California State Assembly

Assembly Budget Agenda

Subcommittee No. 1 on Health

Assemblymember Dr. Akilah Weber, Chair

Monday, April 29, 2024

2:30 P.M. – State Capitol, Room 127

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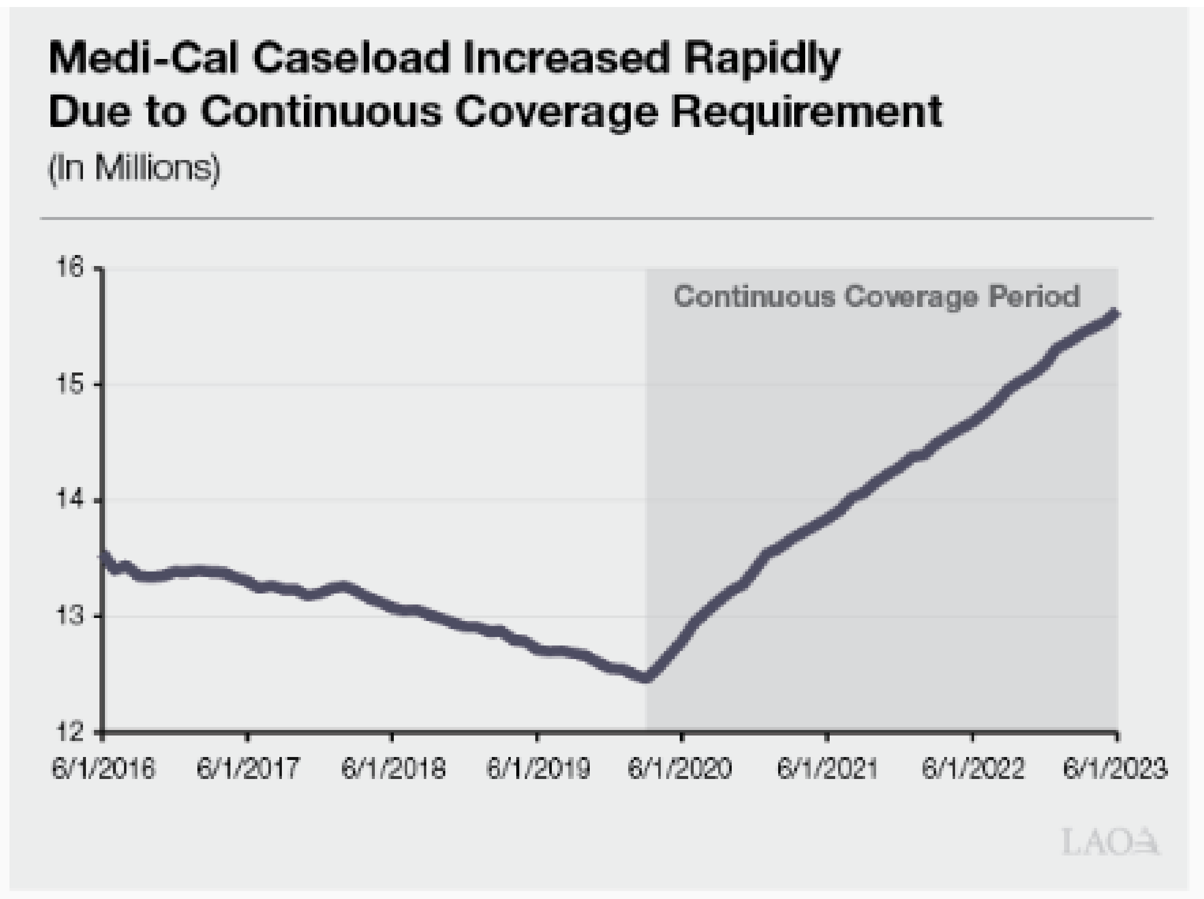
Public Comment will be taken in person after the completion of all of the panels.

