AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 27, 2023

2:30 PM, STATE CAPITOL, ROOM 127

This hearing may be viewed via its live stream on the Assembly's website at https://www.assembly.ca.gov/todaysevents.

We encourage the public to provide written testimony before the hearing. Please send your written testimony to: BudgetSub1@asm.ca.gov. Please note that any written testimony submitted to the committee is considered public comment and may be read into the record or reprinted.

The public may provide public comment after all witnesses on all panels and issues have concluded, and after the conclusion of member questions. ***Toll-free: 877-692-8957, access code: 131 51 27***

ITEMS TO BE HEARD

NON-PRESENTATION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

All panelists are asked to please be succinct and brief in their presentations (5 minutes maximum per speaker please) in order to facilitate the timely hearing of all issues. Thank you.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: OVERVIEW OF DHCS BUDGET, MEDI-CAL ESTIMATE, AND COVID-19 IMPACTS

PANEL

- **Michelle Baass**, Director, Department of Health Care Servcies (DHCS)
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance (DOF)
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office (LAO)

ISSUE 2: FAMILY HEALTH ESTIMATE

PANEL

- **Michelle Baass**, Director, DHCS
- **Tyler Ulrey**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 3: OVERSIGHT: HEARING AID COVERAGE FOR CHILDREN PROGRAM

PANEL

- **Michelle Marciniak**, Co-Chair, Co-Founder, Mom, Let California Kids Hear
- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Aditya Voleti**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 4: OVERSIGHT: CALAIM

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Linda Nguy**, Senior Policy Advocate, Western Center on Law and Poverty

- **Linnea Koopmans**, Chief Executive Officer, Local Health Plans of California
- **Kiran Savage-Sangwan**, Executive Director, California Pan-Ethnic Health Network
- **Allie Budenz**, Director of Population Health Management, California Primary Care Asociation
- **Tyler Ulrey**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 5: CALAIM: 2023 PROPOSALS

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Tyler Ulrey**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

ISSUE 6: CALAIM: DESIGNATED STATE HEALTH PROGRAMS AND DELAYED CARVE-IN OF ICF-DD AND SUBACUTE SERVICES INTO MEDI-CAL MANAGED CARE TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Tyler Ulrey**, Finance Budget Analyst, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

ISSUE 7: OVERSIGHT: PUBLIC HEALTH EMERGENCY UNWINDING

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Cathy Senderling**, Executive Director, County Welfare Director's Association
- **Laura Sheckler**, Deputy Director of Policy & Regulatory Affairs, CaliforniaHealth+ Advocates
- **Linda Nguy**, Senior Policy Advocate, Western Center on Law and Poverty
- **Aditya Voleti**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 8: MANAGED CARE ORGANIZATION TAX

PANEL

- **Michelle Baass**, Director, DHCS
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

ISSUE 9: CALIFORNIA CHILDREN'S SERVICES WHOLE-CHILD MODEL EXPANSION AND MANDATORY MANAGED CARE ENROLLMENT OF FOSTER CARE CHILDREN IN SINGLE PLAN COUNTIES TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Ann-Louise Kuhns**, President & CEO, California Children's Hospital Association
- **Aditya Voleti**, Finance Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

ISSUE 10: PROGRAM WORKLOAD BUDGET CHANGE PROPOSAL

PANEL

- **Michelle Baass**, Director, DHCS
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 11: CONFORM STATUTORY ESTIMATE REQUIREMENTS TO RECENT PROGRAM CHANGES TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 12: DELAY BUYBACK OF TWO-WEEK CHECKWRITE HOLD

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 13: MEDICAL PROVIDER INTERIM PAYMENT LOAN AUTHORITY TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Aditya Voleti**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 14: NEWBORN HOSPITAL GATEWAY TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Aditya Voleti**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

ISSUE 15: ACUTE INPATIENT INTENSIVE REHABILITATION SERVICES TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

There are no panels for non-presentation items (items 16 – 20), however any item can be moved to presentation at any time before or during the hearing by any Member.

Public Comment will be taken on all issues on the agenda, including non-presentation items, after the completion of all panels and any discussion by the Members of the Subcommittee.

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: OVERVIEW OF DHCS BUDGET, MEDI-CAL ESTIMATE, AND COVID-19 IMPACTS

PANEL

- **Michelle Baass**, Director, Department of Health Care Servcies (DHCS)
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance (DOF)
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DHCS BUDGET

The mission of the state Department of Health Care Services (DHCS) is to provide Californians with access to affordable, integrated, high-quality health care including medical, dental, mental health, substance use disorder treatment services, and long-term care. To fulfill its mission, the Department finances and administers a number of individual health care service delivery programs, including the state's Medicaid Program (Medi-Cal), which provides health care services to low-income persons and families who meet defined eligibility requirements. This state/federal partnership provides health care to over 15 million, or about one in three, Californians.

DHCS also administers programs for special populations and several other non-Medi-Cal programs, including:

- Genetically Handicapped Persons Program, California Children's Services Program, and Newborn Hearing Screening Program for low-income and seriously ill children and adults with specific genetic diseases.

- Office of Tribal Affairs is responsible for coordinating and directing the delivery of health care to Californians in rural areas and to underserved populations through the following programs: Indian Health Program, American Indian Maternal Support Services, and Tribal Emergency Preparedness Program.

- Licensing and certification, monitoring, and complaints for Driving-Under-the-Influence Programs, Narcotic Treatment Programs, Psychiatric Health Facilities, Mental Health Rehabilitation Centers, and outpatient and residential behavioral health treatment providers. DHCS also oversees and conducts complaint investigations on registered and certified Alcohol and Other Drug counselors.

- Community mental health services and substance use disorder treatment services funded by federal block grants, the Mental Health Services Fund, and other funding sources.

- Public health, prevention, and treatment programs provided via the Every Woman Counts Program, the Prostate Cancer Treatment Program, and the Family Planning, Access, Care, and Treatment Program.

Governor's Budget for DHCS:

For Fiscal Year (FY) 2023-24, the Governor's Budget proposes a total of $144.4 billion, and 4,772 positions for the support of DHCS programs and services. Of that amount, $1.3 billion funds state operations (DHCS operations), while $143.1 billion supports local assistance (funding for program costs, partners, and administration). The position count for 2023-24 includes the changes requested via budget change proposals.

Total DHCS Budget

(Includes non-Budget Act appropriations)

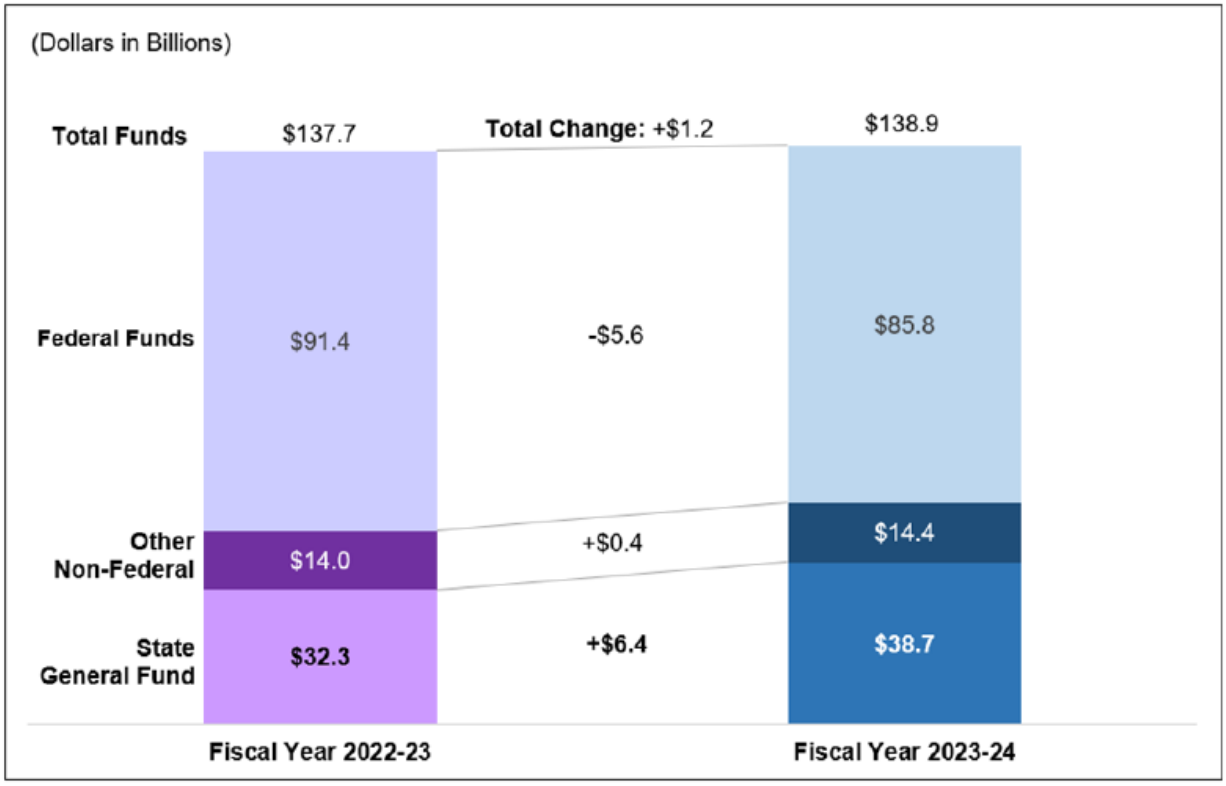
Fund Source*	FY 2022-23 Enacted Budget	FY 2022-23 Revised Budget	FY 2023-24 Governor's Budget
Local Assistance (LA)			
LA General Fund	$ 36,802,077	$ 32,695,025	$ 39,058,284
LA Federal Funds	$ 89,035,408	$ 92,080,489	$ 86,156,282
LA Special Funds	$ 14,773,431	$ 15,300,739	$ 15,801,817
LA Reimbursements	$ 1,978,609	$ 2,270,287	$ 2,066,086
Total Local Assistance	**$ 142,589,525**	**$ 142,346,540**	**$ 143,082,469**
State Operations (SO)			
SO General Fund	$ 530,567	$ 549,327	$ 350,622
SO Federal Funds	$ 644,921	$ 663,526	$ 597,047
SO Special Funds	$ 420,959	$ 569,242	$ 371,979
SO Reimbursements	$ 25,079	$ 25,674	$ 25,612
Total State Operations	**$ 1,621,526**	**$ 1,807,769**	**$ 1,345,260**
Total Funds			
Total General Fund	$ 37,332,644	$ 33,244,352	$ 39,408,906
Total Federal Funds	$ 89,680,329	$ 92,744,015	$ 86,753,329
Total Special Funds	$ 15,194,390	$ 15,869,981	$ 16,173,796
Total Reimbursements	$ 2,003,688	$ 2,295,961	$ 2,091,698
Total Funds	**$ 144,211,051**	**$ 144,154,309**	**$ 144,427,729**
** Dollars in Thousands*			

MEDI-CAL ESTIMATE

DHCS estimates Medi-Cal spending to be $137.7 billion total funds ($32.3 billion General Fund) in FY 2022-23 and $138.9 billion total funds ($38.7 billion General Fund) in FY 2023-24. This does not include Certified Public Expenditures of local governments or General Fund expenditures in other state departments. This amount reflects a $6.4 billion (20 percent) net increase over the revised 2022-23 level. The net increase primarily is driven by current law and policy adjustments as opposed to new budget proposals.

The November 2022 Medi-Cal Local Assistance Estimate projects a $0.4 billion decrease in total spending (a $4.2 billion decrease in General Fund spending) for FY 2022-23 compared to the 2022 Budget Act. This reflects a 0.2 percent increase in estimated total spending and an 11.6 percent decrease in estimated General Fund spending.

