estimates ADAP revenue will be $298.8 million, which is a $3.8 million decrease compared to the 2017-18 Governor's Budget.

- For FY 2017-18, CDPH estimates ADAP revenue will be $329.7 million, which is a $24.7 million increase compared to the 2017-18 Governor's Budget.

For FY 2016-17, the small decrease in revenue is due to estimated expenditures for 2016-Qarter 3 and 2016-Quarter 4 in the 2017-18 Governor's Budget being less than actual expenditures, which are now available and result in a corresponding decrease in rebate.

For FY 2017-18, the increase in revenue is due mainly to the increase in the overall medication expenditures and an increase in the overall rebate percentage rate.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present and explain the proposed changes to the ADAP estimate and proposed trailer bill, and respond to the following:

1) Is there any increased costs associated with the proposed trailer bill?

2) Please provide a brief update on the new ADAP enrollment system.

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

ISSUE 4: GENETIC DISEASE SCREENING PROGRAM MAY ESTIMATE ADJUSTMENTS (ISSUE 402)

PANELISTS

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This issue covers May Revise changes and adjustments to the Genetic Disease Screening Program (GDSP) Estimate, originally proposed as part of the January budget and heard by this Subcommittee on ***March 6, 2017***.

It is requested that Item 4265-111-0203 be decreased by $5,125,000 to reflect updated caseload and expenditure projections for the Newborn Screening and Prenatal Screening programs.

The GDSP 2017-18 Governor's Budget appropriation for FY 2016-17 is $132.3 million, of which $105.8 million is for Local Assistance and $26.5 million is for State Operations. At May Revision, GDSP estimates 2016-17 expenditures to be $130.3 million, which is a decrease of $2.1 million (1.55 percent) compared to the 2017-18 Governor's Budget.

The 2017-18 Governor's Budget proposed total expenditures for GDSP of $136.6 million. At May Revision, the combined State Operations and Local Assistance budget expenditures for 2017-18 are estimated to be $131.6 million, which is a decrease of $5 million (3.81 percent) compared to the 2017-18 Governor's Budget.

Local Assistance Expenditure Projections

Current Year (2016-17)
The 2017-18 Governor's Budget appropriation for GDSP's Local Assistance is $105.8 million in 2016-17. GDSP anticipates revised 2016-17 Local Assistance expenditures of $103.5 million, a decrease of $2.3 million (2.18 percent) compared to the 2017-18 Governor's Budget. The decrease in caseload results from a decrease in the Department of Finance's Demographic Research Unit's projection of live births.

Budget Year (2017-18)
For 2017-18, GDSP estimates Local Assistance expenditures to be $104.7 million, a decrease of $5.1 million (4.7%) compared to the 2017-18 Governor's Budget amount of $109.9 million. This projected decrease in expenditure authority is due to the decrease in the projected caseload.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present and explain the May Revise proposed changes and adjustments to the GDSP Estimate.

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

ISSUE 5: WOMEN, INFANTS, AND CHILDREN PROGRAM MAY ESTIMATE ADJUSTMENTS (ISSUE 403)

PANELISTS

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This issue covers May Revise changes and adjustments to the Women, Infants, and Children (WIC) Estimate, originally proposed as part of the January budget and heard by this Subcommittee on ***March 6, 2017***.

It is requested that Item 4265-111-0890 be decreased by $119,194,000 and Item 4265-111-3023 be increased by $20,299,000 to reflect updated caseload and food expenditure projections and a shift between federal and infant formula rebate funds.

Current Year (2016-17)
In 2016-17, the NSA budget and the anticipated expenditures estimate for local administration are estimated to be $300.9 million which is the same as the 2017-18 Governor's Budget. State Operations expenditures are estimated to be $62.1 million, a $653,000 increase over the 2017-18 Governor's Budget. This increase is the result of the Employee Compensation Adjustment.

Budget Year (2017-18)
In 2017-18, there is no change to the local administration expenditure estimate of $300.9 million in the Governor's Budget. State Operations expenditures are estimated to be $63.5 million which is a $254,000 increase of the 2017-18 Governor's Budget. This increase is the result of the Employee Compensation Adjustment.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present and explain the May Revise proposed changes and adjustments to the WIC Estimate.

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

ISSUE 6: LICENSING AND CERTIFICATION PROGRAM MAY ESTIMATE ADJUSTMENTS

PANELISTS

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This issue covers May Revise changes and adjustments to the Licensing and Certification (L&C) Program Estimate, originally proposed as part of the January budget and heard by this Subcommittee on ***March 6, 2017***.

Current Year (2016-17)
For 2016-17, the Center for Health Care Quality (CHCQ) projects expenditures will total $266.5 million, an increase of $3.5 million (1.3%) from the 2017-18 Governor's Budget. This increase is the result of the Employee Compensation Adjustment.

Budget Year (2017-18)
For 2017-18, CHCQ estimates expenditures will total $263.9 million, an increase of $1.2 million (0.5%) from the 2017-18 Governor's Budget. This increase is the result of the Employee Compensation Adjustment.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present and explain the May Revise proposed changes and adjustments to the L&C Estimate.

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

ISSUE 7: TOBACCO TAX (PROPOSITION 56) TECHNICAL ADJUSTMENTS (ISSUE 404) AND TOBACCO RETAIL INSPECTION CONTRACT TECHNICAL CORRECTION (ISSUE 411)

PANELISTS

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

January proposals related to these issues and programs were heard by the Subcommittee on ***March 6, March 20, and April 24, 2017***.

Proposition 56 Technical Adjustment (Issue 404)
It is requested that Item 4265-001-0001 be increased by $224,000 to reflect the correct General Fund amount for the Oral Health Program, as the proposed General Fund decrease in the Governor's Budget incorrectly included reimbursement authority.

It is also requested that Item 4265-001-3309 be increased by $1,368,000 and Item 4265-111-3309 increased by $1,300,000 to reflect changes to the Proposition 56 revenue estimates. These funds will support media campaigns, competitive grants, and program evaluation activities within the Tobacco Control Program.

Additionally, a net-zero shift is requested between state operations and local assistance for the implementation of Proposition 56 as proposed at Governor's Budget. The shift will align with the 5-percent administrative level specified in the initiative. The details of the funding shifts are as follows:

- Item 4265-001-3307 be increased by $13,125,000 and Item 4265-111-3307 be decreased by a like amount.
- Item 4265-001-3308 be increased by $2,925,000 and Item 4265-111-3308 be decreased by a like amount.
- Item 4265-001-3309 be increased by $73,791,000 and Item 4265-111-3309 be decreased by a like amount.

General Fund Technical Correction to the Tobacco Retail Inspection Contract (Issue 411)
It is requested that Item 4265-001-0001 be increased by $1,078,000 to correct an inadvertent General Fund reduction that occurred at the 2017-18 Governor's Budget. This issue corrects a reduction made to the General Fund for the Youth Tobacco program Retail Inspection Contract.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration present and explain these May Revise adjustments.

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

ISSUE 8: TOBACCO TAX (PROPOSITION 99) MAY REVISE ADJUSTMENTS (ISSUES 416 AND 500)

PANELISTS

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This Subcommittee heard the January proposals on Proposition 99 spending (within DPH) on ***March, 6, 2017.***

The May Revise proposes the following changes and adjustments to Proposition 99 within DPH:

Health Education Account (Issues 416 and 500)
It is requested that Item 4265-001-0231 be decreased by $1,924,000, which reflects a $21,000 decrease resulting from changes in Proposition 99 revenues and a $1,903,000 decrease to reflect a funding shift from state operations to local assistance. It is also requested that Item 4265-111-0231 be increased by $1,903,000 to reflect this change. These adjustments will affect Proposition 99 expenditures for media campaigns, competitive grants, and program evaluation activities.

Research Account (Issue 500)
It is requested that Item 4265-001-0234 be increased by $2,000 to reflect the changes in Proposition 99 revenues. These funds will support external research contracts.

Unallocated Account (Issue 500)
It is requested that Item 4265-001-0236 be increased by $28,000 to reflect changes in Proposition 99 revenues. These funds will support the California Health Interview Survey and external contracts.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration present and explain these Proposition 99 May Revise adjustments. Please clarify if there will be any programmatic changes that will occur due to these adjustments.

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

ISSUE 9: OFFICE OF EMERGENCY PREPAREDNESS BASELINE TECHNICAL CORRECTION (ISSUE 414)

PANELISTS

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This Subcommittee heard the January proposals related to the Office of Emergency Preparedness on ***March 20, 2017***.

It is requested that Item 4265-001-0890 be decreased by $9,441,000 and 76.8 positions to reflect the appropriate funding and position authority for the Office of Emergency Preparedness. These resources were inadvertently left in the baseline budget for the Office at the 2017-18 Governor's Budget. The adjustment correctly removes the limited-term resources set to expire on July 1, 2017.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration present and explain this May Revise correction.

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 10: CALIFORNIA MEDICAID MANAGEMENT INFORMATION SYSTEM (ISSUES 500 AND 501)

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSALS

This issue covers two California Medicaid Management Information System (CA-MMIS) May Revise Budget Change Proposals: Legacy Operations and Modernization.

CA-MMIS Legacy Operations
DHCS requests the conversion of 21.0 limited-term positions set to expire June 30, 2017 to permanent positions, and funding for personal services contractors (consultants). The requested expenditure authority for Fiscal Year (FY) 2017-18 and ongoing is $9,143,000 ($2,104,000 General Fund (GF); $7,039,000 Federal Fund (FF)). This request includes $6,000,000 ($1,500,000 GF; $4,500,000 FF) for contracted resources.