Items To Be Heard

4260 Department of Health Care Services

Issue 1: Medi-Cal Caseload and Enrollment

The expiration of the continuous enrollment condition authorized by the Families First Coronavirus Response Act (FFCRA) presents the single largest health coverage transition event since the first open enrollment period of the Affordable Care Act. As a condition of receiving a temporary 6.2 percentage point Federal Medical Assistance Percentage (FMAP) increase under the FFCRA, states were required to maintain enrollment of nearly all Medicaid enrollees during the COVID-19 Public Health Emergency. In California, this resulted in nearly three million additional enrollees in Medi-Cal, as noted in this graph provided by the Legislative Analyst's Office:



Medicaid Unwinding

The Consolidated Appropriations Act, 2023, delinked the end of the FFCRA's Medicaid continuous enrollment condition from the end of the COVID-19 Public Health Emergency. As a result, the Medicaid continuous enrollment condition ended on March 31, 2023. States were required to resume normal operations, including restarting full Medicaid and CHIP eligibility renewals and terminations of coverage for individuals who are no longer eligible. Beginning April 1, 2023, states were able to terminate Medicaid enrollment for individuals no longer eligible. States will have up to 12 months to return to normal eligibility and enrollment operations. This policy is called "Medicaid unwinding". California began this process in July 2023.

Since this "unwinding" took effect, over 20 million Medicaid enrollees have been disenrolled nationwide. The extent of disenrollment varies by state, with an estimated 57 percent of enrollees losing coverage in Utah to 12 percent in Maine. Most of the loss of coverage is a termination for procedural reasons, with one estimate projecting 76 percent of disenrollments were due to that reason in California, slightly higher than the national average of 69 percent.

This unwinding has impacted Medi-Cal caseload, resulting in a projected reduction overall of 1 million cases in the budget year, as noted in the chart below that was provided by the Legislative Analyst's Office.

Governor's Budget Estimates of Medi-Cal Caseload

Average Monthly Enrollment

				Change From 2023-24	
	2022-23	2023-24	2024-25	Number	Percent
Families and Children	7,835,000	7,492,000	6,950,100	-541,900	-7%
ACA Optional Expansion	5,085,400	4,925,300	4,493,100	-432,200	-9
Seniors	1,203,200	1,218,900	1,209,900	-9,000	-1
Persons With Disabilities	1,087,100	1,062,900	1,044,200	-18,700	-2
Other	63,300	64,700	64,100	-600	-1
Totals	**15,274,000**	**14,763,800**	**13,761,400**	**-1,002,400**	**-7%**

ACA = Patient Protection and Affordable Care Act.

49 states of 50 states have seen a decline in Medicaid caseloads since the unwinding began. Overall, California has retained most of its caseload than most states; 43 other states experienced a bigger drop in caseload.

Medi-Cal Redetermination Process Flexibility

To reduce the workload associated with redetermination of eligibility and retain enrollees on the Medi-Cal caseload, the State has enacted several simplification and flexibility measures. Some of these measures will remain going forward, while others are granted under temporary federal approval that could expire at the end of the calendar year. These measures include:

Increasing Use of an Automatic Renewal Process. The "ex-parte" review process allows counties to automatically renew enrollees in Medi-Cal in cases in which eligibility-related information from federal and state sources allow for renewal without any contact with the beneficiary. Ex-parte renewals are a key tool in increasing the overall number of county redeterminations per month. Flexibilities that increase ex-parte renewals allow:

- Ex-parte renewals in certain cases in which income under 100 percent of the federal poverty level was verified in the previous 12 months.
- Ex-parte renewals for households with income generally derived from stable sources, such as Social Security or pensions.
- Expanded use of asset verification reports for ex-parte renewals until the elimination of the asset test on January 1, 2024.

Reducing Documentation Requirements. The state has also received approval for flexibilities that reduce county workload and simplify processes for enrollees. Specifically:

- When self-attested information cannot be verified with electronic data sources, a beneficiary can provide a reasonable explanation for the discrepancy in lieu of needing to provide documentation.
- Counties can assume no change in assets (and renew on an ex-parte basis) when asset verification data returns no information within a reasonable time frame (20-30 days depending upon the circumstance) rather than seek additional verification from the enrollee.
- Counties can use updated contact information provided by managed care plans, Program of All-Inclusive Care for the Elderly (PACE) organizations, and the United States Postal Service in lieu of requiring confirmation by the beneficiary.
- Counties can extend a renewal date by 12 months when contact is made with certain hard-to-reach populations, including individuals experiencing homelessness, seniors, and persons with disabilities.

- The amount by which income reported by a beneficiary can deviate from that shown in federal data sources is increased from 10 percent to 20 percent.
- The requirement that applicants apply for certain types of available income (such as unemployment or veteran's benefits) and medical support from a non-custodial parent within 90 days of approval is waived.