Year-Over-Year Change from FY 2022-23 to FY 2023-24



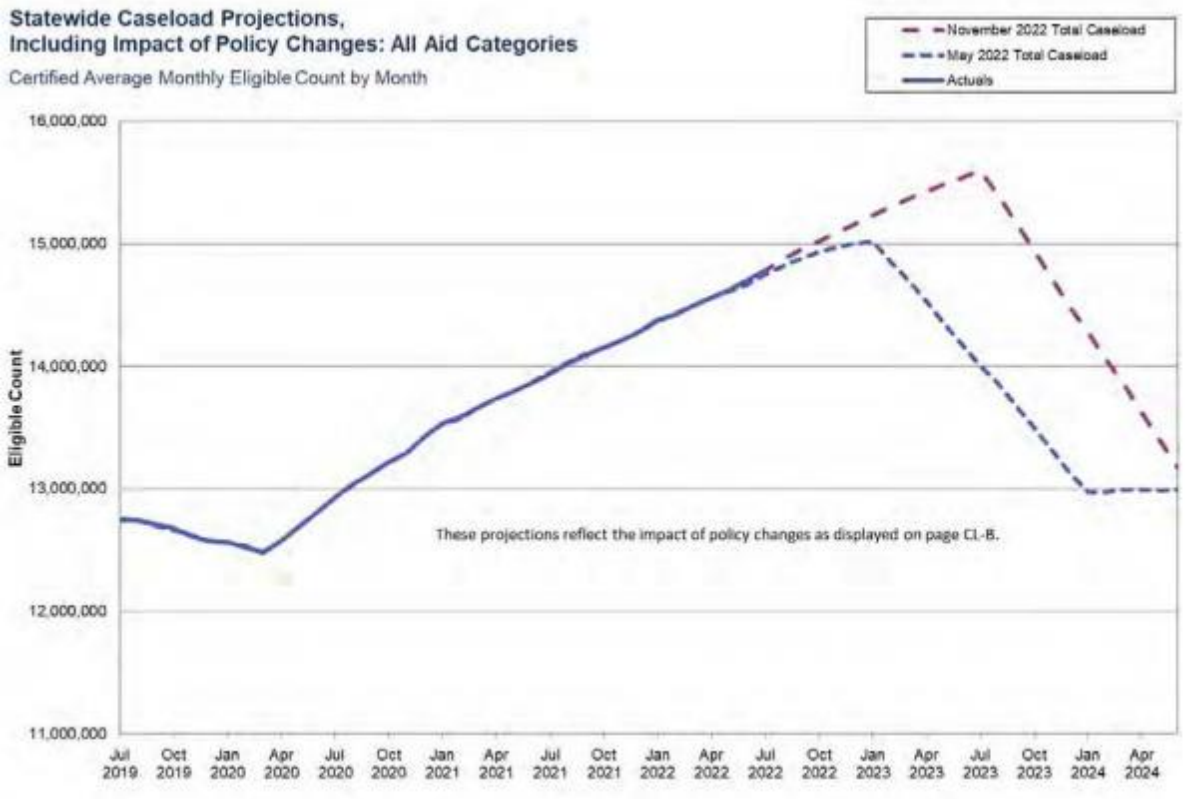
Total Expenditures	FY 2022-23 Appropriation	Nov 2022 Estimate	Change	
			Amount	Percent
Total Funds	$138,060.0	$137,746.0	($314.0)	-0.2%
Federal Funds	$88,609.4	$91,403.5	$2,794.1	3.2%
General Fund	**$36,534.2**	**$32,300.1**	**($4,234.0)**	**-11.6%**
Other Non-Federal Funds	$12,916.6	$14,042.2	$1,125.6	8.7%

Total Expenditures	FY 2022-23 Estimate	FY 2023-24 Estimate	Change Amount	Change Percent
Total Funds	$137,746.0	$138,917.2	$1,171.2	0.9%
Federal Funds	$91,403.5	$85,784.3	($5,619.3)	-6.1%
General Fund	**$32,300.1**	**$38,713.7**	**$6,413.6**	**19.9%**
Other Non-Federal Funds	$14,042.3	$14,419.2	$376.9	2.7%

Medi-Cal Caseload Projections:

November 2022 Estimate

	Eligibles			Year over Year Change Percent	
	FY 2021-22	FY 2022-23	FY 2023-24	FY 2021-22 to FY 2022-23	FY 2022-23 to FY 2023-24
Seniors	1,119,600	1,195,400	1,218,600	6.77%	1.94%
Persons with Disabilities	1,095,200	1,090,300	1,095,500	-0.45%	0.48%
Families and Children	7,492,200	7,846,400	7,458,500	4.73%	-4.94%
Optional Expansion	4,604,200	5,038,700	4,602,800	9.44%	-8.65%
Miscellaneous	57,600	61,800	62,000	7.29%	0.32%
Total	**14,368,800**	**15,232,600**	**14,437,400**	**6.01%**	**-5.22%**



As summarized in the tables and plot above, the Medi-Cal caseload is projected to continue to grow through July 2023, consistent with the Estimate's assumption that the federal PHE will continue through mid-April 2023 and the first individuals to leave the Medi-Cal caseload as a result of redeterminations will begin in August 2023. This equates to approximately 2.7 million members leaving Medi-Cal after the PHE ends and eligibility redeterminations are complete. These projections will be updated for the May Revision to reflect the impact of recent federal changes to the PHE unwinding schedule as well as more recent actual caseload levels.

The LAO analysis found that caseload and associated costs are likely overstated in the Governor's Budget, stating the following:

> "In 2020, the federal government declared the COVID-19 national public health emergency (PHE). Congress also approved policies that significantly impacted Medi-Cal while the PHE is in effect, including policies that impacted caseload and associated costs while providing enhanced federal funding. Recent federal actions decoupled these policies from the PHE and provided a time line for ramping down the policies over the next several months. However, due to the timing of the development of the Governor's budget, the administration was not able to incorporate these recent federal actions into its projections of caseload and General Fund spending for Medi-Cal. In our assessment of the administration's projections, ***after taking into account the recent federal actions and more recent caseload data, we estimate a $1 billion reduction in General Fund spending in 2023-24 relative to the Governor's budget***."

Major New Items Affecting the Medi-Cal Estimate:

PROGRAM CHANGE	COST/SAVINGS 2023-24	SUB 1 HEARING DATE
Managed Care Organization (MCO) Tax Renewal	-$6.5 billion (General Fund offset)	March 27, 2023
Designated State Health Programs (DSHP) Funding and Primary Care and Obstetric Rate Increase	-$22 million ($152.9 million General Fund savings)	March 27, 2023
Two-Week Checkwrite Delay	-$1.1 billion ($378 million General Fund savings)	March 27, 2023
California Behavioral Health Community-Based Continuum Demonstration	$6.1 billion total funds ($314 million General Fund) at DHCS and CDSS. $5.7 million TF ($0.31 million GF) at DHCS.	April 17, 2023
CalAIM Behavioral Health Payment Reform Cash Flow Funding	$375 million General Fund	April 17, 2023

CARE Court Funding	$16.5 million General Fund	April 17, 2023
Behavioral Health Continuum Infrastructure Program Funding Delay	-$480.7 million (General Fund savings)	April 17, 2023
Behavioral Health Bridge Housing Program Funding Delay	-$250 million (General Fund savings)	April 17, 2023

Summary of Major Drivers of Changes in General Fund Spending

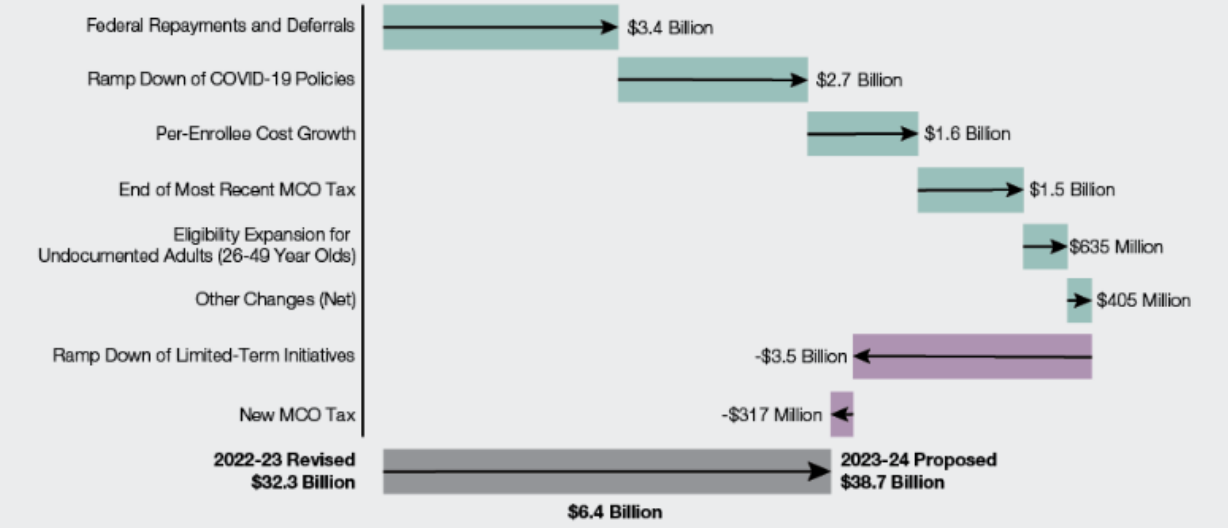
Dollars in Millions

	Current Year FY 2022-23 *Change from 2022 Budget Act*	Budget Year FY 2023-24 *Change from FY 2022-23*
New Items		
CalAIM - Behavioral Health Payment Reform cash flow funding		$375.0
Care Court county funding		$16.5
CalAIM - Designated State Health Program implementation	-$40.4	-$112.6
Proposed 2024 MCO tax		-$316.5
Delay buyback of two-week checkwrite hold	-$309.4	
Delay BHCIP Round 6	-$480.7	
Subtotals	-$830.5	-$37.6

Figure 2

Several Cost Pressures Drive Net Increase in Medi-Cal Spending

General Fund Changes From Current Year to Budget Year



MCO = managed care organization.

LAO

Adult Expansion Age 26 - 49

The Governor's Budget includes $844 million total funds ($634.8 million General Fund) to expand full-scope Medi-Cal coverage to adults aged 26 through 49, regardless of immigration status, effective January 1, 2024. With this expansion, full-scope Medi-Cal coverage will be available to all otherwise eligible Californians regardless of immigration status. This expansion is consistent with the 2022 Budget Act.

COVID-19 Impacts and Federal Public Health Emergency (PHE) Extension

The DHCS budget assumes COVID-19 related impacts of $15.9 billion total funds ($488 million General Fund) in FY 2022-23 and $12.3 billion total funds ($3.2 billion General Fund) in FY 2023-24.

For FY 2022-23, this represents General Fund savings of $773.8 million compared to the 2022 Budget Act. This downward adjustment is primarily related to additional increased federal medical assistance percentage (FMAP) savings from assuming the PHE ends in mid-April 2023 instead of mid-October 2022, offset by increased caseload costs.

For FY 2023-24, the Medi-Cal Local Assistance Estimate projects increased General Fund costs related to COVID-19 impacts of about $2.7 billion compared to FY 2022-23. This increase primarily reflects the net impact of:

- $3.6 billion in General Fund costs from the loss of increased FMAP in FY 2023-24 (only a few hundred million dollars of General Fund savings from the period through March 2023 are projected to lag into FY 2023-24).

- $627 million in General Fund savings as the redeterminations resume and caseload begins to fall in August 2023.

- Other, relatively smaller, offsetting savings as spending related to various other COVID impacts declines.

These estimates do not reflect the impact of recent congressional action to end the continuous enrollment requirement beginning April 2023 or the gradual phase-down of increased FMAP over calendar year 2023. DHCS continues to evaluate the impact of the recent federal legislation and these impacts will be reflected in the May Revision.

Significant General Fund Adjustments

The November 2022 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

Current Year (2022-23) Savings – The Estimate includes total expenditures of $137.7 billion ($32.3 billion General Fund, $91.4 billion federal funds, and $14 billion special funds and reimbursements) for the Medi-Cal program in 2022-23, a 12.9 percent decrease in General Fund expenditures compared to the assumptions included in the

2022 Budget Act. According to DHCS, the primary drivers of these decreased General Fund expenditures are as follows:

- *State Only Claiming*. $2.4 billion General Fund savings from updated estimates of federal repayments for inappropriate claims related to state only populations, as well as shifts of portions of those repayments into future fiscal years.
- *COVID-19 Impacts*. $773.8 million General Fund savings as a net result of additional quarters of enhanced federal matching funds related to the continuation of the federal public health emergency (PHE), offset by increased caseload costs. The budget does not reflect the impact of the federal Consolidated Appropriations Act and its gradual phase-down of enhanced federal matching funds and schedule for eligibility redeterminations for state Medicaid programs.
- *Delay of Behavioral Health Continuum Infrastructure Program Grants*. $480.7 million General Fund savings as a result of the delay of the final round of grant awards in the Behavioral Health Continuum Infrastructure Program (BHCIP) from 2022-23 to 2025-26 and 2026-27.
- *Delay Elimination of Checkwrite Hold*. $309.4 million General Fund savings from shifting the elimination of the two-week checkwrite hold for Medi-Cal fee-for-service claims from 2022-23 to 2024-25.
- *Impact of Federal Deferrals*. $425.3 million General Fund savings as a result of recent decisions and updated estimates of deferrals of federal matching funds for Medi-Cal expenditures.
- *Prior Year MCO Tax Reconciliation*. $308 million General Fund savings as a net result of updated estimates of payments to and recoveries from managed care plans related to risk corridor calculations for the previous tax on managed care organizations (MCO Tax).
- *Proposition 56 Impacts*. $295.5 million General Fund savings as a result of updated Proposition 56 revenue projections reducing the estimated need to backfill supplemental provider payments with General Fund resources.
- *Hospital Quality Assurance Fee Transfers*. $139.2 million General Fund savings from updated savings estimates from the Hospital Quality Assurance Fee.
- *Medi-Cal Drug Rebate Fund Transfer*. $43.6 million General Fund savings from transfer of prescription drug manufacturer rebate funding from the Medi-Cal Drug Rebate Fund to the General Fund.
- *Designated State Health Programs*. $40.4 million General Fund savings from the federal reauthorization of the Designated State Health Program, which will help cover the costs of the justice components of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.
- *Nursing Facility Rate Adjustment*. $41 million General Fund costs due to updated estimates of costs for the Workforce and Quality Incentive Program for nursing facility days and federal PHE-related add-on costs.
- *Coordinated Care Initiative Reconciliation*. $86 million General Fund costs due to reconciliations of payments for in-home supportive services in the Coordinated Care Initiative (CCI).