The 21.0 permanent resources requested are necessary to:

1) Support and oversee the ongoing maintenance and operation of the California Medicaid Management Information System (CA-MMIS) legacy system, including necessary updates and modifications to the system to support DHCS' health care programs;

2) Support and oversee business operations (i.e., telephone services center, provider training and communications, Medi-Cal website, etc.) to support DHCS' health care programs;

3) Transform the CA-MMIS enterprise to state ownership of all project management, transition, integration, multi-vendor management, and testing activities currently managed and/or performed by the Fiscal Intermediary (FI);

4) Support the implementation of deferred System Development Notices (SDN); and

5) Support contract and vendor management, project management, and procurement activities.

CA-MMIS Modernization

DHCS requests 7.0 permanent positions and funding for personal services contractors (consultants), hardware, software and hosting services. The requested expenditure authority for Fiscal Year (FY) 2017-18 and ongoing is $5,754,000 ($575,000 General Fund and $5,179,000 Federal Fund). Within the expenditure authority requested, $3,750,000 will be used for various contractual services and $600,000 for hardware, software, and hosting services annually.

BACKGROUND

CA-MMIS Legacy Operations

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 13.7 million members. DHCS contracts with an fiscal intermediary (FI) to maintain and operate CA-MMIS, which is utilized by Medi-Cal to process approximately 200 million claims annually for payment of medical services provided to Medi-Cal members, resulting in over $20 billion a year in payments to health care providers. Under the CA-MMIS contract, the FI adjudicates both Medi-Cal and non-Medi-Cal claims for the State and delivers other FI services to program providers, beneficiaries, and federal and state users of the system. The CA-MMIS Division is responsible for oversight, management, monitoring, and administration of the single FI vendor responsible for operating the CA-MMIS by providing IT System maintenance and operations (M&O) and FI Business Operations Services, as well as the design, development and implementation (DD&I) of a new system to replace CA-MMIS. CA-MMIS is comprised of 90 systems, hosted in data centers in six states that support 24 DHCS programs.

The IT portion of the FI contract includes hosting, maintaining, operating and enhancing the systems which comprise CA-MMIS. The business operations portion of the contract includes operating a call center, provider outreach and training, production of beneficiary identification cards, and facilities management for 1,200 vendor staff and over 200 state and contractor staff.

DHCS began the procurement work in 2007 to obtain an FI contract for IT M&O and Business Operations, as well as development of a new system to replace CA-MMIS. In May 2010, DHCS awarded the contract to Affiliated Computer Services State Healthcare, LLC (ACS), which was later acquired by Xerox, to provide FI services and to replace the existing thirty-year old Legacy System. Effective October 1, 2011, DHCS successfully implemented the transition and takeover of CA-MMIS from the prior FI, Hewlett Packard, Inc., to Xerox. CA-MMIS operations have been successful and represents approximately 90% of the FI contract value. Key accomplishments to date include:

- Delivered check-writes for over 270 consecutive weeks since October 2011, totaling over $100 billion.
- Implemented over 3,000 system changes, including 150+ major system changes, including:
  - Diagnosis Related Group (DRG)
  - International Classification of Diseases, Tenth Revision (ICD-10)

- Affordable Care Act (ACA) initiatives
- State Level Registry (SLR)
- Presumptive Eligibility (PE)
- Drug Rebates for Managed Care

In October 2012, the Fl began DD&I for the CA-MMIS replacement system, "Health Enterprise" (HE). On December 14, 2014, Release 1.0 of the HE was implemented. This implemented the HE Framework, including infrastructure, security, and single sign-on capability. The migration of internal DHCS users to single sign-on was completed in early June 2015. Release 2.0 was scheduled for a June 30, 2015 release date that was preempted by a Xerox recommended "no-go" for Release 2.0. In October 2015, the Fl, Xerox, announced they would not complete the System Replacement Project (SRP). 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, DHCS and Xerox finalized the proposed settlement agreement and proposed contract amendment. DHCS and Xerox agreed to pause the work on the DD&I of the replacement system while the settlement approval process was underway. On April 8, 2016, DHCS and Xerox signed the settlement agreement, which included terms and conditions for termination of the SRP as well as compensation to the State for all costs incurred by the State for the SRP, and amendments to the Fl contract. Under the agreement, Xerox suspended all of its SRP activities. This included, but was not limited to, DD&I, project management, transition, integration, and testing activities. In order to move forward with project closure, and to initiate a new project based on a modular approach, all of these activities are being shifted to State (DHCS) ownership. Xerox will continue to operate and maintain the current CA-MMIS until September 30, 2019, or until the department has secured other IT M&O and Business Operations services and support.

The CA-MMIS Division developed a plan to: continue ongoing IT M&O and Business Operations, take ownership of activities currently performed by the Fl (project management, integration, transition, and testing, etc.); transition the SRP from Fl ownership to State ownership; and planning for the development of procurements for DD&I of new system modules.

CA-MMIS Modernization

DHCS states that the requested resources are necessary to implement a modernization strategy for the CA-MMIS, as recommended by the United States General Services Administration, Technology Transformation Services' Office of Acquisitions, which includes a user-centered, iterative, modular approach to the design, development, and implementation of system modules to replace the existing legacy system.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present these two CA-MMIS May Revise Budget Change Proposals.

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

ISSUE 11: PALLIATIVE CARE SERVICES (ISSUE 502)

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

The January budget included a proposal to delay implementation of this program until July 1, 2018, which this Subcommittee heard on ***March 27, 2017***.

The May Revise proposes implementation on January 1, 2018 with $1.3 million in resources. Additionally, DHCS, Managed Care Quality and Monitoring Division (MCQMD), requests to convert 1.0 existing limited term (LT) Health Program Specialist I (HPS I) position to a permanent position and the associated expenditure authority of $124,000 ($62,000 General Fund and $62,000 Federal Fund) to implement and provide ongoing oversight of the palliative care services program authorized by Senate Bill (SB) 1004 (Hernandez, Chapter 574, Statutes of 2014).

BACKGROUND

The Affordable Care Act (ACA) was signed into law in 2010 to improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care. The ACA includes provisions requiring DHCS to adopt quality measure reporting and use of evidence-based data for quality improvement projects. Similarly, the goal of palliative care is to improve patient choice and satisfaction and reduce unwanted higher cost services such as hospital stays and readmissions, and emergency room visits. SB 1004 requires the DHCS, in consultation with interested stakeholders, to establish standards and provide technical assistance for Medi-Cal managed care health plans (MCP) to oversee delivery of palliative care services, which would include specified hospice services and any other services determined appropriate by the department. SB 1004 requires DHCS to establish standards for palliative care services delivered concurrently with curative services to Medi-Cal beneficiaries served by Medi-Cal managed care health plans. The bill requires that authorized providers include licensed hospice agencies and home health agencies, licensed to provide hospice care that are contracted with Medi-Cal managed care plans, to provide palliative care services. This bill also requires the department, to the extent practicable, to oversee the delivery of palliative care services under these provisions is provided in a manner that is cost neutral to the General Fund on an ongoing basis. This bill authorizes the department to implement these provisions through All Plan Letters (APL) or similar instructions.

A budget change proposal (BCP) approved in fiscal year (FY) 2015-16, established a 2-year LT HPS I to coordinate with stakeholders and MCPs to develop standards and guidelines for the palliative care program and to provide technical assistance to MCPs to monitor the appropriate delivery of palliative care services. DHCS experienced delays in the development of the policy, and therefore, has not been able to deploy the policy in managed care. The first delay resulted from a data research project for the palliative care program that took longer than anticipated. The data research is important because it validates measures that would be used to monitor the MCPs. In addition, gathering data also assisted in defining the fiscal policy in order to generate cost neutral services. Additional delays also occurred while collaborating with stakeholders in establishing eligible conditions, specifying services and provider qualifications that would best support cost neutral results, developing and overseeing DHCS guidance to the health plans, and providing specific steps that allowed the MCPs the ability to contract with providers that would best support the MCPs. The anticipated finalization of the managed care policy is slated no sooner than 1/1/2018. The HPS I serves as the subject matter expert on palliative care. This position expires 6/30/2017.

SB 1004 presents an opportunity for DHCS to evaluate the potential benefit of providing access to palliative care for beneficiaries of the Medi-Cal Managed Care program, affording them a patient-centered, choice-focused, all-inclusive approach to end-of-life care, with the potential to change health outcomes for many Californians. This program also addresses the department's commitment to "improve the consumer experience," "develop effective, efficient, and sustainable delivery systems," and "be prudent, responsible fiscal stewards." It will better address patient preferences for patients facing advanced illness, shifting more care to the home as opposed to hospitalization. The goal of the program is to be cost neutral on an ongoing basis by decreasing acute hospital stays, referrals to intensive care units, and discharges home without services.

LAO

"The Governor’s January budget proposed to delay the implementation of the palliative care program (established pursuant to 2014 legislation) to no sooner than July 1, 2018. The May Revision budget proposal differs from the January budget proposal in that it would implement the program beginning in January 2018, with estimated net General Fund costs of $1.3 million in 2017-18. We have also reviewed an associated budget change proposal (BCP) to convert one limited-term position to a permanent position to implement the program. We have no concerns with the BCP."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

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

ISSUE 12: CURRENT YEAR OPERATING SHORTFALL (ISSUE 406) AND ENHANCED MEDI-CAL BUDGET ESTIMATE REDESIGN SYSTEM (ISSUE 503)

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This Subcommittee discussed the current year shortfall in Medi-Cal on ***March 13, 2017***, under Issue 2 ("Medi-Cal Estimate Overview").