Panel

- Sarah Brooks, Department of Health Care Services
- Aditya Voleti, Department of Finance
- Meg Sabbah, Department of Finance
- Ryan Miller, Legislative Analyst's Office

LAO Comments

State's Efforts to Limit Impacts of Continuous Coverage Unwinding Appear to Be Working. The Governor's budget estimates that Medi-Cal caseload will decline by about 1 million enrollees in 2024-25 over the previous year - to 13.7 million. This decline reflects that the state and counties currently are redetermining eligibility for a historic high number of Medi-Cal enrollees, as a result of the unwinding of a federal policy that resulted in rapid caseload growth since the start of the pandemic. The state has in place several federally approved flexibilities meant to maximize continuity of coverage for enrollees during this time. Based on our review of recently released data, the state's efforts appear to be working. Specifically, caseload is coming in much higher than was previously assumed to be the case—both by the administration and our office. The Governor's budget caseload estimates are broadly reflective of the recent data on continuous coverage unwinding and therefore are reasonable.

Staff Comments

The State has exceeded expectations in retaining Medi-Cal enrollees on the caseload this year, which deserves recognition. However, it may be too soon to celebrate a victory, as we have also relied on temporary flexibility in our process from the federal government to achieve this outcome and still have 76 percent of our disenrollments stem from bureaucratic procedural reasons.

Staff provides the following questions for consideration of the members at the hearing:

- Do you expect the Medi-Cal caseload to continue to retain enrollees or do you just assume further declines in enrollment going forward?

- Which of the redetermination simplifications and flexibilities do you anticipate the State will be able to continue next year?
- Is the State exploring options to reduce procedural denials of redetermination?
- What is the State performance on timeliness of redetermination?
- Outside of Medicaid unwinding, what are some of the other significant enrollment trends we are seeing in our caseload?

The May Revision will include a revised Medi-Cal caseload estimate that will reflect data from the winter and the spring.

0-5 Continuous Coverage

Given the high rates of procedural denials for coverage, this Subcommittee previously explored mirroring other states and exempting children 0-5 from needing an annual redetermination for Medi-Cal coverage. The 2022 budget included a provision that would allow the Department of Finance to certify funding to implement continuous Medi-Cal enrollment for children ages zero to five if certain state revenue conditions materialized. That provision was not activated by the Department, thus the policy did not go into effect.

Staff Recommendation: No action required.

Issue 2: California Advancing and Innovating Medi-Cal (CalAIM)

Adopted in the 2021-22 budget package, California Advancing and Innovating Medi-Cal (CalAIM) is a large set of reforms in Medi-Cal to expand access to new and existing services and streamline how services are arranged and paid. The reforms are intended to take place over five years and include initiatives to integrate care, improve case management, and expand the level and scope of care the system can provide. For example, as part of CalAIM, managed care plans are authorized to provide certain nonmedical community supports (such as housing support and transitional services) that address the social determinants of health. CalAIM also includes initiatives that help counties and other stakeholders build capacity to provide a continuum of care for individuals.

When adopted, CalAIM had four major components:

- **Increasing Services to High-Risk, High-Cost Populations**: Create an enhanced care management benefits, ensure enrollment assistance for individuals transitioning from incarceration; reimburse managed care plans to provide nonmedical “in lieu of services”; and require managed care plans to develop population health management programs.

- **Transforming and Streamlining Managed Care:** Transition certain benefits and enrollee populations from fee-for-service to managed care and vice versa ,modify approach to coordinating care of beneficiaries eligible for both Medi-Cal and Medicare; et capitated rates on a regional rather than county basis; and require NCQA accreditation of Medi-Cal managed care plans; deem as meeting most federal and state standards.

- **Rethinking Behavioral Health Service Delivery and Financing:** Streamline behavioral health financing; seek new federal funding opportunity for residential mental health services; change medical necessity criteria for beneficiaries to access services; implement “no wrong door” approach for children obtaining mental health services and; integrate county administration of specialty mental health and substance use disorder services.

- **Extending Components of the Current 1115 Waiver:** Continue public hospital funding under other programs; maintain expansion of substance use disorder services begun under DMC-ODS; and extend certain components of the Dental Transformation Initiative and provide a new covered benefit, silver diamine floride.