- *Medicare Eligibility Update*. $95.7 million General Fund costs for updated estimates of state Medicare costs for individuals for whom federal matching funds are not available.
- *Medi-Cal Rx Updated Rebates Amounts*. $124.2 million General Fund costs due to a decrease in estimated supplemental rebates from transition of pharmacy claims from managed care to fee-for-service as part of Medi-Cal Rx.
- *Shift of BHCIP Expenditures from Prior Years*. $160.6 million General Fund costs related to the delay of BHCIP expenditures previously estimated to be spent in 2021-22 into the 2022-23 fiscal year.
- *Various Other Changes*. $439.6 million General Fund costs from various other changes to the Medi-Cal program.

Budget Year (2023-24) Adjustments – The Estimate includes total expenditures of $138.9 billion ($38.7 billion General Fund, $85.8 billion federal funds, and $14.4 billion special funds and reimbursements) for the Medi-Cal program in 2023-24, a 19.9 percent increase compared to the revised General Fund expenditure assumptions for 2022-23. According to DHCS, the primary drivers of these increased General Fund expenditures are as follows:

- *End of One-Time Expenditures*. $2.8 billion General Fund savings due to the end of one-time expenditures, including BHCIP, the Children and Youth Behavioral Health Initiative, Behavioral Health Bridge Housing, and funding for Los Angeles County Justice-Involved Populations Services and Supports.
- *Hospital Quality Assurance Fee Transfers*. $690.9 million General Fund savings from updated savings estimates from the Hospital Quality Assurance Fee.
- *Proposed 2024 MCO Tax*. $316.5 million General Fund savings from the proposed reauthorization of the MCO Tax beginning January 1, 2024.
- *Medi-Cal Rx Updated Rebates Amounts*. $690.9 million General Fund savings due to an increase in estimated supplemental rebates from transition of pharmacy claims from managed care to fee-for-service as part of Medi-Cal Rx.
- *Disproportionate Share Hospital Funding Reduction*. $124.3 million General Fund savings from reduction of state spending on disproportionate share hospitals pursuant to provisions of the federal Affordable Care Act.
- *Designated State Health Programs*. $112.6 million General Fund savings from the federal reauthorization of the Designated State Health Program, which will help cover the costs of the justice components of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.
- *Impact of Federal Deferrals*. $69 million General Fund savings as a result of recent decisions and updated estimates of deferrals of federal matching funds for Medi-Cal expenditures.
- *County Behavioral Health Recoupments*. $63.5 million General Fund savings from recoupments from county behavioral health systems related to inpatient psychiatric hospital claims and state only programs.

- *CARE Act Implementation*. $16.5 million General Fund costs to support county implementation of the Community Assistance, Recovery, and Empowerment (CARE) Act.
- *Proposition 56 Impacts*. $88.4 million General Fund costs as a result of updated Proposition 56 revenue projections and the estimated need to backfill supplemental provider payments with General Fund resources.
- *Growth in Fee-for-Service Costs*. $223.3 million General Fund costs as a result of fee-for-service delivery system expenditures, primarily attributable to growth in pharmacy spending.
- *Increase in Retroactive Managed Care Payments*. $251.6 million General Fund costs related to retroactive payments to managed care plans, primarily attributable to the ten percent add-on for skilled nursing facilities.
- *Growth in Medicare Costs*. $260.1 million General Fund costs related to increases in costs for Medicare for dual eligible beneficiaries.
- *Nursing Facility Rate Adjustment*. $302.4 million General Fund costs due to updated estimates of costs for the Workforce and Quality Incentive Program for nursing facility days and federal PHE-related add-on costs, as well as including a full 12 months of the facility reimbursement rate increase.
- *Medi-Cal Drug Rebate Fund Transfer*. $363.7 million General Fund costs from decreased transfers from the Medi-Cal Drug Rebate Fund to the General Fund due to establishment of an estimated reserve in the fund.
- *Expansion of Full-Scope Medi-Cal Regardless of Immigration Status*. $634.8 million General Fund costs to expand full-scope Medi-Cal to all income-eligible Californians regardless of immigration status, beginning January 1, 2024.
- *Growth in Managed Care Costs*. $664 million General Fund costs due to growth in costs for managed care coverage of health care services for Medi-Cal beneficiaries.
- *End of Prior MCO Tax*. $1.5 billion General Fund costs related to the expiration of the previous MCO Tax.
- *COVID-19 Impacts*. $2.7 billion General Fund costs as a net result of loss of enhanced federal matching funds due to expiration of the federal PHE offset by savings from redeterminations of eligibility for Medi-Cal beneficiaries retained in the program under the federal continuous coverage requirement. The budget does not reflect the impact of the federal Consolidated Appropriations Act and its gradual phase-down of enhanced federal matching funds and schedule for eligibility redeterminations for state Medicaid programs.
- *State Only Claiming*. $3.4 billion General Fund costs from updated estimates of federal repayments for inappropriate claims related to state only populations, as well as shifts of portions of those repayments from prior fiscal years into 2023-24.
- *Various Other Changes*. $15.2 million General Fund savings from various other changes to the Medi-Cal program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests that DHCS provide an overview of the proposed DHCS budget, the November 2022 Medi-Cal Local Assistance Estimate (including COVID-19 impacts), and highlight the most significant changes and impacts on the department and Medi-Cal program.

Staff Recommendation: Staff recommends holding this item open to allow for ongoing discussions as well as updates at the May Revision.

ISSUE 2: FAMILY HEALTH ESTIMATE

PANEL

- **Michelle Baass**, Director, DHCS
- **Tyler Ulrey**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

FAMILY HEALTH PROGRAMS ESTIMATE

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

California Children's Services (CCS): The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.

Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 198,898 in 2022-23, an increase of 19,337 or 10.8 percent, compared to the 2022 Budget Act. The budget estimates Medi-Cal CCS caseload of 190,305 in 2023-24, a decrease of 8,593 or 4.3 percent, compared to the revised 2022-23 estimate.
Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 9,192 in 2022-23, a decrease of 3,620 or 28.3 percent, compared to the 2022 Budget Act. The budget estimates state-only CCS caseload of 11,488 in 2023-24, an increase of 2,296 or 25 percent compared to the revised 2022-23 estimate.

Genetically Handicapped Persons Program (GHPP): The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington's, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal. GHPP costs for Medi-Cal eligible individuals are reflected in the Medi-Cal Local Assistance Estimate.

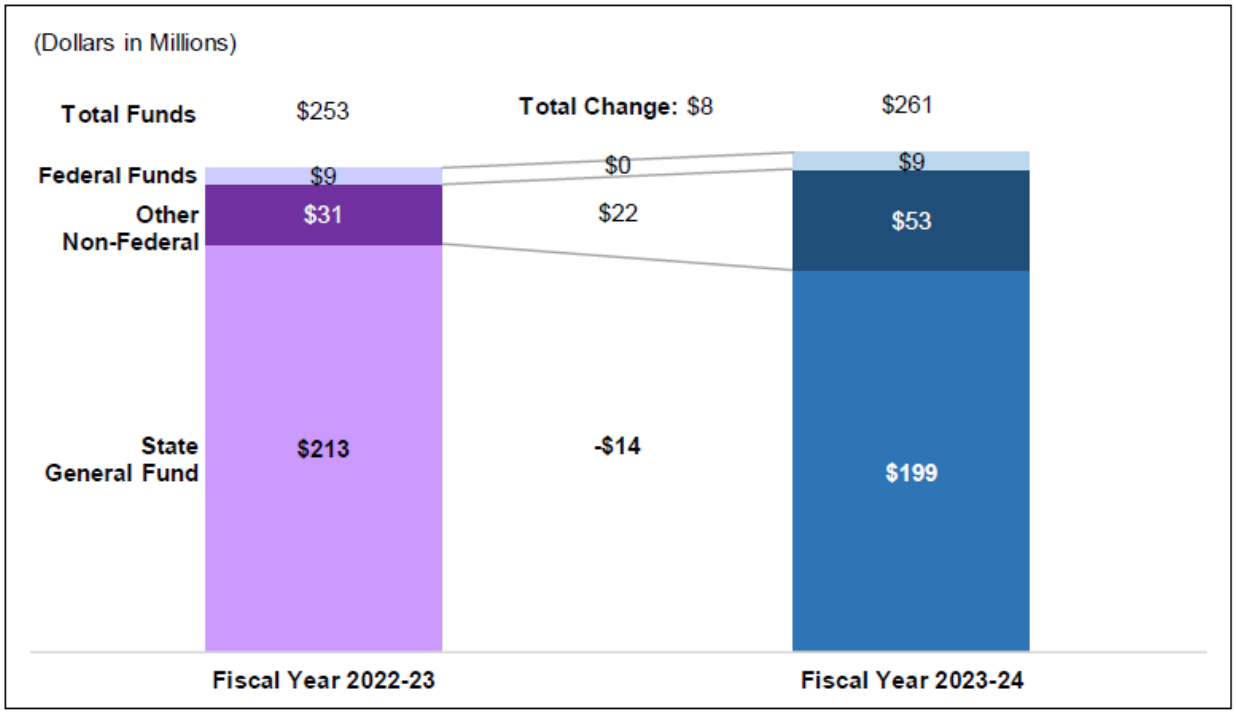
Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal GHPP caseload of 922 in 2022-23, an increase of 117 or 14.5 percent, compared to the 2022 Budget Act. The budget estimates Medi-Cal GHPP caseload of 904 in 2023-24, a decrease of 18 or two percent, compared to the revised 2022-23 estimate.

Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 654 in 2022-23, an increase of two or 0.3 percent, compared to the 2022 Budget Act. The budget estimates state-only GHPP caseload of 656 in 2023-24, an increase of two or 0.3 percent, compared to the revised 2022-23 estimate.

Every Woman Counts (EWC) Program: The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).

Caseload Estimate: The budget estimates EWC caseload of 25,010 in 2022-23, an increase of 689 or 2.8 percent, compared to the 2022 Budget Act. The budget estimates EWC caseload of 24,305 in 2023-24, a decrease of 705 or 2.8 percent compared to the revised 2022-23 estimate.

FY 2022-23 to FY 2023-24 Year over Year Comparison



The Family Health Estimate projects that total spending will increase by $8 million (3.2 percent) and General Fund spending will decrease by $14 million (6.6 percent) between FY 2022-23 and FY 2023-24. The following are the caseload projections for the three Family Health Programs:

California Children's Services

	PY	CY	BY	Change from	
CCS State Only	FY 2021-22	FY 2022-23	FY 2023-24	PY to CY	CY to BY
November 2022	9,546	9,301	12,679	-2.57%	36.32%
May 2022	9,206	12,812			
Change from May 2022	340	(3,511)			
% Change from May 2022	3.69%	-27.40%			

- CCS caseload is based on average quarterly members.
- Members began shifting to Medi-Cal in late FY 2019-20 due to the economic impact of the COVID-19 public health emergency and continued to shift through the end of FY 2020-21. Additional months of enrollment have remained relatively flat through June 2022.
  - November 2022 CCS state only base caseload projections reflect actual COVID-19 impacts through June 2022.
  - The ongoing impact from the public health emergency is estimated in the CCS COVID-19 Caseload Impact policy change and included in the counts shown above.
- The decrease from the prior estimate for FY 2022-23 is due to changes in the assumption of when the public health emergency will end.
- The projected increase between fiscal years is due to the projected end of the public health emergency and the resumption of eligibility redeterminations assumed to result in eligibles returning to the state only program.

Genetically Handicapped Persons Program

	PY	CY	BY	Change from	
GHPP State Only	FY 2021-22	FY 2022-23	FY 2023-24	PY to CY	CY to BY
November 2022	653	654	656	0.15%	0.31%
May 2022	652	655			
Change from May 2022	1	(1)			
% Change from May 2022	0.15%	-0.15%			

- GHPP caseload is based on average monthly members.
- Caseload projections are expected to remain relatively flat from the prior estimate and between fiscal years.

Every Woman Counts

	PY	CY	BY	Change from	
EWC	FY 2021-22	FY 2022-23	FY 2023-24	PY to CY	CY to BY
November 2022	22,809	23,348	28,297	2.36%	21.20%
May 2022	23,899	24,321			
Change from May 2022	(1,090)	(973)			
% Change from May 2022	-4.56%	-4.00%			

- EWC caseload is based on average monthly users by date of payment.
- The decrease from the prior estimate is due to changes in the assumption of when the public health emergency will end.
- The projected increase between fiscal years is due to the projected end of the public health emergency and assuming caseload will return to the pre-COVID-19 level.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of the Family Health Estimate, highlighting any significant changes in these programs in the 2022-23 and 2023-24 fiscal years.

Staff Recommendation: Staff recommends holding this item open to allow for ongoing discussions as well as updates at the May Revision.