Current Year Operating Shortfall (Issue 406)
Medi-Cal program expenditures are expected to exceed the appropriation by approximately $1,142.1 million in 2016-17. This is a decrease of $619.6 million since Governor's Budget. The Administration will seek a supplemental appropriation bill to fund this increase, which is primarily attributable to a one-time retroactive payment of drug rebates to the federal government, miscalculation of costs associated with the Coordinated Care Initiative in prior estimates, and repayment of federal negative account balances consistent with the Special Terms and Conditions of the state's 1115 "Medi-Cal 2020" waiver. These increases are partially offset by increased savings from rebates in drugs used by Medi-Cal managed care beneficiaries, retroactive managed care rate adjustments, and slower caseload growth primarily in the Affordable Care Act Optional Expansion. At Governor's Budget, caseload was projected to increase 4.5 percent from 2015-16 to 2016-17. The May Estimate revises the growth downward to a year-over-year growth of 1.3 percent. Actual enrollment data received through January 2017 reflects slower caseload growth primarily attributable to changes in the enrollment system in 2016 which allowed for more efficient processing of backlogged eligibility redeterminations. Until supplemental funding is provided, the Department will utilize the loan authorized by Government Code section 16531.1 and will work with the Legislature to increase the existing loan authority to prevent a disruption in payments to various Medi-Cal providers.

Enhanced Medi-Cal Budget Estimate Redesign System (Issue 503)
DHCS, Fiscal Forecasting Division, requests one-time contract funding of $495,000 ($248,000 General Fund (GF) and $247,000 Federal Fund (FF)) to upgrade the Enhanced Medi-Cal Budget Estimate Redesign (EMBER) system. The current system utilized to produce the Medi-Cal Local Assistance Estimate has exceeded its technical support, which makes the system increasingly less compatible with newer software and unable to receive ongoing software updates. The upgrade would enhance system stability and improve flexibility making it more adaptable to changes in the Medi-Cal program. Additionally, the upgrades will allow for future enhancements to the system to

provide estimates that are more accurate with increased transparency and reporting capabilities.

BACKGROUND

Welfare and Institutions Code (WIC) section 14100.5 requires DHCS to submit an estimate of Medi-Cal expenditures twice a year. The Medi-Cal Local Assistance Estimate is highly detailed, as specified in WIC section 14100.5, and forecasts expenditures, caseload, and the impact of regulatory and policy changes in the Medi-Cal program. The Estimate is subject to the analysis of the Department of Finance, the Legislative Analyst Office (LAO), the Legislature, and other stakeholders.

The Enhanced Medi-Cal Budget Estimate Redesign (EMBER) System is the state-owned proprietary system that incorporates all aspects of the Medi-Cal Local Assistance Estimate. EMBER is a web-based multi-tiered application that was developed in 2006.

The Medi-Cal Local Assistance Estimate utilizes three methods for estimating expenditures:

- Multi-variate time series regressions for statewide eligible, managed care eligible, and fee-for-service expenditures;
- Estimates of program and policy expenditures developed through independent fiscal analysis and incorporated into the Estimate via Policy Changes;
- Calculation of managed care eligible and rates to provide managed care estimated expenditures.

The EMBER system produced its first Estimate in May 2006. Over the past 11 years, the Medi-Cal Local Assistance Estimate has grown from $33.3 billion to $105.6 billion, added an additional 130 policy changes and 836 regressions. With the Optional Targeted Low Income Children's Program and the Affordable Care Act expansions, Medi-Cal has added over 5.6 million average monthly beneficiaries and the program continues to grow. These expansions along with increases in supplemental payment programs have increased the complexity of the Estimate. The Estimate now tracks 62 funds, up from the 35 funds in the May 2006 Estimate. This trend of increasing complexity in the Medi-Cal program will likely continue in the future, and the EMBER system needs to be flexible to adapt the changes into the Medi-Cal Local Assistance Estimate.

The Department has dedicated technical staff responsible for the functionality of EMBER. Two programmers coordinate the data loads, monitor and resolve issues, update a variety of system areas, and research the compatibility of Department-wide software upgrades and patches. Recent updates include researching and replacing EMBER'S reporting environment. The current EMBER application uses a software framework that is no longer supportable.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 13: MAJOR RISK MEDICAL INSURANCE FUND BALANCE TRANSFER (ISSUE 403) AND PROGRAM ADMINISTRATION (ISSUE 410)

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

The Subcommittee heard the January proposal to abolish the Major Risk Medical Insurance Fund (MRMIF) on ***May 1, 2017***.

MRMIF Abolishment and Balance Transfer to the Health Care Services Plans Fines and Penalties Fund (Issue 403)
It is requested that Item 4260-101-0001 be increased by $19,067,000 and Item 4260-101-3311 be decreased by $19,067,000 to reflect updated Medi-Cal expenditures from the Health Care Services Plans Fines and Penalties Fund as a result of updated Major Risk Medical Insurance Program expenditures.

Major Risk Medical Insurance Program Administration (Issue 410)
It is requested that Item 4260-001-3311 be decreased by $818,000 and Item 4260-017-3311 be eliminated to reflect updated Major Risk Medical Insurance Program administrative expenditures.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present these proposals.

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

ISSUE 14: ADVANTAGE COLLECTIONS APPLICATION PROVISIONAL LANGUAGE

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

It is requested that provisional language in Item 4260-001-0001 be amended to allow for an augmentation of up to $2,456,000 for implementation of the Advantage Collections Application upon project document approval by the Department of Finance and Department of Technology.

Add the following provision to Item 4260-001-0001:

4. The Department of Finance may augment the amount appropriated in Schedule (1)by up to $2,456,000 for implementation of the Advantage Collections Application upon project document approval by the Department of Finance and Department of Technology. The Director of Finance shall authorize the augmentation not sooner than 30 days following written notification to the Chairperson of the Joint Legislative Budget Committee.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

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

ISSUE 15: MEDI-CAL CASELOAD PROJECTIONS AND ESTIMATE ADJUSTMENTS (ISSUE 401, 404, 405)

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This Subcommittee heard the January Medi-Cal Estimate on ***March 13, 2017***.

Caseload
The average monthly caseload for fiscal year 2017-18 is projected to be 13,688,900 beneficiaries, which represents a decrease of 593,000 beneficiaries from the estimate of 14,281,900 beneficiaries reflected in the Governor's Budget. The decrease in caseload is primarily due to lower than projected Affordable Care Act Optional Expansion beneficiaries based on actual data. Total Medi-Cal expenditures for 2017-18 are projected to be $105,627,021,000 ($18,593,690,000 General Fund), which is an increase of $3,041,993,000 total funds and a decrease of $536,352,000 General Fund from the Governor's Budget. A request for information to solicit contractors to assist the Department in refining the current estimate process will be issued in 2017-18.

May 2017 Medi-Cal Estimate (Issue 401)
It is requested that the adjustments below be made to the following items to reflect caseload and other miscellaneous adjustments outlined in the Medi-Cal estimate:

- Item 4260-101-0001 be decreased by $409,075,000 and reimbursements be increased by $2,349,760,000
- Item 4260-101-0232 be decreased by $675,000
- Item 4260-101-0233 be increased by $3,418,000
- Item 4260-101-0236 be decreased by $473,000
- Item 4260-101-0890 be decreased by $1,207,001,000
- Item 4260-101-3156 be added in the amount of $99,407,000
- Item 4260-101-3168 be increased by $852,000
- Item 4260-102-0001 be increased by $23,406,000
- Item 4260-102-0890 be increased by $23,406,000
- Item 4260-104-0001 be increased by $127,000
- Item 4260-105-0001 be increased by $18,250,000
- Item 4260-106-0890 be increased by $355,000
- Item 4260-113-0001 be decreased by $199,408,000
- Item 4260-113-0890 be decreased by $666,322,000

- Item 4260-117-0001 be increased by $25,000
- Item 4260-117-0890 be decreased by $172,000

California Healthcare, Research and Prevention Tobacco Tax Act of 2016, Proposition 56 (Issue 404)
It is requested that Item 4260-101-3305 be increased by $19,773,000 to reflect updated Proposition 56 revenue estimates. As proposed, Proposition 56 revenues support new Medi-Cal program growth for healthcare programs and services.

Duals Demonstration Pilot (Coordinated Care Initiative) (Issue 405)
It is requested that Items 4260-101-0001 and4260-101-0890 both be increased by $11,885,000 to reflect updated enrollment trends from the duals demonstration pilot (Cal MediConnect). Compared to Governor's Budget, savings have eroded due to a decrease in the number of beneficiaries that opt-in to the demonstration program.

LAO: The LAO provided all of the following analyses on various aspects and components of the May Revise Medi-Cal Estimate:

Lower Estimated General Fund Spending in Medi-Cal in 2016-17 Compared to January Budget Estimates. The Governor's May Revision budget proposal estimates Medi-Cal General Fund spending in 2016-17 to be $18.9 billion, a $620 million reduction compared to the Governor's January budget estimate of General Fund Medi-Cal spending. Lower General Fund spending in Medi-Cal in 2016-17 is attributable to many different factors, including lower caseload estimates, higher than anticipated prescription drug rebates, and managed care capitated rate adjustments resulting in greater General Fund savings.

2016-17 Estimated Medi-Cal General Fund Spending Remains Over $1 Billion Higher Than the 2016-17 Medi-Cal General Fund Appropriation…Although estimated Medi-Cal General Fund spending in 2016-17 has been revised downward from the Governor's January estimate, 2016-17 General Fund spending in Medi-Cal is estimated to be about $1.2 billion higher than the program's 2016-17 General Fund appropriation. This $1.2 billion deficiency is to a large degree due to the Medi-Cal budgeting error that was revealed to the Legislature at the time of the release of the Governor's January budget.

…Which Could Require Supplemental Funding for Medi-Cal in 2016-17. Current state law allows Medi-Cal to receive loans of up to $1 billion from the General Fund in years when Medi-Cal General Fund spending exceeds the program's appropriation. However, because Medi-Cal's expected $1.2 billion deficiency in 2016-17 exceeds the program's General Fund loan authority of $1 billion, Medi-Cal payments could be disrupted unless the Legislature takes action to either (1) increase Medi-Cal's General Fund loan authority, or (2) enact a supplemental appropriation. The administration has indicated that they will work with the Legislature in the coming weeks on a proposal that increases the amount of funding available to Medi-Cal and prevents any disruption in Medi-Cal payments.