Since December 2021, CMS has approved four amendments to the CalAIM Section 1115 demonstration, including 1) to permit the state to increase and eventually eliminate asset limits for certain low-income individuals whose eligibility is not determined using the modified adjusted

gross income (MAGI)-based financial methods; 2) to permit the state to provide in-reach services to justice-involved populations for up to 90-days prior to release; 3) to assist the state in delivering the most effective care to its members in light of the COVID-19 PHE, and ensure renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes member burden and promotes continuity of coverage at the end of the COVID-19 PHE; and 4) to implement county-based model changes in its Medi-Cal Managed Care program (aligns with related changes approved in to the CalAIM Section 1915(b) waiver).

Governor's Budget Proposal:

The Department of Health Care Services (DHCS) requests three-year limited-term (LT) expenditure authority of $6,600,000 ($3,300,000 General Fund (GF); $3,300,000 Federal Fund (FF)) in fiscal year (FY) 2024-25 through FY 2026-27. The purpose of the budgeting shift from the Medi-Cal Local Assistance Estimate to state operations is to align with the budget structure for other technical assistance contracts DHCS has engaged in contractor project management, technical assistance, and stakeholder engagements. This contract is for the California Advancing and Innovating Medi-Cal (CalAIM) Managed Long-Term Services and Supports (MLTSS) and the Dual Eligible Special Needs Plan (D-SNP) integration activities. This proposal would result in no new General Fund costs above the 2023-24 budget level for these activities.

CalAIM includes initiatives to expand MLTSS and the Medi-Medi Plan D-SNP approach to all counties by 2026. MLTSS refers to the delivery of long-term services and supports through capitated Medi-Cal managed care programs. Medi-Medi Plans refer to a specific type of Medicare Advantage plan that provides integrated care for members dually eligible for Medicare and Medi-Cal. In these plans, members are enrolled in the same plan for both sets of benefits. Dually eligible members have high rates of chronic conditions and health care utilization, including high utilization of Long-Term Services and Supports under Medi-Cal. D-SNPs are required to coordinate care across all Medicare and Medi-Cal benefits, including benefits carved-in and carved-out of Medi-Cal managed care.

Medi-Medi Plans are the successor plans to Cal MediConnect plans, and are available in seven counties in 2023, with enrollment of approximately 230,000 members as of April 2023. DHCS anticipates that Medi-Medi Plans will be available in five additional counties starting in 2024. Welfare and Institutions Code Section 14184.208(c)(1) requires all Medi-Cal managed care plans to establish Medi-Medi Plans by January 1, 2026, or have a DHCS approved exemption. As of April 2023, there were about 1.6 million members dually eligible for Medicare and Medi-Cal in California that had both Medicare Parts A and B. All these members can or will be able to enroll in Medi-Medi plans, for integrated care.

The current local assistance funding for these CalAIM initiatives supports contractor activities for project management, technical assistance, policy development support, stakeholder engagement meetings and documents, and individual/local provider, member, and health plan outreach for the long-term care Medi-Cal managed care carve-in and the transition to the D-SNP structure in all counties by 2026.

Panel

- Sarah Brooks, Department of Health Care Services
- Ty Ulrey, Department of Finance
- Meg Sabbah, Department of Finance
- Ryan Miller, Legislative Analyst's Office

Staff Comments

What is CalAIM?

It is hard to describe CalAIM without transitioning into a litany of different policy reforms, changes, and system changes that are all occurring at the same time. In many ways, CalAIM is more of a brand than a coherent policy scheme, with it being treated as an umbrella for several different policy initiatives that were previously being considered in separate conversations. While the initial proposal envisioned synergy and integration of these various programs, it is hard to see such a narrative in recent updates, milestones and initiatives Even the overview of the initiative on the Department of Health Care Services website provides a single paragraph of introduction and prompts readers to pick which programmatic silo to explore further.

The sheer number of differing initiatives makes it hard to use the term CalAIM as a meaningful descriptor. It may be more appropriate to think of CalAIM as more of an "era" for health policy during the Newsom Administration, similar to how historians describe the "New Deal" from the Roosevelt Administration and the "Great Society" programs during the Johnson Administration.