ISSUE 3: OVERSIGHT: HEARING AID COVERAGE FOR CHILDREN PROGRAM

PANEL

- **Michelle Marciniak**, Co-Chair, Co-Founder, Mom, Let California Kids Hear
- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Aditya Voleti**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

OVERSIGHT ISSUE

The Hearing Aid Coverage for Children Program (HACCP) was launched by DHCS in July 2021, as authorized and funded (with $10 million General Fund annually) through the state budget to provide hearing aids to children who do not qualify for Medi-Cal, do not have other health insurance coverage of hearing aids, and have family income below 600 percent of the federal poverty level. The 2022 Budget Act expanded eligibility to include older youth (up to age 21) and *under*-insured children (those with $1,500 or less of hearing aid coverage). The following chart shows the annual income limit for HACCP eligibility for 2023:

Annual Income Limit for 2023 for HACCP Eligibility	
Family Size (including parents)	Income Limit
1	$87,480
2	$118,320
3	$149,160
4	$180,000
East Additional	Add $30,840

The HACCP covers:

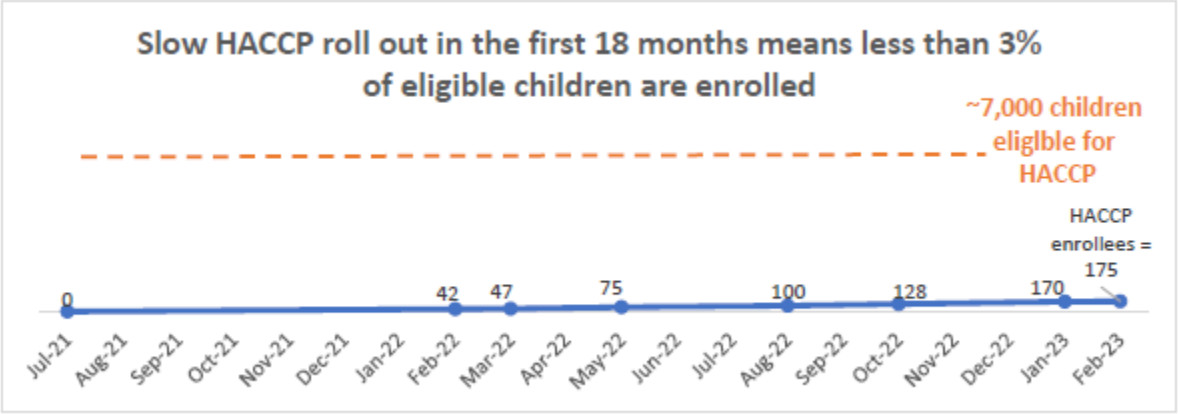
- Hearing aids;
- Hearing aid replacement (including wort bone conduction hearing devices);
- Hearing aid supplies/accessories (including ear molds);
- Hearing aid-related audiology services; and
- Other related post-evaluation services.

California does not mandate hearing aid coverage for children in the commercial health insurance market. According to advocates, over 25 states mandate private hearing aid coverage for children, and only 1 in 10 families on privately-funded health plans in California have coverage. AB 598 (Bloom, 2019) proposed a commercial insurance

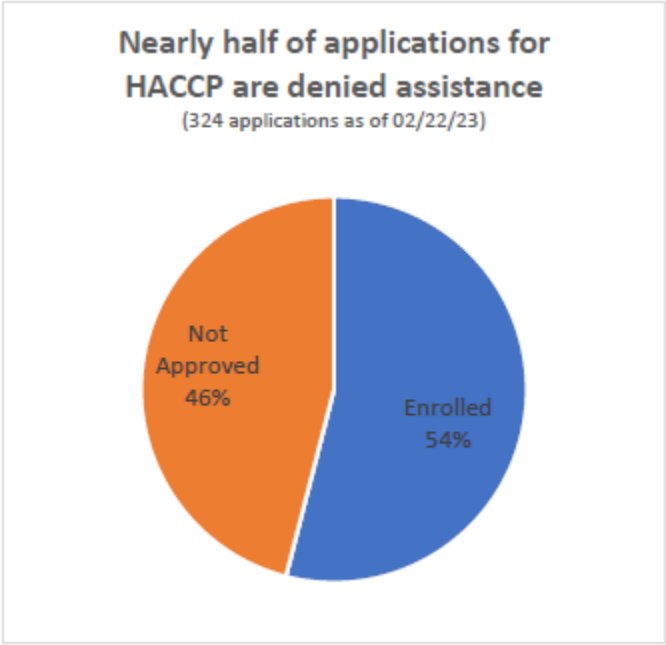
mandate for coverage of hearing aids for children, but the bill was never sent to the Governor, despite bipartisan support, due to concerns raised by the governor's office, including whether the bill runs afoul of Affordable Care Act age discrimination requirements by focusing on children. News reports on the bill quoted staff to Assemblymember Bloom: "If it does conflict with the law, and the bill must instead cover hearing aids for all eligible enrollees, then the costs would be far more than the $2 million to $3 million estimate, the aide says." The state would be responsible for costs since the state did not include hearing aid coverage as part of its essential health benefits benchmark plan.

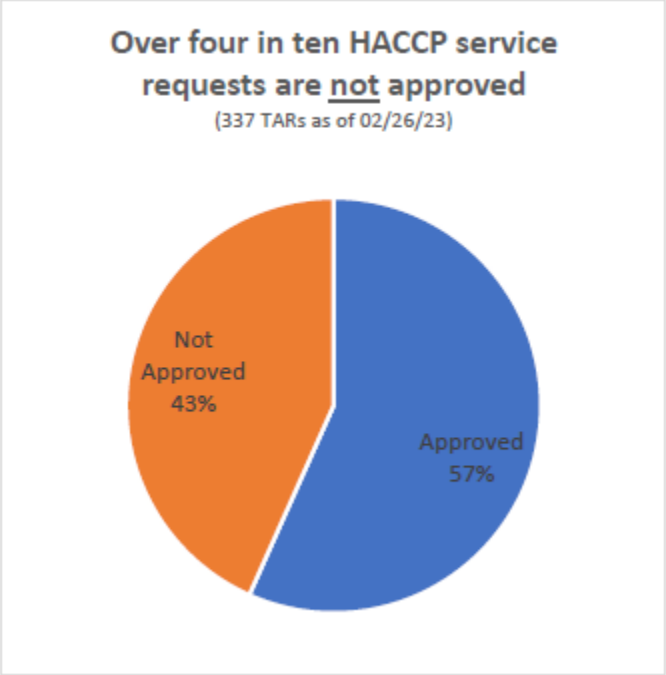
HACCP Created Through the Budget:

Children now provided the following chart which shows the historically-low enrollment in the program, at only about 3 percent of an estimated population of 7,000 eligible children:



Advocates explain that the available data on HACCP enrollment and utilization reflects programmatic barriers, implementation delays, and operational issues, rather than a lack of need for services among eligible children. Promotional materials for HACCP in languages other than English, including Spanish, have yet to become available and plans to produce them were only just announced by DHCS on March 1, 2023. Families face many challenges when trying to access care in HACCP and lack the assistance to navigate fragmentation between various providers and insurance coverage.





Additionally, many families with children who need hearing aids have expressed difficulty finding a qualified pediatric provider in their county, especially one who knows about and accepts HACCP program coverage. Kaiser, the state's largest insurer, still does not participate in HACCP or provide hearing aids for children covered by California Children's Services (CCS), adding to already over-burdened community programs.

> "There is overwhelming evidence that failure to provide appropriate intervention to deaf and hard of hearing children by three to six months of age leads to speech,

language, cognitive, educational, and social-emotional deficits and permanent delays," says Dr. Dylan Chan, Director of the Children's Communications Center at UCSF. "Every month of delay in starting hearing aids correlates with decreased long-term language potential. For this reason, hearing loss is considered a developmental emergency, requiring timely intervention to prevent permanent delays."

HACCP Budget Information:
As indicated in the chart below, the Medi-Cal Estimate includes information on the HACCP and other non-Medi-Cal programs, and shows that the vendor contract costs over $6 million (out of a total budget of $10 million).

4. Contract costs and administrative vendor service costs by program are as follows:

(Dollars in Thousands)

Program	FY 2022-23	FY 2023-24
OTLICP	$19,785	$18,319
MCAP	$5,397	$4,231
CCHIP	$4,418	$4,241
Hearing Aids	$6,711	$6,195

DHCS HACCP Action Plan and Communications Toolkit:
On March 1, 2023, DHCS announced a significant new outreach campaign that will be undertaken to increase enrollment in the program. DHCS stated in their communications:

"The HACCP Action Plan provides an overview of DHCS' comprehensive strategy on HACCP improvements in 2023 with actionable strategies to improve provider participation and increase program enrollment. The HACCP Communications Toolkit includes two major components:

1. Social media messaging for families and providers to understand HACCP eligibility, enrollment, and how to access covered benefits.

2. Printable materials (such as flyers) designed to be distributed by community partners (including advocates, educators, and medical providers) to educate families about HACCP and encourage enrollment.

The HACCP Action Plan and Communications Toolkit are available at DHCS' HACCP Resources for Community Partners webpage."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests an overview of the ongoing program implementation challenges by Let California Kids Hear, and requests DHCS provide reactions to the advocates' concerns and allegations, and respond to the following:

1. Please confirm the cost of the vendor contract, and provide justification for costs over $6 million for a program with a total annual budget of $10 million.

2. What is DHCS's goal for how many children will enroll in the program as a result of the new action plan? How will you measure success?

3. What timeline can the Legislature expect for seeing significant increases in enrollment in the program?

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 4: OVERSIGHT: CALAIM

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Linda Nguy**, Senior Policy Advocate, Western Center on Law and Poverty
- **Linnea Koopmans**, Chief Executive Officer, Local Health Plans of California
- **Kiran Savage-Sangwan**, Executive Director, California Pan-Ethnic Health Network
- **Allie Budenz**, Director of Population Health Management, California Primary Care Association
- **Tyler Ulrey**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

OVERSIGHT ISSUE

During the fall of 2019, the Newsom Administration released its comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program, which would ultimately become known as CalAIM. Due to the pandemic, the Administration delayed implementation of CalAIM in the 2020-21 fiscal year. The Administration returned to its implementation planning for CalAIM in the 2021 Budget Act, which included 69 positions and expenditure authority of $1.6 billion ($675.7 million General Fund and $954.7 million federal funds). The Legislature also approved trailer bill language to authorize implementation of CalAIM in the health omnibus, AB 133 (Committee on Budget), Chapter 143, Statutes of 2021. (Codified in Article 5.51, commencing with Section 14184.100, of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code).

CalAIM is an ambitious effort to incorporate evidence-based investments in prevention, case management, and non-traditional services into the Medi-Cal program. Many of these investments were piloted during the state's most recent 1115 Waiver, Medi-Cal 2020, and CalAIM incorporates many of these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for Medi-Cal managed care plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD), and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity.

Enhanced Care Management

Beginning January 1, 2022, CalAIM expanded the Whole Person Care delivery concept statewide through implementation of a mandatory enhanced care management (ECM) benefit and voluntary community supports benefits delivered by Medi-Cal managed care plans in each county. ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Medi-Cal beneficiaries with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high touch, and person-centered. Medi-Cal beneficiaries are eligible for ECM if they are included in one of the following populations of focus:

Children and Youth Populations of Focus

- Children (up to age 21) experiencing homelessness
- High utilizers
- Children with serious emotional disturbance or identified to be at clinical high risk for psychosis
- California Children's Services (CCS) with additional needs beyond CCS qualifying conditions
- Involved in, or with a history of involvement in, child welfare
- Children transitioning from incarceration

Adult Populations of Focus

- *Individuals and Families Experiencing Homelessness*. Individuals who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes or decreased utilization of high-cost services.
- *High Utilizers*. Adult high utilizers including those with five or more avoidable emergency room, or three or more avoidable, unplanned hospital or short-term skilled nursing facility stays in a six month period.
- *SMI/SUD*. Adults with serious mental illness (SMI) or substance use disorders (SUD), with at least one complex social factor influencing their health (e.g. food, housing, or economic insecurity; history of Adverse Childhood Experiences, former foster youth, justice-involvement), and are at high risk for institutionalization, overdose and/or suicide; use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care; experienced two or more emergency department or hospital visits due to SMI or SUD in the past 12 months; or are pregnant or post-partum.
- *Individuals Transitioning From Incarceration*. Adults transitioning from incarceration within the past 12 months with at least one of the following conditions: chronic mental illness, SUD, chronic disease, intellectual or developmental

disability, traumatic brain injury, human immunodeficiency virus (HIV), or pregnancy.

- *Individuals at Risk for Institutionalization*. Adults at risk of institutionalization eligible for long-term care services who, in the absence of services and supports, would otherwise require care for 90 days or more in an inpatient nursing facility.
- *Nursing Facility Residents Seeking Community Transition*. Adults residing in nursing facilities who desire to transition back to the community and are likely to make a successful transition.