Lower Estimated Federal Funding in 2016-17 Compared to January Budget Proposal. The Governor's May Revision budget proposal estimates Medi-Cal federal funding in 2016-17 to be $57.7 billion, a $9.1 billion reduction compared to the Governor's January budget estimate of federal funding in Medi-Cal. Much of this reduction is attributable to shifts in hospital quality assurance fee payments and intergovernmental transfer payments to public hospitals from 2015-16 and the first half of 2016-17 into 2017-18, as well as to higher than anticipated prescription drug rebates in 2016-17. Since these reductions in federal funding are primarily due to the timing of certain federal payments in Medi-Cal, lower estimated federal funding in 2016-17 is not expected to result in higher General Fund spending in either 2016-17 or 2017-18.

Changes to 2017-18 Medi-Cal Spending Estimate

Lower Proposed Medi-Cal General Fund Spending in 2017-18. The Governor's May Revision proposes $18.6 billion in General Fund funding for Medi-Cal in 2017-18, a $540 million reduction compared to the Governor's January budget proposal. Lower caseload estimates and shifts in the timing of certain payments that have the effect of reducing General Fund Medi-Cal spending are the main drivers of lower proposed spending in 2017-18. Although, on net, proposed General Fund spending is down relative to the January budget, certain factors are resulting in significantly higher Medi-Cal spending. Notably, higher managed care capitated rates for certain seniors and persons with disabilities (SPDs) appear to be causing higher spending in 2017-18 in the hundreds of millions of dollars.

Year-Over-Year Reduction in Proposed Medi-Cal Spending

Between 2016-17 and 2017-18, General Fund spending in Medi-Cal is projected to decline from $18.9 billion to $18.6 billion, a 2 percent reduction in spending. This year-over-year decline does not appear to reflect declining overall costs in the Medi-Cal program. Rather, the decline is attributable to a significant extent to the timing of certain payments, such as managed care organization tax payments, that have the effect of reducing overall General Fund spending in 2017-18 relative to 2016-17.

Caseload

Medi-Cal Caseload Growth Not as High as Previously Projected. The Governor's May Revision budget projects continued Medi-Cal caseload growth from both 2015-16 to 2016-17 and 2016-17 to 2017-18, though not as high of growth as previously projected. Total average monthly enrollment is projected to be about 13.6 million enrollees in 2016-17 and 13.7 million enrollees in 2017-18. These caseload estimates are significantly lower than the Governor's January estimates, which projected average monthly caseload to be 14 million in 2016-17 and 14.3 million in 2017-18. According to the administration, the lower caseload projections in the May Revision result in Medi-Cal savings in the low hundreds of millions of dollars in both 2016-17 and 2017-18, savings which have been incorporated into the budget.

LAO Assessment: Updated Caseload Numbers Appear Reasonable. We have reviewed the Governor's May Revision caseload estimates and find them to be reasonable. We have reviewed recent months' data on actual Medi-Cal enrollment, and

believe that they support the lower caseload growth projections that have been incorporated into the Governor's revised Medi-Cal budget.

May Revision Revises Cal MediConnect Savings Downward. Estimated savings under Cal MediConnect were revised downward from around $20 million to around $8 million in 2016-17 and 2017-18. Lower savings in Cal MediConnect are largely attributable to decreasing enrollment in Cal MediConnect managed care plans, a result of high continued opt-out rates. The administration has indicated that they are continuing to explore strategies for improving enrollment in Cal MediConnect. In our CCI report, we lay out a couple of options to improve Cal MediConnect enrollment. These are to (1) introduce ongoing passive enrollment into Cal MediConnect for Medi-Cal managed care enrollees at age 65 when they become eligible for Medicare benefits and (2) provide funding for outreach and engagement activities that encourage enrollment by outlining the benefits of coordinated care under the Cal MediConnect program.

Proposition 56

Governor's May Revision Proposal for Proposition 56 Revenues in Medi-Cal Is Largely Consistent With the January Proposal to Fund Year-Over-Year Program Growth. As required by Proposition 56, a voter-approved initiative which raised state taxes on tobacco products, the Governor's May Revision allocates around $1.3 billion in Proposition 56 revenue to Medi-Cal in 2017-18, a $20 million increase over the amount projected in the Governor's January proposal. Consistent with the Governor's January Proposition 56 proposal, the Governor does not propose using Proposition 56 revenues to pay for new policy changes in the Medi-Cal program, such as higher provider rates. Instead, Proposition 56 revenues would largely support anticipated spending increases from growth in the Medi-Cal program between the 2016 Budget Act and the 2017-18 May Revision budget proposal. While the Governor's proposed uses of Proposition 56 revenues within Medi-Cal in the May Revision proposal are generally consistent with the Governor's January budget proposal in terms of their paying for year-over-year program growth, there are several new areas within the existing Medi-Cal program where the Governor's May Revision proposes to allocate Proposition 56 revenues to pay for year-over-year growth. These include, for example, dental services, substance use treatment services, and specialty mental health services. Because the Governor's budget allocates Proposition 56 revenues to fund growth in the existing Medi-Cal program, other funding sources would have to be identified should the Legislature choose to reallocate Proposition 56 revenues to fund any new policy changes in Medi-Cal.

Children's Health Insurance Program (CHIP)

The Governor's January budget proposal assumes federal CHIP funding will be reauthorized in federal fiscal year (FFY) 2016-17 at the historical 65 percent federal medical assistance percentage (FMAP), instead of the enhanced 88 percent FMAP authorized under the ACA through FFY 2018-19. As we noted in our analysis of the Governor's January budget proposed for Medi-Cal, the Governor's approach to budgeting CHIP funding is reasonable given the significant uncertainty around the Congressional reauthorization of CHIP funding beyond FFY 2016-17. The May Revision budget proposal assumes an increase in General Fund spending of $396 million in 2017-18 relative to what would be the cost if California received the enhanced 88

percent FMAP. This is $139 million less than estimated in the January budget proposal. This downward revision is a technical adjustment to the January estimate.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the major changes and updates to the Medi-Cal Estimate contained in the May Revise.

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

ISSUE 16: PERFORMANCE OUTCOME SYSTEM BUDGET ADJUSTMENT (ISSUE 407)

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

It is requested that Item 4260-101-0001 be decreased by $629,000 and Item 4260-101-0890 be increased by $1,944,000 to reflect training, staff, and information technology costs associated with implementation of the newly-selected proposed functional assessment tools for children up to age 21 receiving mental health services through Medi-Cal.

The May Estimate includes $6.2 million General Fund for the implementation of functional assessment tools for populations receiving specialty mental health services through county mental health plans. These assessment tools will gather data from both a clinician's and caregiver's perspective and will be used to track the outcomes for Medi-Cal mental health services provided to children up to age 21. The revised funding reflects training, staff, and information technology costs associated with implementation of the newly-selected functional assessment tools.

The January budget includes $10.2 million ($5.1 million General Fund and $5.1 million federal funds) in 2016-17 and $13.7 million ($6.8 million General Fund and $6.8 million federal funds) in 2017- 18 for costs to reimburse mental health plans for the costs of capturing and reporting functional assessment data as part of the Performance Outcomes System (POS) for EPSDT mental health services.

BACKGROUND

SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012, required DHCS to convene stakeholders to develop a plan for a POS for EPSDT mental health services provided to Medi-Cal eligible children. The department was required to consider the following objectives: 1) enables provision of high quality and accessible EPSDT services for eligible children and youth; 2) collects information that improves practice at the individual, program, and system levels; 3) minimizes costs by building on existing resources; and 4) generates reliable data that are collected and analyzed in a timely fashion. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, implemented the following additional requirements for the department:

- Convene a stakeholder advisory committee to develop methods to routinely measure, assess, and communicate program information regarding informing,

identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services.

- The committee reviews health plan screenings for mental health illness, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county mental health plans. This information is to be included in the POS implemented by the department.

- Propose how to implement the updated POS plan no later than January 10, 2015.

The department's implementation plan for the POS includes the following elements:

1) Establish the POS methodology – The department is required to develop a clear methodology for specifying the purpose of the project, stakeholder and partner involvement, the target population, data availability, data limitations or strengths, reporting elements and timelines, and other relevant details necessary for implementation and development of the POS. The department has focused the methodology first on its reporting requirements from existing DHCS databases, with further development of data collection protocols expected in the future.

2) Report performance outcomes from existing DHCS databases – The department is required to utilize existing DHCS data systems to evaluate performance outcomes on a preliminary basis. The systems used are as follows:

    a) Short Doyle/Medi-Cal (SD/MC) Claiming System – Provides information from county mental health plans about who is receiving services, how often the services are received, and the amount claimed for federal reimbursement of services to Medi-Cal beneficiaries.
    b) Client and Services Information System -- Collects data pertaining to mental health clients and the services they receive at the county level including information about non-Medi-Cal mental health services, Medi-Cal SMHS, client demographics, diagnoses, living arrangement, service strategy, race/ethnicity, employment, and education level.
    c) Web-Based Data Collection Reporting System - Consumer Perception Surveys – Provides information about the client or family member's perception of satisfaction with regards to services including general satisfaction, access, quality or appropriateness of care, social connectedness, client functioning, criminal justice, and quality of life. Other data include perceived impacts to quality of life including general life satisfaction, living situation, daily activities and functioning, family and social relations, finances, legal and safety, and health.
    d) Data Collection and Reporting System – Collects data pertaining to any client enrolled in an MHSA funded Full Service Partnership program. Data includes residential status, education, criminal justice, legal designations, co-occurring disorders, source of financial support, and emergency intervention.
    e) Management Information System/Decision Support System – Provides data pertaining to claims and encounter data (mental health Medi-Cal, Drug Medi-

Cal, managed care, pharmacy, fee-for-service Medi-Cal), Medi-Cal eligibility data, provider data, and other reference data such as National External Norms and Benchmarks.