Given the Subcommittee's previous hearing on the changes in the behavioral health reforms underway, which are part of the CalAIM umbrella, staff suggest focusing on the two of the other initiatives:

Improving care for hardest to serve/"frequent flyers". This initiative was highlighted as the major feature of the initial CalAIM waiver - looking at how California can better coordinate care for the small percentage of population that disproportionately results in health care costs. This includes the recent federal ability to claim federal funds for some non-medical services and items, including some limited housing assistance. The Department has created the Enhanced Care Management program for this purpose, as well as had several initiatives such as the

Providing Access and Transforming Health (PATH) capacity building effort and the Justice Involved Initiative targeting that hard to serve population.

The Subcommittee may wish to explore this further with the following questions:

- Please provide an update on the Enhanced Care Management?
- Have the expanded and new reimbursable services been implemented for Californians? If not, when do we expect to see that happen?
- How have access and equity considerations been incorporated in our approach?
- What outcomes have we seen from the State's PATH investments?
- What should we expect to see from this effort over the next 12 months?

Continuing movement of Medi-Cal cases to managed care. Perhaps the most significant initiative in CalAIM is to finally achieve the long standing goal of the Administration to move most of the remaining fee for service Medi-Cal caseload into managed care. This includes initiatives to move existing programs the serve dual-eligible populations, long-term care, and children and families into a managed care approach. One of these transitions, involving the CHDP program, is discussed in the next issue of the agenda.

The populations being moved to manage care were typically left in fee for service because of their high costs per case or unique medical characteristics that made their health care needs and costs difficult to fit into a generic managed care model. While the scale of managed care and the synergy with across health specialties may reduce the costs and improve the care for these individuals, managed care has traditionally struggled to meet the needs of individuals that are outliers in health needs and costs. Given this, staff has prepared the following questions for the Subcommittee to consider.

- Can you provide an update on the transitions underway at this time?
- After the CalAIM transitions are complete, how many MediCal enrollees do you expect to remain on fee for service and what populations will be left using that payment model?
- How will the state insure that managed care plans offer the quality care that our vulnerable populations need?
- What accountability measures should this Subcommittee consider to measure that the migration of these populations to managed care did not diminish or reduce services to these populations?
- Can you provide an update on the Incentive Payment Program and what type of outcomes we expect from that initiative?

Staff Recommendation: Hold Open

Issue 3: Child Health and Disability Prevention Program Phase-out

The 2022 Health Trailer bill, Senate Bill (SB) 184 (Committee on Budget and Fiscal Review, Chapter 47, Statute of 2022), authorized DHCS to phase out the Child Health and Disability Prevention (CHDP) program and transition services to other Medi-Cal delivery systems by July 1, 2024. This transition's goal was to simplify and streamline the delivery of services to children and youth under the age of 21, in alignment with the goals of the California Advancing and Innovating Medi-Cal (CalAIM) initiative. CalAIM increases standardization of care across Medi-Cal by consolidating care responsibilities for children and youth under Medi-Cal managed care health plans (MCP). DHCS plans to reallocate CHDP county allocations starting in fiscal year (FY) 2024-2025.

Currently, the CHDP program includes:

- Preventive health, vision, dental screening, and care coordination for Fee For-Service (FFS) members eligible for Medi-Cal for Kids & Teens, federally known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit;
- CHDP Gateway which serves as a presumptive eligibility (PE) entry point for children to receive temporary preventive, primary and specialty health care coverage through the Medi-Cal Fee-For-Service (FFS) delivery system;
- Responsibility for local administration of the Health Care Program for Children in Foster Care (HCPCFC); and
- CHDP-Childhood Lead Poisoning Prevention (CLPP) program activities.

According to DHCS, the transition of CHDP programs and services will not result in a loss of EPSDT services, as these services are covered in both the Medi-Cal fee for service and managed care delivery systems. PE services will continue and expand under the new Children's Presumptive Eligibility (CPE) program, and PE services for individuals over the age of 19 will continue under Hospital Presumptive Eligibility (HPE).

HCPCFC will be preserved as a standalone, locally self-administered program. CHDP-CLPP activities will transition to MCPs and the California Department of Public Health (CDPH) Lead Poisoning Prevention Program Branch. DHCS will continue to share childhood lead poisoning data with CDPH and work in close partnership with CDPH on this front.