By July 1, 2023, ECM requires Medi-Cal managed care plans and their contracted ECM providers to deliver the following core services:

- Outreach and Engagement
- Comprehensive Assessment and Care Management Plan
- Enhanced Coordination of Care
- Health Promotion
- Comprehensive Transitional Care
- Member and Family Supports
- Coordination of and Referral to Community and Social Support Services

Community Supports

Previously known as In-Lieu of Services, community supports are services or service settings that Medi-Cal managed care plans may offer as a medically appropriate, cost-effective alternative to Medi-Cal eligible services or settings. Provision of community supports is voluntary for Medi-Cal managed care plans to provide and voluntary for Medi-Cal beneficiaries to receive. Plans may change their election of which community supports they provide every six months. The community supports plans may provide include the following:

- Housing Transition Navigation Services (Currently available in all 58 counties)
- Housing Deposits (Currently available in all 58 counties)
- Housing Tenancy and Sustaining Services (Currently available in all 58 counties)
- Short-Term Post-Hospitalization Housing (Currently available in 37 counties)
- Recuperative Care (Medical Respite) (Currently available in 42 counties)
- Caregiver Respite (Currently available in 53 counties)
- Day Habilitation Programs (Currently available in 23 counties)
- Nursing Facility Transition/Diversion to Assisted Living Facilities (Currently available in 39 counties)
- Nursing Facility Transition to a Home (Currently available in 39 counties)
- Personal Care and Homemaker Services (Currently available in 53 counties)
- Environmental Accessibility Adaptations (Home Modifications) (Currently available in 42 counties)

- Medically-Supportive Food/Meals/Medically Tailored Meals (Currently available in all 58 counties)
- Sobering Centers (Currently available in 19 counties)
- Asthma Remediation (Currently available in 37 counties)

Managed Care Plan Incentives

Beginning January 1, 2022, Medi-Cal managed care plans were eligible for incentive payments for investing in expanding and improving delivery of ECM and community supports. Federal regulations allow a percentage above a Medi-Cal managed care plans capitation payment to be allocated for quality improvement programs. To receive incentive payments, Medi-Cal managed care plans must improve delivery system infrastructure, build provider capacity for ECM and community supports services, and achieve certain quality benchmarks.

Medi-Cal Providing Access and Transforming Health (PATH)

The Medi-Cal PATH initiative is intended to provide a smooth transition between current 1115 Waiver pilots and statewide services and capacity building, including for effective pre-release care and coordination with justice agencies. PATH funding will support the transition from Whole Person Care pilots to ECM and community supports, including funding for counties, community-based organizations, and other providers to build the capacity and infrastructure necessary for these new statewide services. In addition, PATH funding will help ensure jails and prisons are ready for service delivery for the justice-involved, including mandatory Medi-Cal applications; behavioral health referrals, linkages, and warm hand-offs from county jails to Medi-Cal managed care plans and county behavioral health departments; “in reach” services up to 90 days prior to release, and the re-entry ECM benefit available in January 2023. PATH funding will also support workforce development for the homeless and home- and community-based services systems of care, including outreach, training in evidence-based practices, information technology for data sharing, and training stipends.

Dental Initiatives

During the previous 1115 Waiver, DHCS implemented the Dental Transformation Initiative, which included four dental “domains”, including: 1) incentive payments for increasing preventive services utilization in children; 2) incentive payments for caries risk assessment and disease management; 3) incentive payments to encourage continuity of care; and 4) local dental pilot projects. Beginning January 1, 2022, DHCS transitioned the three incentive payments programs of the Dental Transformation Initiative into the State Plan and included coverage of silver diamine fluoride as a dental benefit for certain populations. The department reports it has set an initial goal of achieving a 60 percent dental utilization rate for eligible Medi-Cal children and adults.

Population Health Management (PHM) Service

The PHM service would utilize Medi-Cal administrative and clinical data and information for the department, Medi-Cal managed care plans, counties, providers, beneficiaries, and other partners to use in support of the delivery of care for Medi-Cal beneficiaries. According to DHCS, this service would also allow for identification of potential gaps in care, provider or care manager information, information on social determinants of health, as well as allow for population health analytics, health education, and tips for beneficiaries. The PHM system would also provide Medi-Cal beneficiaries with access to their administrative and clinical information.

Transitions of Populations Between Fee-for-Service and Managed Care

CalAIM includes several changes to how certain populations of Medi-Cal beneficiaries would access certain benefits. CalAIM seeks to standardize which benefits are available through the managed care delivery system and which are available through the fee-for-service delivery system. Similarly, CalAIM seeks to standardize the populations of Medi-Cal beneficiaries that would receive services through managed care or through fee-for-service.

Benefit Standardization. CalAIM standardizes which Medi-Cal benefits are provided in the managed care delivery system and which benefits are provided in another delivery system. The proposed changes are as follows:

• Managed Care Benefits ("Carved In")

- Long-term care – Effective January 1, 2023, all institutional long-term care services have become the responsibility of a beneficiary's managed care plan including skilled nursing facilities, pediatric and adult subacute care facilities, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, and specialized rehabilitation in a skilled nursing facility or intermediate care facility.
- Organ transplants – Effective January 1, 2022, all major organ transplants are the responsibility of a beneficiary's managed care plan.

• Fee-for-Service Benefits ("Carved Out")

- Pharmacy – Under the department's Medi-Cal Rx initiative, all prescription drugs and/or pharmacy services billed on a pharmacy claim are provided in the fee-for-service delivery system as of January 1, 2022. This carve-out does not apply to SCAN Health Plan, Programs for All-Inclusive Care for the Elderly (PACE), Cal MediConnect plans, and the Major Risk Medical Insurance Program (MRMIP).
- Specialty mental health services (Solano and Sacramento) – Effective July 1, 2023, specialty mental health services currently the responsibility of Kaiser health plans in Solano and Sacramento counties, would be provided by the county mental health plans.
- Multipurpose Senior Services Program – Effective January 1, 2022, the Multipurpose Senior Services Program, which had previously been scheduled to

become the responsibility of Medi-Cal managed care plans in Coordinated Care Initiative counties, will instead remain a benefit under the existing 1915(c) Home- and Community-Based Services Waiver.

Long-Term Services and Supports Integration. Under CalAIM, DHCS will make several changes to the delivery system for long-term services and supports (LTSS) that build upon the state's duals demonstration project, the Coordinated Care Initiative (CCI). DHCS intends to use selective contracting to move toward aligned enrollment in a Medi-Cal managed care plan and a dual-eligible special needs plan (D-SNP) operated by one integrated organization. In the seven CCI demonstration counties, all Medi-Cal beneficiaries in a Cal MediConnect plan would transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product, beginning January 1, 2023. Aligned enrollment would occur in non-CCI counties by 2026. Dual-eligible beneficiaries already in a non-aligned D-SNP (not affiliated with their managed care plan) would be allowed to maintain their enrollment, but new enrollment in non-aligned D-SNPs would be closed.

Beginning January 1, 2023, DHCS implemented mandatory enrollment of full- and partial-benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and nondual eligible long-term care residents. Long-term care benefits will be integrated into Medi-Cal managed care statewide. Cal MediConnect plans and the Coordinated Care Initiative were also scheduled to be discontinued at this time.

Behavioral Health Quality Improvement Program and Payment Reform
These components of CalAIM will be covered at the Subcommittee's hearing on April 17, 2023.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of CalAIM (excluding the behavioral health components), and requests the stakeholders on the panel provide perspectives on the strengths and weaknesses of CalAIM as well as implementation challenges.

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 5: CALAIM: 2023 PROPOSALS

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Tyler Ulrey**, Finance Budget Analyst, DOF
- **Will Owens**, Fiscal and Policy Analyst, LAO

PROPOSAL

The Governor's Budget includes the following new proposals, among others, as part of CalAIM:

Transitional Rent

To improve the well-being and health outcomes of Medi-Cal members during critical transitions, DHCS will seek an amendment to the CalAIM waiver to authorize an additional Community Support for use by Medi-Cal Managed Care Plans. The new Community Support would allow the provision of up to six months of rent or temporary housing to eligible individuals experiencing homelessness or at risk of homelessness and transitioning out of institutional levels of care, a correctional facility, or the foster care system and who are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits.

Reproductive Waiver

DHCS states: "California has long prioritized the goal of providing access to contraceptives and other reproductive health services. Disparities in access persist, however, including disparities based on geography, income, and race. Since the Supreme Court's June 2022 decision in Dobbs v. Jackson Women's Health Organization, California's providers have seen an influx of patients traveling from other states to access abortion and other reproductive health services that are no longer available in their state, whether due to express legal prohibitions, the chilling effect those prohibitions create for other reproductive health services or growing "reproductive health deserts" that lack local providers due to the hostile state regulatory and reimbursement landscape."

DHCS seeks to continue California's progress toward equitable access to comprehensive family planning and related services, even as the state's reproductive health safety net grapples with the multifaceted pressures described above. In partnership with the Centers for Medicare and Medicaid Services, DHCS will develop an 1115 demonstration waiver that would advance the following goals:

- Support access to family planning and related services for Medi-Cal enrollees, as well as other individuals who may face barriers to access.

- Support the capacity and sustainability of California's reproductive-health safety net.
- Promote system transformation for California's reproductive-health safety net.

The Governor's Budget proposes to invest $200 million total funds ($15 million General Fund) in FY 2024-25 for the Reproductive Health Services 1115 waiver.

CalAIM Behavioral Health Proposals

The Governor's Budget also includes various CalAIM behavioral health proposals, including the "Justice Involved Initiative;" these will be covered and discussed at the Subcommittee's hearing on April 17, 2023.

Designated State Health Programs

This CalAIM proposal is discussed under the next issue in this agenda.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present the Transitional Rent and Reproductive Waiver proposals and respond to the following:

1. Please describe both of these proposals in more detail.

2. What are the total budgets of these programs? Are there state costs associated with Transitional Rent?

3. How do you plan to incorporate stakeholder input in the development of these programs?

Staff Recommendation: Staff recommends holding this item open to allow for additional discussion and consideration of these proposals.

ISSUE 6: CALAIM: DESIGNATED STATE HEALTH PROGRAMS AND DELAYED CARVE-IN OF ICF-DD AND SUBACUTE SERVICES INTO MEDI-CAL MANAGED CARE TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Tyler Ulrey**, Finance Budget Analyst, DOF
- **Ryan Miller**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS has submitted a proposal to continue the DSHP program under the California Advancing and Innovating Medi-Cal (CalAIM) 1115 waiver effective January 1, 2023 to December 31, 2026. The DSHP proposal would allow DHCS to claim $646.4 million in federal funding over four years to support the Providing Access and Transforming Health (PATH) program. As part of its approval of DSHP proposals, the federal Centers for Medicare and Medicaid Services (CMS) require that states provide rate increases for certain services if the Medicaid to Medicare provider rate ratio is below 80 percent. Effective January 1, 2024, primary care will receive a 10 percent increase in fee-for-service for all codes under 80 percent of Medicare and obstetric and doula care will receive a 10 percent increase (including for the codes that don't have a Medicare equivalent) in both fee-for-service and managed care. The impact in FY 2022-23 is estimated to be $40.4 million General Fund savings from DSHP claiming. The net impact from the provider rate increases and DSHP claiming is estimated to be $22 million total funds ($152.9 million General Fund savings) in FY 2023-24.

DHCS proposes trailer bill language to: 1) authorize reimbursement levels for primary care, obstetric care, and behavioral health services to the extent required by the federal Centers for Medicare and Medicaid Services (CMS) as a condition of claiming federal financial participation for Designated State Health Programs (DSHP); and 2) delay the transition of ICF-DD and subacute services into the Medi-Cal managed care delivery system from July 1, 2023, to January 1, 2024.

The full trailer bill language can be found here:
CalAIM: Designated State Health Programs and Delay Intermediate Care Facilities for the Developmentally Disabled and Subacute Services Medi-Cal Managed Care Carve-in

BACKGROUND

The administration provided the following background information:

DSHP

Under the CalAIM initiative, and pursuant to Welfare and Institutions Code (WIC) Section 14184.102(k), DHCS may claim federal financial participation for expenditures associated with the Designated State Health Programs identified in the CalAIM Terms and Conditions.

As a condition of approval for new DSHP funding, CMS has provided new conditions that states are required to meet. One such condition requires minimum average Medicaid to Medicare provider reimbursement rate ratio for specific service categories. If states do not meet this minimum ratio, states are required to provide defined provider rate increases. DHCS proposes to update the CalAIM statute that requires DHCS to maintain or increase reimbursement rates in the Medi-Cal program for primary care, obstetric care, and behavioral health service codes to meet federally imposed minimum ratio levels as a percentage of Medicare for dates of service on or after January 1, 2024, to the extent required by CMS as a condition to gain DSHP approval.

The CalAIM DSHP proposal allows DHCS to claim additional federal funding at minimal state investment while providing additional reimbursement for services.

ICF-DD and Subacute Care Facilities Carve-In to Medi-Cal Managed Care

Currently, long-term care (LTC) facility benefits are carved into managed care in County Organized Health Systems (COHS) and Coordinated Care Initiative (CCI) plans. (Note: For CCI counties, adult subacute care is currently carved-in to managed care, but pediatric subacute care is carved out.) In non-COHS and non-CCI counties, Medi-Cal Managed Care Plans (MCP) are responsible for the month of admission and the following month. Subsequently, the member is disenrolled from the MCP into the fee-for-service (FFS) delivery system and LTC services are covered under FFS.

Under the current CalAIM timeline, all MCPs will be required to cover LTC in ICF-DD and subacute care facilities (adult and pediatric) effective July 1, 2023. This means that members who reside in an ICF-DD home and subacute facility as of July 1, 2023, would be transitioned to the managed care delivery system.

The LTC facility benefits to be carved-in to MCPs statewide include the following:

- ICF-DD, ICF-DD-Habilitative, and ICF-DD-Nursing
- Adult Subacute Care Services
- Pediatric Subacute Care Services

DHCS, in collaboration with the Department of Developmental Services (DDS), convened a stakeholder workgroup to address transition specifically for ICF-DD facilities and beneficiaries, pursuant to WIC Section 14184.201(b)(4). Through stakeholder feedback, DHCS identified various policy and operational considerations that require additional planning and deliberation. Hence, DHCS proposes to delay the transition of ICF-DDs and subacute care facilities into Medi-Cal managed care from July 1, 2023, to January 1, 2024 (WIC Section 14184.201(c)).