Using existing data between 2011-12 and 2014-15, the department has produced several data reports including a statewide aggregate report and county-specific reports (for small, medium, large and rural counties). A county-level aggregate report is still in development. The reports include the following data elements: 1) unique counts of children and youth receiving SMHS; 2) penetration rates of services compared to eligible population; 3) utilization; 4) arrivals, continuance, and exiting of services; and 5) time to step down. Many of these elements are organized in the aggregate, as well as by race, age group, and gender.

3) Comprehensive Data Collection and Reporting – The department, in partnership with stakeholders and academic researchers, is developing a functional assessment tool to assess client clinical and functional status over time. This tool will be deployed at the county level to collect the data needed to assess outcomes in the POS. According to DHCS, the tool is expected to be approved within the next few weeks and provided to county stakeholders in Spring 2017. The department expects additional costs for purchasing the new tool and training 14,614 county clinical staff in its use.

4) Continuous Quality Improvement Using POS Reports – The department plans to utilize existing processes to develop a quality assurance and improvement process. This process is intended to ensure consistent, high-quality, and fiscally effective services are delivered to children and their families to improve school performance, the home environment, child safety, and involvement with the juvenile justice system.

5) Tracking Continuum of Care Screenings and Referrals – The department has required managed care plans to report data on mental health screenings and referrals to specialty mental health services since May 2014. According to DHCS, however, this data is not adequate to evaluate the linkages between managed care and the SMHS system, as required by statute. The department is attempting to evaluate the data needed to appropriately track these linkages.

The 2015 Budget Act approved three permanent positions and annual expenditure authority of $350,000 ($175,000 General Fund and $175,000 federal funds) to implement the data collection, analysis and IT functions of the POS. Prior to these resources, existing staff were redirected from other divisions to manage the workload

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 17: FEDERAL OPIOID RESPONSE GRANT (ISSUE 412) AND CONTRACTING AUTHORITY TRAILER BILL

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

Federal Cures Act Opioid Targeted Response Grant (Issue 412)
It is requested that Item 4260-116-0890 be increased by $44.7 million to reflect the award of the federal Opioid State Targeted Response grant. This grant will provide increased medication assisted treatment for individuals with substance use disorders. In addition, trailer bill language is requested to allow the Department to be exempted from certain state contract processes to quickly get funding distributed. The grant requires expanded substance use services begin September 2017.

BACKGROUND

The May Estimate includes an increase of $44.7 million in federal funding to reflect the award of the federal Opioid State Targeted Response grant. This grant will allow for increased medication assisted treatment for individuals with substance use disorders. The Department will establish 15 “hub and spoke” systems, where a Narcotic Treatment Program will serve as a “hub” and the “spokes” are regional physicians approved to prescribed medication assisted treatment. Narcotic Treatment Programs will begin providing expanded substance use services by September 1, 2017 as required by the grant provisions. In addition, the Department is proposing trailer bill language in order to expedite the ability to provide these funds to the receiving entities

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 18: FAMILY HEALTH MAY REVISION ESTIMATES (ISSUE 402)

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This Subcommittee heard the Family Health Estimates included in the January budget on ***March 27, 2017***.

The "Family Health Estimates" includes estimates for the following programs:

1) California Children's Services (CCS)
2) Child Health and Disability Prevention Program (CHDP)
3) Genetically Handicapped Persons Program (GHPP)
4) Every Woman Counts Program (EWC)

It is requested that Item 4260-111-0001 be decreased by $4,773,000 and reimbursements be increased by $2,000. It is also requested that Item 4260-114-0001 be added in the amount of $87,000 for the Every Woman Counts program. These changes reflect revised expenditure estimates in the four Family Health programs based on: (1) revised caseload estimates, (2) an increase in high cost treatments recently approved by the U.S. Food and Drug Administration, (3) a decrease in average annual cost per case in the Genetically Handicapped Persons Program, and (4) other miscellaneous adjustments.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present all significant changes and adjustments included in the May Revise to the Family Health Estimates.

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

ISSUE 19: CALIFORNIA CHILDREN'S SERVICES (CCS) MEDICAL THERAPY PROGRAMS TRAILER BILL

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

Trailer bill language is requested to clarify that in the California Children's Services program, occupational therapy and physical therapy services are available when medically necessary.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposed trailer bill and respond to the following:

1. What is the reason that the proposed trailer bill covers physical and occupational therapy, but not speech therapy?

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

ISSUE 20: 340B PRESCRIPTION DRUGS TRAILER BILL

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

Trailer bill language is requested to restrict 340B entities, consistent with federal law, from contracting with pharmacies to dispense drugs they purchased under a 340B program discount.

BACKGROUND

The Department is proposing trailer bill language to correct problems regarding the use of contract pharmacies in the 340B Drug Billing program. There are instances where a 340B covered entity does not directly dispense medications to a beneficiary, instead they contract with a different pharmacy, typically a non-340B entity, who dispenses the drug at a non-340B price that is billed to the department or health plan. The trailer bill language proposes to no longer permit the use of contract pharmacies in the 340B program in Medi-Cal, consistent with recent concerns raised by federal agencies. DHCS states that this helps avoid inappropriate duplicate discounts by claiming federal drug rebates on already discounted drugs and prevents unnecessary overpayment in Medi-Cal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposed trailer bill.

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

ISSUE 21: DISPROPORTIONATE SHARE HOSPITAL ALLOCATION ADJUSTMENTS TRAILER BILL

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

Trailer bill language is requested to implement federal policy affecting the distribution of federal matching funds for uncompensated costs in hospitals.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposed trailer bill.

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

ISSUE 22: GRADUATE MEDICAL EDUCATION PROGRAM FOR PUBLIC HOSPITALS TRAILER BILL

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

Trailer bill language is requested to implement a Graduate Medical Education program that would reimburse designated public hospitals for the costs of training health care providers. This proposal is intended to improve the delivery of services to Medi-Cal beneficiaries in managed care settings, and is to be funded by hospital funds and federal funds.

Western Center on Law and Poverty has requested an amendment to the proposed trailer bill to reflect their belief that public hospitals that receive additional funding should serve all Medi-Cal enrollees. Some of the University of California hospitals do not serve all Medi-Cal enrollees as a result of not contracting with all Medi-Cal managed care plans. Their proposed amendment is as follows:

> 14105.29 (a)(1)
> Subject to subdivision (e), additional Medi-Cal payments shall be made to designated public hospitals and their affiliated government entities, in recognition of the Medi-Cal managed care share of graduate medical education costs. To the extent permissible under federal law, the department shall make such payments directly to the designated public hospitals that contract with all Medi-Cal managed care plans in the area served by the designated public hospital and their applicable affiliated government entities.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal and provide reaction to the amendments proposed by Western Center on Law and Poverty.

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

ISSUE 23: COVERED OUTPATIENT DRUG FINAL RULE TRAILER BILL

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

Trailer bill language is requested to codify the new drug ingredient reimbursement methodology and dispensing fee based on a study of outpatient pharmacy provider costs in purchasing and dispensing outpatient prescription drugs to Medi-Cal beneficiaries. This change is consistent with the federal rule on covered outpatient drugs.

BACKGROUND

The Department is proposing trailer bill language to codify the new drug ingredient reimbursement methodology and dispensing fee based on a study of pharmacy provider costs in the Medi-Cal program and reflected in the Department's proposal released earlier this year. The May Estimate does not reflect the expected costs and savings associated with these changes as the Department expects that receipt of federal approval and time needed to implement the necessary system changes will shift implementation into FY 2018-19; however, the changes will be retroactively effective to April 1, 2017 consistent with the federal regulations.

The Deficit Reduction Act (DRA) of 2005 required the Centers for Medicare & Medicaid Services (CMS) to use 250 percent of the Average Manufacturer Price (AMP) to establish the federal upper limit (FUL) on generic drugs. CMS had estimated that the new FULs would be implemented on January 30, 2008. However, an injunction preventing CMS from implementing these changes and sharing pricing information with the states put the AMP and FUL changes on hold. The Affordable Care Act (ACA) modified federal statute to establish the FUL to be no less than 175 percent of the weighted average (based on utilization) of the AMP and redefined how AMP is calculated.

On February 1, 2016, in accordance with the final regulation with comment CMS-2345-FC, CMS published a final rule establishing an exception to the ACA FUL calculation which allows for a higher multiplier. This multiplier is used when the FUL falls below the average retail acquisition cost. In these instances, CMS will establish the respective FUL at an equal value to the most current average retail community pharmacy acquisition cost. The final rule further stipulates that the updated FUL reimbursement

rates shall be effective beginning April 1, 2016, and, that future updates will be published on a monthly basis.

Last year, the pharmaceutical industry explained that both components of pharmacy reimbursement have warranted change for a long time in that the dispensing fees are too low, but are compensated by high ingredient-cost reimbursements. The new federal rules effectively reduced the reimbursements for the ingredient costs, but did not increase dispensing fees. The rules require states to pay an appropriate dispensing fee by April 1, 2017, and 2016 budget trailer bill authorizes DHCS to change the fees.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposed trailer bill.

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

ISSUE 24: NEWLY QUALIFIED IMMIGRANT MAY REVISE PROPOSAL

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

The January budget contains a proposal from the Administration to expand the Newly Qualified Immigrant (NQI) Affordability and Benefit Program. Stakeholders submitted an alternative proposal which was to repeal the existing statutory program altogether, a proposal that was heard by this Subcommittee on May 1, 2017.

The May Revise contains a proposal (consistent with the proposal from stakeholders) to eliminate the NQI Affordability Benefit Program, adding $48 million General Fund to the Medi-Cal program. However, this proposal does not include trailer bill to repeal the statute that establishes this program.