According to DHCS: "HCPCFC utilizes a comprehensive shared nursing care management model, serving as a central point of contact to bridge and connect all entities providing health services and support, to meet the unique health needs of this population. HCPCFC provides consultation and resource guidance to the multidisciplinary care team to address and oversee the medical, dental, developmental, and behavioral health needs of foster children and youth.

The program navigates the health care system to facilitate appropriate referrals and continuity of care for children and youth who are in out-of-home placement."

In March, the Department issued a transition plan that articulated how these activities would change, with the expectation that the migration would take effect at the beginning of the fiscal year.

Panel

- Sarah Brooks, Department of Health Care Services
- Michelle Gibbons, County Health Executives Association of California
- Andrew Huitt, Department of Finance
- Paula Fonacier-Tang, Department of Finance
- Jason Constantouros, Legislative Analyst's Office

Staff Comments

Foster children are the most vulnerable population in the state. Children in foster care have among the worst outcomes in income, health, incarceration, homelessness, behavioral health, educational attainment, employment, and life expectancy. These children are wards of the State of California, and the state has recognized its failure as a parent to provide the safety and stable environments necessary to change these outcomes. This includes a decade long initiative at the Department of Social Services to deinstitutionalize care and reform rates to increase the likelihood of family-based placements. Our failures in the past are manifesting in lower quality of life for all Californians and most costs to the State. We are working to break that cycle and have made progress to that goal.

One of the critical responsibilities for the CHDP program is to provide the case support necessary to ensure foster care children get health care. Because foster care placements can involve frequent relocations, that could include moving far distances, the managed care model does not fit the coverage needs for this population. The proposed transition from CHDP to the new HCPCFC program represents a great deal of risk to this powerless and fragile population. Yet, the overall plan lacks finesse and certainty. We are on the verge of failing our children once again.

When the proposed change was included in the 2022 budget package, the Legislature sought to mitigate the disruption and uncertainty that this proposal would have during implementation. The health trailer bill included provisions specifically to consider continuity of services and preservation of institutional knowledge of existing county staff. However, the January budget proposed a reshuffling of local funding to county health departments, which would sizably reduce

the dedicated funds for the foster care population. Additionally, counties will have to reshuffle their existing staff into a new staffing model that does not fully resemble what is in place at this time. Noting that many staff would not land in this abrupt musical-chairs that would happen on Monday July 1, the transition report hopefully mentions that the skills of these staff could be transferrable to other health-related programs, if any happen to have vacancies in the next 60 days. Thus, the plan itself assumes that counties would lose many staff with decades of work experience working with the foster care population, a loss of expertise that would linger in counties for years.

While the stakes are high for the children being transitioned, the immediate costs are pretty small to delay or provide some type of transition buffer. The Subcommittee could explore if the State is really in the position to make all of the proposed changes in the next two months, and if there are provisions to offer flexibility to help counties adapt their current models to the new models with minimal disruption. To that end, staff suggest the following questions:

1. Transition of "CHDP Gateway" to Children's Presumptive Eligibility (CPE). DHCS indicates the CHDP Gateway will be replaced by CPE, and all current CHDP Gateway providers will be automatically enrolled in CPE. DHCS notes in 2022-23, approximately 2,500 monthly (30,000 annually) were enrolled through the CHDP Gateway.

- DHCS is doing outreach to providers, but what assurance can DHCS provider that there will be no gaps in access to coverage, and providers will be ready on July 1,2024 to use the CPE process versus the CHDP Gateway?
- How many providers have done the CPE training to date?
- DHCS explains Health Enrollment Navigators will be available to assist families in submitting Medi-Cal applications through the CHDP transition period.
- Are Navigators available statewide?

2. EPSDT and Case Management/Care Coordination. DHCS notes that historically, local CHDP programs provided EPSDT screenings, including preventive health, vision, and dental screenings, follow-up services, and care coordination for children and youth under the age of 21 who were enrolled in the Medi-Cal FFS. CHDP thus forms a local, county-based safety net for children who initially enroll in Medi-Cal through the CHDP Gateway, and for those who remain enrolled in FFS, who may not be linked with primary care provider (PCP), to facilitate rapid screening and the provision of needed follow-up services. Thus, it is a gateway to care, not just an eligibility pathway. Ensuring access to care is especially critical given California's relatively low utilization of children's preventive care and difficulties with access, as noted in recent Bureau of State Audit reports.