The ICF-DD carve-in will require complex policy considerations due to the ICF-DD facilities' regulatory and oversight structure that must take into consideration the specific roles of DDS and regional centers, as well as Lanterman Act rights and protections for the ICF-DD residents.

Further, patients receiving care in subacute care facilities must meet subacute level of care. These individuals are medically fragile and require specialized services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care. Many are ventilator-dependent and require subacute care for long periods of time. Additional time for careful planning, network development, and other operational readiness is needed to ensure minimum disruption for this population.

The delay of the transition of ICF-DDs and subacute care facilities into Medi-Cal managed care provides DHCS more time to develop and provide operational guidance to MCPs, ICF-DD homes, subacute care facilities, and providers that serve these populations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Staff is not aware of any significant concerns with this proposed trailer bill and therefore recommends adoption at a future hearing.

ISSUE 7: OVERSIGHT: PUBLIC HEALTH EMERGENCY UNWINDING

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Cathy Senderling**, Executive Director, County Welfare Director's Association
- **Laura Sheckler**, Deputy Director of Policy & Regulatory Affairs, CaliforniaHealth+ Advocates
- **Linda Nguy**, Senior Policy Advocate, Western Center on Law and Poverty
- **Aditya Voleti**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

OVERSIGHT ISSUE

In 2020, in response to the pandemic, Congress approved a temporary increase in federal funding for most Medicaid costs. To be eligible for this increased federal funding, states had to comply with several requirements on top of standard Medicaid rules, the most important being the continuous coverage requirement, which prohibits states from terminating eligibility for existing beneficiaries except in limited circumstances, for the duration of the Public Health Emergency (PHE). Largely as a result of these policies, caseload and associated Medi-Cal spending across all fund sources have increased substantially since the beginning of the PHE. However, to date, the General Fund costs have been more than offset by the enhanced federal funding.

In late December 2022, Congress enacted legislation that decouples the end dates of the continuous coverage requirement and enhanced federal funding from the PHE. In addition, in late January 2023, the federal administration announced an intended end date to the PHE in May.

As a result of recent federal legislation, the continuous coverage requirement will expire at the end of March 2023. Counties will resume processing eligibility redeterminations on a monthly basis beginning April 1, 2023, with the first individuals determined to be no longer eligible for Medi-Cal expected to lose Medi-Cal coverage on July 1, 2023. To comply with federal requirements, counties must complete all eligibility redeterminations by May 31, 2024. Thereafter, annual eligibility redeterminations will be staggered throughout the year, similar to practices before the PHE.

DHCS indicates the following:

- Medi-Cal eligibility redeterminations will begin on April 1.
- Discontinuances will begin in July.
- 1.8-2.8 million enrollees are anticipated to be no longer eligible.

DHCS, in partnership with Covered California, is engaging in significant outreach and public education in order to inform the Medi-Cal population that they must meet redetermination requirements or they will be discontinued from the program. DHCS indicates that there will be significant media as part of this public education effort, and that the media will urge people to update their contact information with the Medi-Cal program so that they receive all critical redetermination communications.

Covered California plans to have special open enrollment periods during the PHE unwinding period, and enrollees who are found ineligible for Medi-Cal will be referred to Covered California.

DHCS already created one communications tool kit for legislators, and will send out another one once the unwinding starts. DHCS requests the Legislature's help in getting these tool kits and resources out to legislative district offices.

Historically, there have been very high rates of outdated, inaccurate contact information for Medi-Cal enrollees. However, DHCS states that it has done a lot of work on this issue based on the returned mail rate.

STAFF COMMENTS/QUESTIONS

Stakeholders have raised significant concerns about the potential harm that may result from this redetermination process as a result of the potential for high numbers of inappropriate discontinuances (i.e., people getting dis-enrolled who are still Medi-Cal eligible). The risk of this happening results from various circumstances including:

- County Welfare Offices (which conduct most of the Medi-Cal eligibility and redetermination work) are short-staffed.
- Counties will have a lot of new, inexperienced staff who have never done this type of work before.
- Counties have never been burdened with a workload of this magnitude (conducting redeterminations for nearly the entire Medi-Cal population).
- Many Medi-Cal enrollees moved during the pandemic, and therefore may not get the redetermination information being sent out in the mail, and therefore may not know that they have to complete the redetermination application.
- Many enrollees may find the redetermination application too complicated and difficult.

The Subcommittee requests DHCS provide an overview of this issue and the work that the state is engaged in to support counties and ensure that the redetermination process proceeds as smoothly as possible, while minimizing inappropriate discontinuances. Please also respond to the following:

1. What is the latest update on the returned mail rate (outdated/inaccurate mailing addresses)?

2. How is the state supporting counties generally, and specifically for providing training to county staff?

3. How and when will a county know if their redetermination process is resulting in inappropriate discontinuances? What flexibilities will counties have to pause or slow their process if they discover significant problems resulting?

4. Please describe how the state is deprioritizing certain populations in this process, including related to the elimination of the asset test.

The Subcommittee requests the stakeholders on the panel provide their perspective on how ready the state and counties are to handle this process and to minimize harm to this population, and respond to the following:

1. What challenges has the state not yet addressed?

2. Do counties have capacity to be responsive to the likely number of callers (i.e., people needing assistance)? What are average telephone wait times now?

3. What challenges are counties facing in hiring and training new staff?

Staff Recommendation: This is an oversight issue and therefore no action is recommended at this time.

ISSUE 8: MANAGED CARE ORGANIZATION TAX

PANEL

- **Michelle Baass**, Director, DHCS
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS proposes to enact a three-year managed care organization (MCO) tax renewal effective January 1, 2024 through December 31, 2026, to provide additional revenue for the Medi-Cal program to support access to health care services and minimize the need for reductions to the program. This tax renewal will maintain the structure from the prior tax authorized in AB 115 (Chapter 348, Statutes of 2019) with minor modifications including updates to the base enrollment period to reflect calendar year 2021 enrollment data and adjusted for enrollment changes to managed care plans effective January 1, 2024. The proposed MCO provider tax would offset an estimated $6.5 billion in General Fund costs in Medi-Cal through FY 2026-27 ($316.5 million FY 2023-24 and about $2 billion annually in FY 2024-25 and each of the following two years). The Department is proposing trailer bill language related to the MCO tax proposal.

BACKGROUND

The LAO's Analysis of the Medi-Cal Budget includes the following background and history on the MCO tax:

MCO Tax Has Helped Offset General Fund Medi-Cal Spending. For over a decade and following multiple renewals, the state has imposed a tax on managed care plans (also known as MCOs). The structure of the tax has changed over time. For example, earlier versions imposed a tax on managed care plans' revenues, whereas later versions imposed a tax on managed care plans' enrollment. The state has used the MCO tax to claim additional federal Medicaid matching funds, which help offset the General Fund cost to provide payments to Medi-Cal managed care plans.

Tax Requires Federal Approval. Federal approval of the MCO tax is necessary for the state to use it to draw down federal Medicaid funds. To receive approval, the state must prove to the federal government that the burden of paying the tax does not fall too disproportionately on Medicaid as opposed to non-Medicaid services. In addition, the state may not hold managed care plans harmless by providing them direct or indirect payments that do so, as determined by the federal government. In some years, the federal government rejected the state's proposed tax, necessitating changes to the structure and resubmission to the federal government before it could go into effect.

Recent Versions of Tax Have Imposed Relatively Small Net Cost on Health Insurance Industry. While the structure of the MCO tax has changed over time, recent versions have taxed both Medi-Cal and non-Medi-Cal enrollment. The rates charged on Medi-Cal enrollment have been substantially higher than the rates on non-Medi-Cal enrollment. The Medi-Cal tax liability is cost neutral to plans, as Medi-Cal includes the associated cost of the tax in its payments to managed care plans (as allowed under federal law). The non-Medi-Cal tax liability, by contrast, is not covered by the state and reflects a net cost to the health insurance industry. Analyses of recent versions of the MCO tax estimated the net cost to the health insurance industry to be in the low tens of millions of dollars annually.

Most Recent MCO Tax Has Expired. The most recent MCO tax began in January 2020 and generated annual General Fund savings of over $1.5 billion. The tax was enrollment-based, with rates charged on tiers of each plan's cumulative monthly enrollment in the 2018 calendar year. State authorization and federal approval of the MCO tax expired at the end of December 2022.

The LAO concludes that, in concept, adopting a new MCO tax makes budgetary sense since it can offset Medi-Cal General Fund costs while imposing a relatively small net cost to the health insurance industry. The LAO also points out, however, that the administration has yet to share a detailed proposal and therefore the proposal cannot be fully evaluated as of yet.

STAFF COMMENTS/QUESTIONS

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

1. When do you expect to release the trailer bill language needed for this proposal?

2. Does the Governor's budget propose to fund new activities with the projected tax revenue, or just support the overall Medi-Cal budget?

3. Do you expect any new challenges from either the federal government or stakeholders in the development of this proposal?

Staff Recommendation: Staff recommends support for authorization of a new MCO tax, in concept, however recommends holding this item open until DHCS provides additional detail and the proposed trailer bill language.

ISSUE 9: CALIFORNIA CHILDREN'S SERVICES WHOLE-CHILD MODEL EXPANSION AND MANDATORY MANAGED CARE ENROLLMENT OF FOSTER CARE CHILDREN IN SINGLE PLAN COUNTIES TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Ann-Louise Kuhns**, President & CEO, California Children's Hospital Association
- **Aditya Voleti**, Finance Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS proposes trailer bill language to: 1) implement the California Children's Services (CCS) Whole-Child Model (WCM) in the 15 counties converting to County Organized Health System (COHS) and Single Plan models as part of the county model change; and 2) mandatorily enroll Foster Care children in Single Plan counties in order to align policies in all Medi-Cal Managed Care Plan (MCP) models where there is a single plan operating in the county.

The full language can be found here:
The Whole Child Model

BACKGROUND

SB 586 (Hernandez, Chapter 625, Statutes of 2016) authorized DHCS to establish the Whole Child Model program in designated County Organized Health System (COHS) or Regional Health Authority counties. Services previously provided to CCS beneficiaries on a fee-for-service basis are delivered by Medi-Cal managed care plans in Whole Child Model counties. The Whole Child Model program has been implemented in 21 counties with 5 health plans, with the goal to improve care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.

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

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

Whole Child Model Pilot Evaluation

SB 586 also requires DHCS to contract with an independent entity to conduct an evaluation to assess Medi-Cal managed care plan performance and the outcomes and experience of CCS-eligible children and youth participating in the Whole Child Model program. The evaluation is required to: (1) compare plan performance to performance of the CCS program prior to implementation in each county; (2) compare plan performance in participating counties to CCS program performance in non-participating counties; and (3) evaluate whether inclusion of CCS services in managed care improves access, quality, and the patient experience. The evaluation must also, when possible, disaggregate results based on the child's or youth's race, ethnicity, and primary language spoken at home.

The 2019 Budget Act included expenditure authority of $1.6 million ($800,000 General Fund and $800,000 federal funds), available for expenditure or encumbrance until June 30, 2021 to conduct the program evaluation of the Whole Child Model required pursuant to SB 586.

Although DHCS has not released the full evaluation (as of the writing of this agenda), the department and UCSF (the contracted evaluator) provided a briefing to legislative staff on the results of the evaluation on March 14, 2023. Evaluation results include:

- Overall access to care was maintained in the WCM with high rates of continuity with primary care and specialty care, high rates of authorization approval, and lower grievances rate as compared to Classic CCS and generally.

- While specialist visit use outcomes were mixed in this evaluation, less than 13% of families reported unmet specialist needs. While not statistically significant, a higher proportion of Classic CCS respondents have higher unmet specialist needs as compared to WCM clients.

- The increase in emergency department visits in the WCM warrant further investigation and quality improvement work.

- The WCM was successful in either keeping satisfaction unchanged or improving satisfaction for CCS related services as compared to Classic CCS after implementation.

- On most measures of satisfaction, the majority (>70%) of parent respondents in all WCM study groups indicated they were "satisfied" or "very satisfied" with the various specialty and CCS related services they have been receiving. Only 3% had any grievance reported indicating high levels of satisfaction with CCS services in the WCM.

- Key informants (KI) from the CCS program reported increased CCS staff workload they experienced immediately after the Specialists WCM implementation and suggested more funding support to account for this unanticipated increased workload.

- The DME vendor key informants were quite satisfied with a quicker and more efficient authorization process in the WCM, as compared to the lengthy DME authorization process in Classic CCS.

- Providers were mixed on reimbursement on the provider survey, which likely depends on what services are being rendered and billed for. The survey results mirror the findings of the key informant interviews, with satisfaction with DME, but also dissatisfaction, which may stem from difficulties with contracting providers and differences in provider networks.

- Overall, the quality of CCS-level care in the WCM appeared to be maintained at a similar level with that of Classic CCS clients. The majority of survey respondents in each WCM study group indicated that since the transition to WCM, the quality of services remained the same.

- HEDIS quality measures (Depression screening and vaccinations) mostly improved or stayed the same.