BACKGROUND

Existing law authorizes the Department to implement a program to transition most NQIs covered under state-only funded full-scope Medi-Cal to a Covered California qualified health plan and have all of their out-of-pocket costs covered by the State and also provide access to and cover any services that are covered only by Medi-Cal.

Due to operational and programmatic uncertainties, the Department will stop efforts to implement the program. In addition, the Department will seek a “minimum essential coverage” designation from the federal government for full-scope state-only Medi-Cal programs to resolve the potential that NQIs receiving coverage through Medi-Cal will be assessed a tax penalty.

LAO -- The LAO provided the following analysis of this proposal:

May Revision Budget Proposes to Eliminate Transition of All NQIs From Medi-Cal to Covered California. Current state law calls for the transition of Patient Protection and Affordable Care Act (ACA) optional expansion NQIs from the state-only Medi-Cal program into Covered California coverage with a Medi-Cal wraparound. The Governor’s January budget proposal included additional NQIs—namely, parents and caretaker relatives—in the transition. (For further background on issues related to the NQI proposal, refer to our report, *The 2017-18 Budget: Analysis of the Medi-Cal Budget*.) The May Revision budget proposal reflects the administration’s intent to no longer pursue the transition of *all* NQIs into Covered California at a cost of $48 million

General Fund in 2017-18 ($100 million General Fund annually). The administration cites operational and programmatic challenges, similar to what we outlined in our analysis of the Governor's January Medi-Cal budget, as its reason for no longer pursuing the transition. The administration has indicated that the Department of Health Care Services (DHCS) will apply for the Centers for Medicare and Medicaid Services (CMS) to certify the state-only Medi-Cal program for NQIs as minimum essential coverage (MEC) to protect NQIs against any potential tax liabilities under the ACA's individual mandate. If CMS certifies the state-only Medi-Cal program for NQIs as MEC, these individuals would no longer be eligible for federal funding through Covered California. Without federal funding, the state would have no fiscal rationale to transition NQIs into Covered California, provided it wishes to maintain comparable health coverage for this population.

LAO Assessment: Consider Conforming Changes to State Law to Reflect May Revision Budget Proposal, if Approved. The administration suggests that changes to state law may not be required to implement the changes in the May Revision budget proposal. Should the Legislature approve the proposal, we recommend that the Legislature adopt new trailer bill language to repeal existing state statutory language that calls for the transition of certain NQIs from Medi-Cal into Covered California, thus ensuring consistency between state law and legislative intent.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal, and respond to the following:

1) Would the Administration be supportive of trailer bill to eliminate the statute that establishes the NQI Affordability Benefit Program?

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

ISSUE 25: SCHOOL-BASED MOBILE VISION SERVICES PROGRAM EXPANSION

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

Proposes to expand the School-Based Mobile Vision Services Program statewide in 2018-19 depending on the outcome of an evaluation of the pilot program which is due by end of 2017.

BACKGROUND

The 2014 Budget Act appropriates $2 million ($1 million General Fund) for a pilot program to increase utilization of pediatric vision services utilizing qualified mobile vision providers to expand vision screenings and services in schools.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 26: MEDICARE ENROLLEES IN THE OPTIONAL EXPANSION AID CATEGORY

PANELISTS

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

Effective January 1, 2014, the ACA expanded Medicaid coverage to previously ineligible persons, primarily adults at or below 138 percent of the federal poverty level. This new coverage group excludes those with Minimum Essential Coverage. A small portion of eligibles enrolled in Optional Expansion categories have Medicare Part A, which qualifies as Minimum Essential Coverage. Enrollment systems were corrected in August 2016 to eliminate further enrollment of Medicare Part A eligible persons into the Optional Expansion eligibility group.

The May Revision includes the following necessary adjustments:

- Adjusting the federal dollars claimed of approximately $63 million in Medi-Cal FFS claims, reflecting an equivalent amount of new General Fund cost.
- Adjusting the dollars claimed of approximately $32 million in Specialty Mental Health claims, requiring a recoupment from counties of that amount.
- Two adjustments are necessary for the managed care enrollees affected by this issue, an adjustment of federal funding, as well as an adjustment of the rates paid to Medi-Cal managed care plans.
    - Since dual eligible beneficiary managed care rates are lower than the optional expansion beneficiary rates (given that Medicare covers most of their care), the Department will need to recoup approximately $365 million from Medi-Cal managed care plans.
    - In addition, the Department must adjust the federal dollars claimed by approximately $174 million, resulting in an equivalent increase in General Fund cost.

This proposal requires the recoupment of $365 million from Medi-Cal managed care plans, and federal repayments by the state of $742.4 million, resulting in a net General Fund cost to the state of $227.1 million in 2017-18.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 27: MEMBER REQUEST – MEDICALLY-TAILORED MEALS PILOT PROGRAM

PANELISTS

Assemblymember David Chiu

Public Comment

PROPOSAL

Assemblymember David Chiu requests $9 million over three years ($3 million per year) to fund a Medically-Tailored Meals Pilot Program within Medi-Cal.

BACKGROUND

The proposal indicates that the pilot would be operated as follows:

- The pilot will be conducted over 3 years in Los Angeles, San Diego, San Francisco, Alameda, Marin and Sonoma counties.
- An estimated 4,000 patients could receive 14 meals a week for 12 weeks, with the balance of funding covering administration costs and data collection and analysis.
- Individuals who have certain serious health conditions and other criteria established by Medi-Cal (e.g. have a positive screening for food insecurity or higher-than-average costs for someone with a similar diagnosis) will be identified to receive pilot program services.
- Pilot program services include medically-tailored, home-delivered meals[1] that are appropriate for the individual's diagnoses.
- Eligible meal providers (nonprofit organizations serving the six counties that have the capacity to provide medically-tailored meals) deliver medically-tailored meals to participants' home for a period of time established by Medi-Cal.
- The impact of the program on beneficiaries will be evaluated through, e.g., average monthly overall Medi-Cal expenditures per participant, number and length of participant hospitalizations, and utilization of emergency department services. Clinical outcomes that have been measured in other medically-tailored meal studies include: change in self-reported measures related to depression, trade-off behaviors between food and medication among beneficiaries, impact on substance use, and changes in blood pressure and blood glucose measures.

Supporters of this proposal anticipate the following impacts of the pilot:

- Reduction in total costs to Medi-Cal per participant during the period of the pilot intervention and post-intervention compared to a pre-intervention period and/or compared to a group of non-participants with similar health profiles.

[1] Medically-tailored meals are meals designed by Registered Dieticians to provide for the specific nutritional needs of individuals living with serious illness.

- Decreased rate of hospital admissions and decreased length of hospital stays for participants during the period of the pilot intervention.
- Higher rates of discharge from inpatient hospitalization to home as opposed to an acute care facility for participants during the period of the pilot intervention.
- Improved outcomes on select clinical measurements.

Assemblymember Chiu provided the following background information, and states that this initiative which would make cost-effective medically-tailored meal services accessible to Medi-Cal beneficiaries with certain complex and traditionally high-cost health conditions, and provide better health outcomes and reduced costs of care for Medi-Cal recipients.

Research demonstrates that the provision of medically-tailored meals to individuals who live with serious illness is highly effective at reducing health care costs. Individuals with serious health conditions enrolled in a Medicaid Managed Care Organization (MMCO) in Pennsylvania who were provided with medically-tailored meals had 55% lower overall health care costs compared to individuals with similar health profiles who did not receive meals. The MMCO beneficiaries who received medically-tailored meals were also admitted to the hospital half as often as similar patients. In addition, those patients had hospital stays that were 37% shorter than patients without tailored meals.

The Medi-Cal Medically-Tailored Meals Pilot Program will treat and support Californians suffering from serious illness who are deemed eligible for program services based on their diagnoses and other criteria established by Medi-Cal. The pilot will be conducted in Los Angeles, San Diego, Santa Clara, San Mateo, Alameda, San Francisco, Marin and Sonoma Counties, four high-population urban and urban-rural counties home to approximately 4,000 patients with 14 meals per week for 12 weeks.

Many residents in these counties live with serious illnesses which require dietary modifications that are often not easily achieved for low-income patients. Supporters state that the pilot program responds to the persistent problems of food insecurity and malnutrition among low-income individuals living with disease, which are associated with higher overall health care costs and contribute to avoidable and expensive hospital readmissions.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Chiu to present this proposal.

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

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 28: ADMISSION, EVALUATION, AND STABILIZATION CENTER DELAY (ISSUE 210)

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

The Subcommittee heard the January proposal on the Admission, Evaluation and Stabilization Center (AES) on ***February 27, 2017***.

It is requested that Item 4440-011-0001 be decreased by $3,599,000 to reflect a six-month delay in activation. The 60-bed AES Center (in Kern County) is now scheduled to be activated in January 2018, and the savings resulting from this delay will be partially offset by additional staff training in advance of activation, as well as contract resources to support the involuntary medication (IM) process for Incompetent to Stand Trial (IST) patients in the AES Center. The statutory IM process requires the Department of State Hospitals (DSH) to contract with an Administrative Law Judge, through the Office of Administrative Hearings, for medication review hearings.

DSH explains that the cause of the delay is that Kern County had been planning to work with their county's mental health plan but the county has come to the realization and conclusion that the county mental health plan does not have the appropriate expertise or resources to do this type of work. Therefore, the County will be seeking a contractor for the needed treatment services which will take approximately 6 months.

The increased costs for the IM process include:

- $7,000 for 2017-18
- $14,000 for 2018-19 and on-going

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

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

ISSUE 29: METROPOLITAN STATE HOSPITAL MOVEMENT OF CIVIL COMMITMENTS STAFFING (ISSUE 120)

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This proposal is one of several projects that DSH has undertaken in order to reduce the size of the waiting list for Incompetent to Stand Trial (IST) commitments. This issue was discussed by the Subcommittee at its hearing on DSH issues on ***February 27, 2017***.