Although FFS providers are required to provide EPSDT services, local CHDP programs seem to be filling a need for children who may otherwise fall through the cracks by enrolling them through the Gateway, initiating care and getting them connected with a PCP and other referrals.

- Can DHCS provide assurance that on-the-ground in counties where CHDP programs formed an important safety net, that children will still be effectively linked to care?
- Per All-Plan Letter (APL) 23-005, Medi-Cal managed care plans are required to provide case management and care coordination to ensure that Members under the age of 21 can access medically necessary EPSDT services as determined by the managed care plan provider.
- However, in the CHDP transition plan, as it pertains to FFS, DHCS states, “Referrals and care management or case management services for the FFS population will continue to be processed or provided by any FFS provider, FQHCs, CCS programs, HCPCFC, or MCAH or receive services from county social workers, TCM, HCBS waiver providers, or through the community health worker (CHW) benefit or other programs as identified.” This implies some children will have less access to care than they have now under CHDP because children who are newly enrolled and/or who remain in FFS will lose access to care management and case management that they now have under CHDP, unless they qualify for case management programs that are targeted to specific eligibility/population, like CCS or HCPCFC.
- Has DHCS evaluated how many children currently served by CHDP would not be eligible for those other case management programs?
- To prevent children from losing access to services they now have access to, is DHCS willing to clarify that all children in Medi-Cal are eligible for care coordination and/or case management, as medically necessary under EPSDT, such that a primary care provider in FFS can provide care coordination or case management as necessary for any child, regardless of whether they meet specific eligibility/population status?

3. HCPCFC and DHCS Certification of Activities. Pursuant to the requirements of SB 184, Section 124024 (d), DHCS certified that all activities required pursuant to subdivision (a) of that section have been completed. However, it appears some of the activities are still in process or not clearly addressed. In addition, there is limited detail demonstrating the adequacy of the budget allocation for county administration to continue HCPCFC as a stand-alone program.

- SB 184 requires “An analysis and plan for retaining existing local CHDP positions through the exploration of new partnerships and roles, or through bolstering existing programs that can leverage CHDP expertise, or through both.” The transition plan appears to only reflect an analysis of programs that may have overlapping position classifications.

- Is there also a plan for retaining these positions, as required in statute? For instance, is there a crosswalk at the county level of how these positions would be retained and reallocated?
- SB 184 requires DHCS to take actions necessary to continue HCPCFC and Childhood Lead Poisoning Prevention program. However, it appears interagency agreements are have not been finalized.
- Please provide a status update on these IAs.

DHCS proposes to allocate approximately $13 million to fund HCPCFC administrative costs, and to redirect the majority of CHDP funding to fund costs for an unrelated county activity, the California Children's Services (CCS) Monitoring and Oversight initiative. DHCS's November 2023 Local Assistance Estimate proposes to redirect $20.8 million of the total $33.9 million CHDP county allocation for FY 2024-25 to CCS Monitoring and Oversight.

- Please explain the budget methodology used to develop the $13 million HCPCFC allocation. Please address specifically how the proposed allocation to HCPCFC was developed to account for the backfill of administrative support lost with the phase-out of CHDP, and whether and how the allocation was adjusted for new program requirements associated with revisions of the new HCPCFC manual.
- The CHDP Transition Plan indicates that one of the steps on the transition of HCPCFC is to establish county-by-county allocations. However, county allocations have not been shared. Please provide an update on the development and publishing of proposed county allocations.

4. Vaccines. The transition plan notes that CHDP requires providers to participate in the federal Vaccines for Children (VFC) program. Once CHDP is phased out, there will be no such requirement for providers to participate in VFC. Medi-Cal does not pay for vaccines for children younger than 19 because vaccines are available at no cost to participating providers for this population through VFC. Medi-Cal reimburses only an administration fee for vaccines provided through the VFC program. Therefore, in a practical sense, children enrolled in Medi-Cal can only receive vaccines through Medi-Cal if the provider is also enrolled in VFC.

DHCS's March 2022 document, "Medi-Cal's Strategy to Support Health and Opportunity for Children and Families," notes DHCS is working with CDPH and partners to identify strategies to ensure that all Medi-Cal providers participate in VFC, as well as to streamline enrollment and oversight processes for VFC sites, and to address disparities in vaccination rates by race, ethnicity, and geography

- Has DHCS analyzed the potential impact on VFC participation from removing the CHDP requirement that providers participate in VFC?