- For those who thought care was worse, subgroup analyses showed that those with greater specialty use and poorer self-reported health status was associated with higher dissatisfaction with the WCM. Further investigation would be needed to evaluate the impact of the WCM on the more medically complex patients.

- Care coordination as executed by high-quality case management has been identified across families and key stakeholders as a critical core of the CCS program.

- KI reports in the first year of the WCM, CCS case management was different from MCP case management. In MCPs, case managers were not as easily accessible to the CCS clients and MCP case management was neither centralized nor coordinated by one person, but instead it was fragmented, and CCS clients accessed services through a telephone triage system.

- Despite the KI reports, the majority of survey respondents in all WCM study groups (69%) were “usually” or “always” able to get as much help as they wanted with arranging or coordinating healthcare. The differences between the WCM study groups and Classic CCS comparison group were not statistically significant.

- Overall case management claims were higher as compared to and outcomes similar to that of Classic CCS.

Managed Care Procurement and Model Changes

On February 9, 2022, DHCS released a Request for Proposal (RFP) for its commercial managed care plan contracts, seeking managed care plans committed and able to advance equity, quality, access, accountability, and transparency to reduce health disparities and improve health outcomes for Californians. While the RFP is only for commercial plans, DHCS indicated the updated contract released with the RFP would be executed with all Medi-Cal managed care plans, including local initiatives and County Organized Health Systems, as of January 1, 2024.

During the procurement process, counties were permitted to change their model for Medi-Cal managed care plans. The following counties made changes to their plan models:

- Alameda – From Two Plan Model to a Single Plan with Alameda Alliance
- Contra Costa – From Two Plan Model to a Single Plan with Contra Costa Health Plan
- Imperial – From Regional Model to a Single Plan with California Health and Wellness
- Mariposa – From Regional Model to County Organized Health System with Central California Alliance for Health
- San Benito – From Regional Model to County Organized Health System with Central California Alliance for Health
- Butte – From Regional Model to County Organized Health System with Partnership Health Plan
- Colusa – From Regional Model to County Organized Health System with Partnership Health Plan
- Glenn – From Regional Model to County Organized Health System with Partnership Health Plan
- Nevada – From Regional Model to County Organized Health System with Partnership Health Plan
- Placer – From Regional Model to County Organized Health System with Partnership Health Plan
- Plumas – From Regional Model to County Organized Health System with Partnership Health Plan
- Sierra – From Regional Model to County Organized Health System with Partnership Health Plan
- Sutter – From Regional Model to County Organized Health System with Partnership Health Plan
- Tehama – From Regional Model to County Organized Health System with Partnership Health Plan

- Yuba – From Regional Model to County Organized Health System with Partnership Health Plan
- Alpine – From Regional Model to Two Plan Model with Health Plan of San Joaquin
- El Dorado – From Regional Model to Two Plan Model with Health Plan of San Joaquin

DHCS proposes to align the DHCS policies for these counties, including WCM and mandatory managed care enrollment for Foster Care children, to standardize policy in Single Plan counties across the State and ensure consistency with how benefits, services, and MCP practices are applied.

Mandatory Enrollment of Foster Care Children in Single Plan Counties

Federal Medicaid law prohibits States from requiring Foster Care children to enroll in managed care programs (42 United States Code Section 1396u-2(a)(2)(A)), but in California state law (Welfare and Institutions Code (WIC) Section 14184.200(b)(2)(H)) and Medi-Cal's 1915(b) Waiver and the 1115(a) Waiver allow DHCS to mandatorily enroll Foster Care children in managed care in COHS counties and allow for voluntary enrollment in managed care in all non-COHS counties.

In alignment with CalAIM core principles to standardize benefits and reduce complexity of the varying models of care delivery, DHCS proposes to implement WCM in the 15 counties converting to COHS and Single Plan counties to conform policy across all counties operating with one plan. Currently, COHS MCPs in WCM counties assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services, including but not limited to, service authorization activities, claims processing and payment, case management, and quality oversite. DHCS proposes to integrate WCM in COHS expansion and Single Plan counties using a phase-in approach based on plan model type and CCS county designation. These changes are needed to align the CCS model with the County plan model type changes.

DHCS proposes to take a phased approach to the alignment efforts to allow time for MCP readiness as well as transition of county-specific functions to MCPs:

- Phase 1: Implement WCM expansion in the ten COHS expansion counties that have a dependent county designation in the CCS program by 2024. These include: Colusa, Glenn, Nevada, Plumas, Sierra, Sutter, Tehama, Yuba, Mariposa, and San Benito. The COHS plans for these counties are Partnership Health Plan and Central California Alliance for Health. Dependent counties rely on DHCS to conduct certain functions on the counties' behalf (such as service authorizations) and therefore have significantly fewer CCS functions that would transition to the MCP. Additionally, while DHCS must still perform an extensive operational readiness assessment, the COHS plans are already operating WCM and have various key contracts in place with CCS paneled providers and Special Care Centers, and as such, alignment efforts can feasibly be implemented by 2024.

- Phase 2: Implement WCM expansion in the two COHS expansion counties that have an independent county designation in the CCS program as well as the three new Single Plan counties by January 1, 2025. These independent counties for the COHS expansion include Butte and Placer. The COHS plan for these two counties is Partnership Health Plan. The Single Plan counties include Alameda, Contra Costa, and Imperial and the MCPs for those counties are Alameda Alliance for Health, Contra Costa Health Plan and Community Health Plan of Imperial Valley respectively. Independent counties administer various CCS functions directly, such as adjudicating service authorization requests. Thus, preparing counties and MCPs will require significant planning and time to ensure a seamless transition of duties and responsibilities. In addition, in the Single Plan counties, the MCPs newly taking on WCM functions will need time to build infrastructure, enter into contractual arrangements, and complete operational readiness requirements.

DHCS will release guidance and work with MCPs implementing WCM in the Single Plan counties to ensure readiness. For example, DHCS will clarify that continuity of care protections will apply. MCPs will be required to establish and maintain a process to allow members to receive continuity of care with existing CCS provider(s) for up to 12 months. If a member has established authorizations for durable medical equipment, the MCP must provide access to those services. DHCS will also work with COHS expansion counties to ensure that the new counties follow existing CCS protocols in their other COHS counties. DHCS readiness review process for both Single Plan and COHS expansion counties will evaluate MCPs networks to assess compliance with CCS-paneled provider requirements.

Mandatory Enrollment of Foster Care Children in Single Plan Counties (WIC Section 14184.200(b)(2)(H))

As the COHS model expands to new counties in 2024, and the COHS-like Single Plan model is implemented in three counties, Foster Care children living in COHS and Single Plan counties will be moved into mandatory managed care. Therefore, DHCS is seeking express statutory authority to include mandatory enrollment of Foster Care children into managed care in Single Plan counties. DHCS will undertake stakeholder engagement, consider noticing timeline and approach, and obtain State and federal authorization updates needed to implement the policy.

DHCS is currently in the process of seeking federal authority for the Single Plan model through amendments to the CalAIM 1915(b) Waiver and 1115(a) Waiver, which will be submitted to the federal Centers for Medicare and Medicaid Services in November 2022.

Stakeholder Concerns

The California Children's Hospital Association has serious concerns with this proposal highlighting the following:

- There is no funding for this proposal included in the Governor's budget;
- The evaluation found that WCM counties have higher rates of kids not being enrolled in CCS;

- WCM counties have seen a reduction in the number of kids being referred to and treated in specialty care centers;
- The WCM should not be expanded until there is a better understanding of the program's strengths and weaknesses; and
- WCM providers (Children's Hospitals) end up with a rate cut because there is no rate adjuster for acuity.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal, respond to the concerns of the Children's Hospitals, and respond to the following:

1. When will the full evaluation be released?

2. What are the most positive results from the evaluation that justify expanding this program?

3. Can DHCS confirm that kids in the WCM program are: enrolled in CCS; getting the highest quality care available (through specialty care centers); and getting high-quality case management and appropriate referrals?

Staff Recommendation: In light of significant stakeholder concerns with this proposal, staff recommends holding this item open to allow for ongoing discussions with the administration and stakeholders.

ISSUE 10: PROGRAM WORKLOAD BUDGET CHANGE PROPOSAL

PANEL

- **Michelle Baass**, Director, DHCS
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS requests 16.0 permanent positions, five-year limited-term (LT) resources equivalent to 5.0 positions, the conversion of 3.0 LT resources to permanent positions, expenditure authority of $3,807,000 ($1,904,000 General Fund (GF); $1,903,000 Federal Fund (FF)) in fiscal year (FY) 2023-24, $3,654,000 ($1,827,000 GF; $1,827,000 FF) in FY 2024-25 through 2027-28 and $2,959,000 ($1,480,000 GF; $1,479,000 FF) in FY 2028-29 and ongoing. The resources are requested to address ongoing workload associated with the following:

- Medi-Cal Health Enrollment Navigators (Navigators) Project
- Strengthening Preventive Services for Children in Medi-Cal
- Short-Term Residential Therapeutic Program (STRTP) Mental Health Program Approval (MHPA) Oversight and Monitoring
- Administration

BACKGROUND

The administration provided the following background information:

Medi-Cal Health Enrollment Navigators

DHCS was appropriated $29,842,000 total funds ($14,921,000 GF) in FY 2019-20 and $29,878,000 total funds ($14,939,000 GF) in FY 2020-21 to distribute to counties and Community-Based Organizations (CBO) (in the absence of county interest in the project) for outreach and enrollment support, which may include assistance with retaining and using health coverage and gaining access to needed medical care. The Navigators Project has existed in various iterations since its inception in state FY 2013-14. The project was initially implemented as AB 82 (Statutes of 2013), continued with SB 18 (Statues of 2014), and extended by SB 75 (Statutes of 2015). There was a one-year gap in the project (FY 2018-19), and was reinstated on July 1, 2019 through AB 74. Previous LT funded resources were authorized via 4260-600-ECP2019-L “Medi-Cal Health Enrollment Navigators”, 4260-056-BCP-2021-GB “Limited-Term Workload Extension” and an additional $60 million ($30 million GF) were appropriated by SB 154 (Skinner, Chapter 43, Statutes of 2022) through June 2026.

DHCS has generally adhered to AB 82 and AB 74's project requirements, when feasible, to provide a greater degree of consistency to its project partners and, by extension, the individuals ultimately served by this project. SB 154 continues to provide funds to partnered counties and CBOs to contact hard-to-reach target populations to engage in outreach activities, help qualifying individuals and/or families enroll in publicly funded healthcare coverage, and retain that coverage at the time of annual redetermination. By continuing to target these specific populations, it is DHCS's intent to continue engaging these vulnerable populations that require a more locally specific approach to ensure that they have the necessary support to enroll into the program and to maintain access to medical care and services.

Strengthening Preventative Services for Children in Medi-Cal

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services benefit is provides a comprehensive array of preventive, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal. DHCS is committed to improving Medi-Cal's EPSDT benefit by strengthening the preventive services that are provided to Medi-Cal's EPSDT children. Medi-Cal managed care is an instrumental part in executing this objective as there are nearly 5 million children under the age of 21 enrolled in Medi-Cal, of which 82 percent are enrolled in managed care.

Because of the audit findings issued by the California State Auditor (CSA) report, *Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services Report Number: 2018-111 (C18-16)*, DHCS (MCOD) was required to develop and implement a more robust process to verify the accuracy of the managed care plans' (MCPs) provider directories and create a new methodology for determining compliance thresholds with this requirement.

Based on the CSA audit and the need for increased oversight of the provider directory review process, DHCS received LT resources equivalent to 2.0 AGPA positions and 1.0 Attorney IV position through BCP 4260-312-BCP-2019-A1 (Strengthening Preventative Services for Children in Medi-Cal). Although these positions are set to expire June 30, 2023, the work and oversight of the provider directory process is ongoing, as it is a requirement of the managed care contract between DHCS and managed care plans as well as the Medicaid managed care final rule.

Additionally, CSA initiated a new audit (CSA – item 22-18) of the previous audit report (C18-16) and there are findings that remain outstanding due to the COVID-19 Public Health Emergency. The positions will not only support the work tied to both the current and new audit, but also serve as contract managers responsible for enforcing the provider directory requirements in the managed care plan contract. The Attorney IV position will answer supporting legal questions.

STRTP MHPA Oversight and Monitoring

DHCS is leading state and local reform efforts to improve and develop children's community residential services through California's historic Continuum of Care Reform (CCR) initiative. Children's residential therapeutic services and the assurance of the provision of onsite Specialty Mental Health Services (SMHS) for Medi-Cal beneficiaries are a vital component to the success of CCR.

CCR required California Health and Human Services (CalHHS) Agencies and state departments under CalHHS, Associations, Legislature and stakeholders to collaborate in a coordinated and transparent manner to make strategic statutory, regulatory, administrative and local policy and procedural changes necessary, so that all children and youth have access to available level of care options; in particular, access to children's residential and community-based services to better meet therapeutic, outpatient, and inpatient behavioral health needs which includes STRTPs and Children's Crisis Residential Programs (CCRP) that are licensed by California Department of Social Services (CDSS) and that obtain a Mental Health Program Approval (MHPA) from DHCS.