It is requested that Item 4440-011-0001 be increased by $7,827,000 and 22.2 positions (and $12,370,000 and 35.5 positions in fiscal year 2018-19) to support the transfer of approximately 150 Lanterman-Petris-Short (LPS) (civilly committed) patients at Metropolitan State Hospital. The LPS patients will be moved to another building to allow additional IST waitlist commitments (currently over 500) to be placed in secured treatment beds beginning in 2018-19. Additionally, this funding will allow DSH to temporarily expand the Hospital Police Officer Academy for two years to prepare for the increased patient population at Metropolitan State Hospital.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

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

ISSUE 30: JAIL-BASED RESTORATION OF COMPETENCY PROGRAM EXPANSION (ISSUE 117)

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This proposal is one of several projects that DSH has undertaken in order to reduce the size of the waiting list for Incompetent to Stand Trial (IST) commitments, an issue that this Subcommittee discussed at its hearing on DSH issues on ***February 27, 2017***.

In addition to previous proposals to increase capacity, it is requested that Item 4440-011-0001 be increased by $3,054,000 to contract with counties for up to 24 Jail-Based Competency Treatment (JBCT) beds serving IST commitments, as DSH continues to identify additional expansion opportunities throughout the state to assist in addressing the current waitlist.

Delays in the previously authorized expansion of JBCTs in the current year have resulted in additional one-time General Fund savings of $1,310,000 since the Governor's Budget. These delays have occurred in programs in San Diego, Sonoma, and Mendocino Counties.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

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

ISSUE 31: JAIL-BASED COMPETENCY TREATMENT CONTRACT RENEWAL COST INCREASE (ISSUE 119)

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This proposal is one of several projects that DSH has undertaken in order to reduce the size of the waiting list for Incompetent to Stand Trial (IST) commitments, an issue that was discussed by the Subcommittee at its hearing on DSH issues on ***February 27, 2017***.

It is requested that Item 4440-011-0001 be increased by $1,647,000 ($2.5 million ongoing) to support the increased costs of three existing JBCT program contract renewals. This includes contracts in Riverside and San Bernardino counties for 40 beds ($556,000), the San Bernardino County contract that started in 2016 for 76 beds ($828,000), and the recent Sacramento County 32-bed contract ($263,000).

The Sacramento JBCT is a unique large regional model, for which the county has identified a larger workload than anticipated and therefore a need for more staff than originally anticipated. Therefore, this request includes $263,000 in resources for Sacramento.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

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

ISSUE 32: ENHANCED TREATMENT PROGRAM STAFFING ADJUSTMENT (ISSUE 208)

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This proposal is an update to the Enhanced Treatment Program (ETP) staffing proposal included in the January budget, which this Subcommittee heard on ***February 27, 2017***.

It is requested that Item 4440-011-0001 be increased by $122,000 to reflect updated costs associated with the activation of four ETP units. This request includes funding for a contracted Patients-Rights Advocate at each location to provide advocacy services to patients during the ETP referral and certification process to meet statutory requirements. This funding increase is also for additional recruitment and retention of Hospital Police Officers.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

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

ISSUE 33: CONDITIONAL RELEASE PROGRAM (CONREP) SEXUALLY VIOLENT PREDATOR CASELOAD ADJUSTMENTS (ISSUE 209)

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

The CONREP program and January proposed budget were heard by the Subcommittee on ***February 27, 2017***.

It is requested that Item 4440-011-0001 be decreased by $2,452,000 to reflect a decrease in CONREP Sexually Violent Predator (SVP) caseload. The caseload reduction projections are as follows:

	2016-17	2017-18
Caseload Reduction	19 - 15	23 - 17
Budget Savings	$854,000	$2.5 million

LAO

"As part of the *Budget Act of 2016*, the Legislature required DSH to report what treatment services provided to CONREP patients could be reimbursed by Medi-Cal and to start seeking reimbursement by July 1, 2017. The report provided by DSH in response stated that the department was seeking additional clarity from the Centers for Medicare and Medicaid Services (CMS) as to whether CONREP patients were eligible for federal reimbursement. In the May Revision, the department reported that CMS confirmed CONREP patients were eligible for reimbursement and is now planning to move forward with reimbursement. However, the department does not currently have a timeline for when they will start seeking reimbursement. Accordingly, we recommend the Legislature include provisional language requiring the department to report its plans and a timeline for seeking Medi-Cal reimbursement by January 10, 2018."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

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

ISSUE 34: NAPA STATE HOSPITAL EARTHQUAKE REPAIRS (ISSUES 111 AND 112)

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

The costs of repairs at Napa State Hospital as a result of the earthquake were contained in a January proposal that was heard by this Subcommittee on ***February 27, 2017***.

It is requested that Item 4440-011-0001 be increased by $654,000 as a one-time General Fund loan to reflect the updated 2017-18 costs associated with the repair of damages sustained at Napa State Hospital during the August 2014 earthquake. It is also requested that Item 4440-011-0001 be amended by increasing reimbursements by $654,000. It is further requested that provisional language (see below) be amended to reflect the total General Fund loan amount of $6,879,000 (an increase of $654,000).

Amend Provision 9 of Item 4440-011-0001 as follows:

> "9. A loan or loans shall be available from the General Fund to the State Department of State Hospitals not to exceed ~~$6,225,000~~ $6,879,000. The loan funds shall be transferred to this item as needed to meet cash flow needs due to delays in collecting federal reimbursements associated with repairs caused by the 2014 South Napa Earthquake. All moneys so transferred shall be repaid as soon as sufficient reimbursements have been collected to meet immediate cash needs and in installments as reimbursements accumulate if the loan is outstanding for more than one year."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

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

ISSUE 35: TRANSFER OF SEXUALLY VIOLENT PREDATOR SCREENING SERVICES TO CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION (ISSUE 017)

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

The Department of State Hospitals (DSH) and the California Department of Corrections and Rehabilitation (CDCR), Board of Parole Hearings (BPH) request the transfer of $483,000 General Fund (GF) and 2.5 positions from DSH to CDCR, BPH effective July 1, 2017. This transfer represents a mutual agreement of the agencies to transfer responsibility for the Sexually Violent Predator (SVP) Clinical Screening of CDCR inmates from DSH to the CDCR, BPH along with the associated resources in order to comply with Welfare and Institutions Code (WIC) 6601(b).

BACKGROUND

Under an existing MOU, CDCR and BPH contracted with DSH to perform the clinical portion of the screening process required by WIC section 6601, subdivision (b). Included as part of this MOU, CDCR, BPH and DSH agreed to utilize the screening instrument developed and updated by DSH, in consultation with CDCR. Screening duties consist of two parts: Part A and Part B.

Part A
CDCR and BPH's responsibility consists of identifying qualifying offenses for commitment as an SVP. If CDCR and BPH identify that an inmate has a qualifying offense, the screening proceeds to Part B. If a qualifying offense is not identified, the screening procedure is complete.

Part B
DSH, as a subcontractor of CDCR and BPH, is responsible for the following:

1) Conducting a clinical review of the individual's qualifying offense(s) and social, criminal, and institutional history. Note: This clinical review is not a referral for full evaluation pursuant to WIC section 6601, subdivision (c).
2) Forwarding the outcome of Part B to CDCR.

If CDCR determines, as a result of the screening procedure described above, that the individual is likely to be a SVP, CDCR refers the individual to DSH , for a full evaluation to be conducted by DSH (WIC section 6601, subdivision (c) as to whether the individual meets the criteria for commitment as a SVP.

Statutory Requirement
As part of the SVP Act (SVPA), WIC section 6601, subdivision (b) states:

> *The person shall be screened by the Department of Corrections and Rehabilitation and the Board of Parole Hearings based on whether the person has committed a sexually violent predatory offense and on a review of the person's social, criminal, and Institutional history. This screening shall be conducted in accordance with a structured screening instrument developed and updated by the State Department of State Hospitals in consultation with the Department of Corrections and Rehabilitation. If, as a result of this screening, it is determined that the person Is likely to be a sexually violent predator, the Department of Corrections and Rehabilitation shall refer the person to the State Department of State Hospitals for a full evaluation of whether the person meets the criteria In Section 6600.*

Recent legal analysis conducted by CDCR and DSH indicates that CDCR is required to perform the SVP screenings and that they should not be conducted by DSH via an MOU on behalf of CDCR. Specifically, the statute incorporates the word "shall" which has been interpreted to mean that CDCR/BPH has a mandatory duty to perform the screenings as set forth in the SVPA. As such, DSH, CDCR and BPH are in agreement that the responsibilities should be transferred to BPH.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

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

ISSUE 36: PSYCHIATRIC PROGRAM TRANSFER -- TECHNICAL ADJUSTMENT AND PROVISIONAL LANGUAGE (ISSUE 015)

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This proposal makes technical adjustments to the larger proposal to transfer psychiatric care from DSH to CDCR, a January budget proposal that was heard by this Subcommittee (jointly with Subcommittee #5) on ***April 3, 2017***.

The California Department of Corrections and Rehabilitation (CDCR), the California Correctional Health Care Services (CCHCS), and Department of State Hospitals (DSH) request a transfer of $4 million General Fund (GF) from DSH to CDCR and CCHCS beginning in 2017-18 for additional employee compensation resources related to various memoranda of understanding bargaining agreements and Budget Bill language to transfer expenditure authority from DSH to CDCR for prior year appropriations associated with the transfer of inpatient psychiatric programs.