- Please provide an update on activities related to the VFC Strategic Plan. What is DHCS doing to ensure robust VFC participation?

Again, staff will note that the Legislature was asked by the Administration to give this discretion and implementation timeline to the Department, and did so with the expectation that effort would be taken to minimize the disruption of services to this critical population and important institutional workforce. Therefore, staff expects the administration to bring forward a plan that honors this agreement and mitigates any potential disruptions in the final implementation of this transition.

Staff Recommendation: Hold Open, anticipating a further update in the May Revision from the Administration

Issue 4: Children and Youth Behavioral Health Initiative Fee Schedule

The Department of Health Care Services proposes statutory changes to authorize a third-party administrator to provide statewide support services to the health care plans by centralizing provider oversight functions and claiming processes for eligible school sites eligible for reimbursement for school-linked behavioral health services.

The fee would support the ongoing statewide administrative costs associated with local education agencies billing health care plans for behavioral health care costs. The vendor provides standardized, streamlined processes for schools and health care plans as a single point of contact for 1) credentialing, 2) claims adjudication, 3) reimbursement and 4) dispute resolution. Under the CYBHI, schools districts, colleges and universities can bill health care plans for services furnished at a school site to students under the age of 26, but would have to manage claims administration, payment remittance, and provider network oversight and management processes for each health care plan that covers the provision of behavioral health services for a student 25 years of age or younger. The proposed change would allow DHCS to fund a contractor to provide services on behalf of the health care plans and be able to charge the fee to the health plans to recover the costs. Given that California has over 1,000 local education agencies, it is expected that it will also be more efficient and economical for most districts to use a vendor for billing, especially given there are existing professional services that bill health care plans for services for other clients and already have the informational technology systems and business relationships with some plans in place.

Panel

- Sarah Brooks, Department of Health Care Services
- Nathanael Williams, Department of Finance
- Paula Fonacier-Tang, Department of Finance
- Jason Constantouros, Legislative Analyst’s Office

Staff Comments

Conceptually, this proposed trailer bill seems technical and straightforward, but the actual language for the proposal has only been released in draft form and was withdrawn from the Department of Finance website.

Staff recommends the following questions regarding this proposal:

- What is the status of the draft of the bill?

- Have stakeholders in education seen this proposal and had a chance to give input on how it would work for them?
- Is the proposed fee amounts the same for the private vendor as it would be if the Local Education Agency performed the billing?

Staff Recommendation: Hold Open

California Health Facilities Financing Authority

Issue 5: Update on CHFFA

The California Health Facilities Financing Authority (CHFFA) was established to be the State's vehicle for providing financial assistance to public and non-profit health care providers through loans, grants and tax-exempt bonds. In order to meet the requirements for CHFFA financing, an institution must be a public hospital, a private non-profit corporation, or an association authorized by the laws of California to provide or operate a health facility and undertake the financing or refinancing of a project. Generally, non-profit, licensed health facilities in the State of California including adult day health centers, community clinics, developmentally disabled centers, drug and alcohol rehabilitation centers are eligible for financing.

In 2022, CHFFA issued nearly $1.4 billion in bonds, $8.1 million of HELP II Financing Loans, $62.2 million in Nondesignated Hospital Bridge Loans, and about $86.7 million of Children's Hospital Program grants.

Panel

- Carolyn Aboubechara, California Health Facilities Financing Authority
- Ty Ulrey, Department of Finance
- Ryan Miller, Legislative Analyst's Office

Staff Comments

The CHFFA plays a critical role in addressing the state's massive needs for health care facilities, including administering bonds approved by voters.

Possible questions members may consider:

- Are the higher interest rates impacting the Authority's ability to issue and refinance bonds?
- Can you provide an update on the repayment of the Nondesignated Hospital Bridget Loans?

This issue was moved from the April 8, 2024 Subcommittee hearing.

Staff Recommendation: No Action Needed

This agenda and other publications are available on the Assembly Budget Committee's website at: Sub 1 Hearing Agendas | California State Assembly. You may contact the Committee at (916) 319-2099. This agenda was prepared by Christian Griffith.