It is requested that Item 4440-011-0001 be decreased by $3,999,000 to reflect the transfer of employee compensation and benefits associated with the transfer of psychiatric programs to CDCR. Along with the proposal to transfer psychiatric programs to CDCR effective July 1, 2017, this adjustment will transfer the associated employee compensation and benefit adjustments made since the Governor's Budget. Additionally, it is requested that provisional language be added to provide flexibility for CDCR and the California Correctional Health Care Services to process vendor invoices and employee payment activities incurred by DSH for the psychiatric programs as of June 30, 2017.

The proposed provisional language is to add the following provisions to Item 4440-011-0001:

> 10. The State Controller shall transfer unspent appropriation balances as of June 30, 2017, from the Department of State Hospitals' State Controller Items 4520-011-0001, 4530-011-0001, and 4550-011-0001 to the California Department of Corrections and Rehabilitation's Item 5225-002-0001. The unspent appropriation balances will be used to fund outstanding obligations for the psychiatric in-patient programs located at the California Medical Facility, the California Health Care Facility, and Salinas Valley State Prison. The intent of this language is to provide authority and flexibility for the California Department of

Corrections and Rehabilitation to process the aforementioned outstanding obligations, which include, but are not limited to, vendor invoices, employee worker's compensation claims, legal settlements (lawsuit costs), or employee payroll activities owed by the psychiatric programs under the Department of State Hospitals as of June 30, 2017. The outstanding vendor invoices shall be limited to existing contracts or purchase orders executed by the Department of State Hospitals. The California Department of Corrections and Rehabilitation may collect outstanding Department of State Hospitals receivables from employees or vendors as of July 1, 2017.

11. If necessary, the State Controller shall transfer unspent appropriation balances as of June 30, 2017 from Item 4440-011-0001 to Item 5225-002-0001 consistent with direction provided by the California Department of Corrections and Rehabilitation and the Department of State Hospitals.

BACKGROUND

The 2017-18 Governor's Budget includes the transfer of three of DSH's inpatient psychiatric programs, located on the grounds of the California Medical Facility (CMF), California Health Care Facility (CHCF), and Salinas Valley State Prison (SVSP), effective July 1, 2017. If approved, the operations and administration of these programs will transfer to CDCR, including all associated staff and costs. The total budget of these programs equates to approximately $250.4 million and contains 1,977.6 associated staff.

With the recent signing of Senate Bills 28 (Chapter 1, Statutes of 2017), 47 (Chapter 2, Statutes of 2017), and 48 (Chapter 3, Statutes of 2017) on March 15, 2017, the Governor has now approved multiple pieces of legislation that authorize funding for the state's new Memoranda of Understanding (MOUs) with 15 of the 21 collective bargaining units (1, 3, 4, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21).

The Spring 2017 budget process included additional employee compensation adjustments related to various memoranda of understanding bargaining agreements, which impacted classifications included in the transfer of inpatient psychiatric programs. The calculated impact of these adjustments is $4 million GF. The employee compensation adjustment for these positions was built into DSH's budget for current year, and must be transferred to CDCR's budget when the inpatient psychiatric programs are transferred beginning in 2017-18.

The intent of the Budget Bill language is to provide a process that is seamless to the program, vendors, and stakeholders. Both departments have different accounting systems and it would be inefficient for DSH to process prior year activities. This language will also give CDCR the authority to collect outstanding receivables from employees or vendors as of June 30, 2017. Expenditure authority to be transferred will require a vetting process of the outstanding obligations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

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

ISSUE 37: METROPOLITAN STATE HOSPITAL CENTRAL UTILITY PLANT

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

The Department of State Hospitals (DSH) requests provisional budget bill language to provide General Fund flexibility beginning in Fiscal Year 2017-18, for the ongoing operation of DSH-Metropolitan's (DSH-Metro) existing Central Utility Plant (CUP) prior to the expiration of the current third-party owner-operator's contract in February 2018. The existing CUP supplies steam for hot water and central heating as well as chilled water for air conditioning to 32 patient housing and administrative buildings.

It is requested that provisional language be added to Item 4440-011-0001 to enable DSH to request funding necessary to continue to contract for heating and cooling through the existing central utility plant for the Metropolitan State Hospital. Currently, the central utility plant is owned and operated by a third-party contractor whose lease is scheduled to end in February 2018. The following requested provisional language reflects the flexibility needed to continue operating the plant, and includes legislative notification.

Add the following provision to Item 4440-011-0001:

> 12. Upon approval of the Department of Finance, the amount available for expenditure in this item shall be augmented for the purposes of continued operation of the existing vendor-operated central utility plant at the Metropolitan State Hospital. The Department of Finance shall provide written notification of the augmentation to the Joint Legislative Budget Committee within 10 days from the date of approval.

BACKGROUND

Opened in 1916 and located in the city of Norwalk, DSH-Metro includes 162 acres with 109 onsite structures such as patient housing, administrative buildings, and warehouses. DSH-Metro accommodates Incompetent to Stand Trial (1ST), Not Guilty by Reason of Insanity (NGI), Mentally Disordered Offenders (MDO) and other court-committed patients. Approximately 1,500 employees work at DSH-Metro providing around-the-clock care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, psychiatric technicians, and other clinical and administrative staff.

DSH is required by the California Code of Regulations (CCR) to provide comfortable ambient air and water temperatures for patient and staff use. The Joint Commission and California Department of Public Health perform life/safety, Centers for Medicare and Medicaid Services (CMS) conditions of participation and licensing compliance reviews. Federal reimbursement from CMS is contingent upon DSH compliance with all licensing requirements.

Construction of DSH-Metro's CUP was completed in spring 1988 with a net electrical output of 27,800 Kilowatts. The CUP contains the central steam boiler system and chiller plants, separate power cogeneration plant, underground mechanical, electrical and steam distribution infrastructure, heating, ventilation and air-conditioning (HVAC) and energy management systems. This CUP is also connected to natural gas, water and sanitary sewer lines.

Wheelabrator Norwalk Energy Corporation (WNEC) presently owns and operates the CUP and is party to a long-term Power Purchase Agreement (PPA) with Southern California Edison Company (SCE). The revenue-based PPA between WNEC and SCE allows WNEC to sell electricity to SCE that is produced in excess of the levels needed to meet the DSH-Metro CUP's operational needs. SCE has recently communicated an interest to discontinue the contract agreement with WNEC which would be dissolved in February 2018. In addition, WNEC leases the CUP's buildings and grounds from the State via a ground lease between the Department of General Services (DGS) and WNEC. This lease will also expire in February 2018.

Upon termination of the PPA, WNEC will no longer have an active agreement with SCE which obligates DSH-Metro to purchase and assume responsibility for the ongoing reliability, performance and maintenance requirements of the heating and cooling systems or explore other options to keep the hospital operational. Due to the inefficient design of the CUP and age of the equipment, along with the lack of modern environmental controls, future repair and maintenance aspects of the CUP are difficult and costly due to the limited availability of replacement parts and specialized resources (i.e. Stationary Engineers) required to maintain the 24/7 operations.

As such, DSH and DGS explored three viable options for providing continued utility services while it evaluates future potential energy efficient options for the provision of hot water and central heating plus chilled water for air conditioning at DSH-Metro. DSH anticipates a future Capital Outlay proposal to facilitate a long-term energy efficient solution. The timing of this potential request is unknown at this time and is contingent upon costs and options available.

To retain licensure, CCR Title 22 requires facilities to comply with acceptable ambient air and water temperatures for patient areas. In addition to basic standards of living and dignity, aggression perpetuated from patient frustration due to a lack of hot water or uncomfortable hot or cold ambient air may impede medical and clinical treatment, as well as increase the risk of multiple adverse psychosocial and psychological outcomes. For example, psychotropic medications may impair the body's ability to regulate its own temperature. During hot and humid weather, individuals taking antipsychotic

medications are at risk of developing excessive body temperature, or hyperthermia, which can be fatal. Individuals with chronic medical conditions (i.e., heart and pulmonary disease, diabetes, alcoholism, etc.) are especially vulnerable.

It is unknown if the existing agreements between WNEC/SCE will be extended, thus DSH must take action to ensure ongoing central utility services to DSH-Metro.

LAO

"For many years, DSH has contracted with Wheelabrator Norwalk Energy Corporation to provide steam and chilled water to DSH-Metropolitan from a central utilities plant located at the facility that is owned and operated by the corporation. However, the contract is set to expire in February 2018. In November 2017, the Department of General Services informed the department that it cannot extend the existing contract, but has to go through a competitive bid process or purchase the facility and operate it with DSH staff. According to the department, if no action is taken by February 2018, the plant could cease operating, which could threaten the licensure of DSH-Metropolitan. In response, the administration is proposing provisional language giving it the authority to spend any amount necessary to continue to operate the central utilities plant. While it is critical to maintain access to the utilities provided by the plant, we recommend rejecting the proposed provisional language as it significantly undermines legislative control. At budget hearings, the administration should discuss possible alternatives—both short-term and long-term. In addition, we will be researching alternatives available to address the ongoing need for the plant and will advise you of them in the near future."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

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

ISSUE 38: PATTON STATE HOSPITAL FIRE ALARM CAPITAL OUTLAY DELAY (ISSUE 400)

PANELISTS

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**

Public Comment

PROPOSAL

This proposal effectively is a withdrawal of the January proposal for $6,140,000 to move forward with this project. Now, however, this project must be delayed due to the reasons described below. This Subcommittee heard the original request for funding on ***February 27, 2017***.

It is requested that Item 4440-301-0001 be decreased by $6,140,000 to reflect the deletion of the construction phase of the Patton Fire Alarm System Upgrade Project.

BACKGROUND

While finalizing design, it was discovered that the design needed to be altered. For example, alarms will need to be placed in new locations and new wiring and lights will need to be added above patient rooms. These unanticipated changes led to increased project costs and more time is needed to analyze the revised design and the total project estimate. Funding for the construction phase of this project will be requested again in the future.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration present this proposal.

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