As specified in Welfare and Intuitions Code 11462.01, DHCS is required to provide monitoring and oversight to STRTPs, which includes ensuring conformity to state law and regulatory requirements. DHCS may grant delegated authority to County Mental Health Plans (MHPs) to carry out the certification and oversight of Mental Health Program Approval for the STRTPs within the delegated region. Per Welfare and Intuition Code 4096.5, DHCS, or its delegate county MHP, is required to approve initially and annually certify the MHPA for STRTPs. Due to the low amount of counties that have accepted delegation, DHCS is tasked with the review of applications and all documents required as part of the program statement, initial onsite reviews, and annual onsite reviews for all of the STRTP providers as well as overseeing the delegate counties to meet compliance with mental health program standards.

The number of current counties with delegated authority has decreased from 12 to 7 in just 2 FYs. As a result, only seven of the 57 MHPs currently maintain their delegation of the MHPA oversight. The delegate counties are responsible for monitoring and providing ongoing compliance oversight to 116 STRTPs. However, Los Angeles County, which is one of the largest counties that held delegated authority, notified DHCS on July 5, 2022 that effective immediately, they have elected to relinquish their delegated authority. Los Angeles County has provided DHCS with a six month transition period that began July 15, 2022. As a result, beginning December 31, 2022, Los Angeles County MHP no longer provides the ongoing oversight and monitoring of 65 STRTPs within their geographic region. In addition, DHCS was notified that Fresno County MHP is considering relinquishing their delegated authority resulting in the transfer to DHCS, the oversight and monitoring responsibilities for an additional 41 STRTPs. Fresno County is in the process of consulting with their executive leadership team on the date they are planning to relinquish their delegated authority.

DHCS will be required to assume the annual approval and ongoing oversight and monitoring responsibilities for an additional 106 STRTPs, which will require additional resources to meet the significant increase in workload. With the existing 260 STRTPs under DHCS purview, 49 STRTPs pending MHPA and the increase of 106 STRTPs from the delegated counties, DHCS will have approximately 415 under our purview and will be unable to meet statutory requirements for the oversight and monitoring of these programs without additional resources. This poses a significant risk to the children and youth in care. DHCS anticipates the 3.0 AGPAs will provide the staffing resources necessary to meet this increased workload.

STAFF COMMENTS/QUESTIONS

This request is for substantial resources in a year with a budget deficit. The Subcommittee requests DHCS present this proposal, provide the justification for needing 16 additional positions to support this workload, and respond to the following questions:

1. Does the DHCS budget include ongoing funding for navigators and has this program been established in statute?

2. Has Fresno County relinquished its delegated STRTP MHPA oversight authority yet?

Staff Recommendation: Staff recommends holding this item open and urging the administration to minimize and streamline proposals like this one given the state's current fiscal condition.

ISSUE 11: CONFORM STATUTORY ESTIMATE REQUIREMENTS TO RECENT PROGRAM CHANGES TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS proposes trailer bill language to update and conform statutory requirements related to the Medi-Cal Local Assistance Estimate (hereafter "Medi-Cal Estimate") with recent program changes in Medi-Cal and reorganize the estimate and budget act information.

The full language can be found here:
Conform Statutory Estimate Requirements to Recent Program Changes

BACKGROUND

The administration provided the following background information:

Existing law establishes requirements for how the Medi-Cal Estimate should be organized and how fiscal information will be displayed (Welfare & Institutions Code (WIC) section 14100.5). These requirements were developed in 1984, when the program looked very different from its current form and had a much greater reliance on the fee-for-service (FFS) delivery system than is the case today. For example, current law requires that individual FFS rate increases be budgeted separately and that fiscal intermediary management spending and county administration have their own schedules in the Budget Act. Additionally, current law places disproportionate emphasis on county administration compared to the larger amount of other administrative funding currently budgeted in the Medi-Cal Estimate.

Specifically, this proposal would:

- Remove the requirement that FFS rate increases be separately displayed.
- Starting with the 2024-25 fiscal year, consolidate all local assistance administration costs, including county administration, fiscal intermediary management, and other local assistance administration, under a single budget line item referred to as "County and other local assistance administration."
- Remove the requirement for Department of Finance to produce a range of estimates of Medi-Cal spending, to reflect current practice.

- Remove the requirement for county-by-county administrative cost projections, to reflect current practice.

DHCS proposes to align requirements in law with how the Medi-Cal program is currently funded and budgeted. Specifically, the changes will streamline the display of information in the Budget Act and simplify the information displayed in the Medi-Cal Estimate, while maintaining much of the same information and transparency that is provided today.
The justification for the proposed changes includes:

- Today, the "county administration" item in the annual budget act includes all local assistance administrative spending (other than spending related to fiscal intermediaries), not just spending on county administration. For example, this line item includes funding for a number of contracts that are budgeted as local assistance because of their tie to enrollment levels and other major local assistance items. In light of the growing significance of these non-county items, a broader administration designation would make more sense in state law than the currently required "county administration" item.

- Fiscal intermediary funding is not fundamentally different from other administrative funding budgeted in the Medi-Cal Estimate and makes up a small share of the overall funding. Specifically, in the May 2022 Medi-Cal Estimate, fiscal intermediary spending made up only 7.5 percent of total administrative dollars. Fiscal Intermediaries and the FFS delivery system play a less significant role in the program going forward with the implementation of California Advancing and Innovating Medi-Cal (CalAIM) and the increasing and dominant role of the managed care delivery system. In light of this, statutory changes are proposed to eliminate a separate line item for fiscal intermediary management. Combining authority for fiscal intermediary management with other local assistance administrative spending in a single line item would also improve budget administration and minimize the need for mid-year budget revisions.

- FFS rate increases are less central to the Medi-Cal program now than they once were due to the increased use of managed care.

- The Medi-Cal Estimate no longer features county-by-county projections of administrative spending and has not included this information for more than 10 years.

DHCS states that the proposal creates efficiencies for the Administration and the Legislature in ongoing administration of the Department's budget authority as well as the Medi-Cal Estimate development process. Specifically, DHCS explains that there will be fewer mid-year budget adjustments as a result of collapsing the eligibility and FI into one program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Staff recommends holding this item open to allow for additional input from stakeholders.

ISSUE 12: DELAY BUYBACK OF TWO-WEEK CHECKWRITE HOLD

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

PROPOSAL

The 2022 Budget Act included funding to buy back the current two-week delay of fee-for-service (FFS) checkwrite payments at the end of each June. This buyback is now proposed to be delayed until FY 2024-25. This action reduces costs by $1.1 billion total funds ($378 million General Fund) in FY 2022-23.

BACKGROUND

The two-week check write delay was adopted during the Great Recession in order to create a one-time savings in the budget. Last year's budget included funding to buy it back.

STAFF COMMENTS/QUESTIONS

While unfortunate, this proposal appears to make sense given the state's current fiscal condition. The Subcommittee requests DHCS present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Staff is unaware of any significant concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 13: MEDICAL PROVIDER INTERIM PAYMENT LOAN AUTHORITY TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Aditya Voleti**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS proposes trailer bill to set the Medical Provider Interim Payment (MPIP) loan authority at 10 percent of the amount appropriated from the General Fund and 6 percent of the amount appropriated from the Federal Trust Fund for Medi-Cal benefit costs in the Budget Act from the most recent fiscal year, instead of a fixed $2 billion, in the event there is a deficiency in budget authority or a signed budget is not in place at the beginning of a fiscal year (FY).

The full language can be found here:
Medical Provider Interim Payment Loan Authority

BACKGROUND

The administration provided the following background information:

A signed budget act appropriation is generally required for DHCS to make expenditures. Unexpected changes in the economy and overall health care program spending can sometimes result in a Medi-Cal budget appropriation deficiency during the FY. Such lapses in budget authority can hinder DHCS's ability to process the significant volume of transactions (estimated to be over $130 billion in FY 2022-23) required to reimburse Medi-Cal managed care plans, health care providers, and many other entities that participate in Medi-Cal. Additionally, in the event a budget is not enacted by the beginning of the FY, DHCS may not have budget authority to process payments. This is referred to as a "no budget scenario."

The federal government requires that the state make Medi-Cal fee-for-service (FFS) payments to certain health care providers (generally non-institutional providers such as physicians, nurses, psychologists, etc.) on a timely basis. Additionally, Medicare buy-in and Part D payments are also mandatory. Based on previous case law (i.e., White v. Davis, 108 Cal. App. 4th 197), DHCS is federally required to make these FFS payments even without budget authority.

However, the largest portion of DHCS expenditures are capitation payments to Medi-Cal managed care plans, which are not federally mandatory. State law allows DHCS to request interim General Fund amounts and federal fund expenditure authority from the Federal Trust Fund as a loan to be deposited into the MPIP Fund in the event of a no budget or other deficiency scenario (Government Code section 16531.1). These funds are used for non-federally-mandated payments on a temporary basis until new budget act authority or a supplemental appropriation bill is enacted and the General Fund loan is repaid. The MPIP funding is also used to provide advances to other departments, such as the Department of Developmental Services, that rely on federal Medicaid funding.

When the MPIP was initially established, the General Fund loan amount was set at no more than $1 billion, with an additional $1 billion federal funds expenditure authority, in a FY. At the time, this represented approximately 13 percent of estimated General Fund spending and about 9 percent of estimated federal funds spending. However, the amount of MPIP funding available to DHCS was increased to $2 billion General Fund and $2 billion federal funds as part of the Budget Act of 2018 and, in part, AB 1810 (Committee on Budget, Chapter 34, Statutes of 2018) the health omnibus budget trailer bill, due to growth in the Medi-Cal program which made the previous $1 billion amount too low to sustain even one month of basic operations.

Based on recent estimates, the current MPIP amounts are insufficient due to the significant growth and recent changes in the Medi-Cal program. DHCS generally prepares an estimate each year to determine if the loan amount is adequate. Based on these estimates, funding available in the MPIP is not sufficient to cover one month's required expenditures, including capitation payments to its Medi-Cal managed care plans. For example, as of the end of June 2022, capitation payments alone for July 2022 are estimated to be $1.5 billion General Fund and $2.5 billion federal funds, which exceed the MPIP amounts. This shortfall exposes DHCS to the risk of being unable to make payments to Medi-Cal managed care plans or other providers during a budget deficiency or a no budget scenario.

DHCS estimates that to continue to provide basic Medi-Cal services through one month (i.e., an entire month of capitation payments), it would need approximately $3.5 billion General Fund and $4.2 billion in federal funds for the month of July 2023. These amounts represent approximately 10 percent of the General Fund appropriation for benefits costs and 6 percent of the federal funds appropriation for benefit costs, respectively, as calculated in the May 2022 Medi-Cal Estimate for FY 2022-23.

In order to minimize the anticipated need to update the statutory limits on MPIP loan authority in the future, DHCS proposes to extend MPIP loan authority from a fixed $2 billion to 10 percent of the estimated non-federal share expenditures from the General Fund and 6 percent of federal fund expenditures from the Federal Trust Fund for Medi-Cal benefit costs in the Budget Act from the most recent fiscal year. Substituting

percentage amounts rather than a dollar amount will allow caps on MPIP support to grow or shrink with Medi-Cal expenditures over time.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Staff is unaware of any significant concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 14: NEWBORN HOSPITAL GATEWAY TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Aditya Voleti**, Finance Budget Analyst, DOF
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS proposes trailer bill language to require all qualified Medi-Cal providers participating in presumptive eligibility (PE) programs to report the births of any Medi-Cal eligible infant born in their facilities, including hospitals and birthing centers or other birthing settings, within 24 hours after birth through the Newborn Hospital Gateway.

The full language can be found here:
Newborn Hospital Gateway

BACKGROUND

The administration provided the following background information:

Existing law allows infants born to individuals eligible for and receiving Medi-Cal at the time of birth to be automatically deemed eligible for one year without a separate Medi-Cal application or Social Security Number, and may be reported directly to Medi-Cal by the facility in which they are born (Title 42, United States Code, Section 1396a(e)(4), and Welfare & Institution Code Section 14148.04). Today, providers currently report infants through the Child Health and Disability Prevention (CHDP) Gateway, or the Newborn Referral Form (MC 330). This is a voluntary process with no requirement that facilities refer an infant born to a Medi-Cal enrolled individual to the county, creating inconsistent processes for establishing eligibility for deemed infants.

DHCS proposes to require all qualified and participating Medi-Cal PE providers who have access to the CHDP Gateway, Hospital Presumptive Eligibility (HPE) and Presumptive Eligibility for Pregnancy (PE4PW) online portals, to register deemed infants who are born in the provider's facility, or with the provider's supervision outside of the traditional hospital or birthing center setting, within 24 hours after birth through the Newborn Hospital Gateway, in order to properly establish Medi-Cal eligibility and obviate any coverage gaps or delays in care when accessing coverage benefits for which these infants are entitled (W&I Code Section 14148.04(a) and (b)). This requirement will result in more expeditious eligibility activation for Medi-Cal newborns, instead of waiting for the parents to report the

birth to the county. This will help to mitigate any issues at the provider level regarding eligibility of the newborn when covered services are being accessed.

DHCS also proposes a technical change to remove outdated language which required the implementation of the Newborn Hospital Gateway within 12 months of funding as the Gateway Fund referenced in the original text was abolished in 2012 (W&I Code Section 14148.04(d) and (e)).

Lastly, the CHDP will sunset June 30, 2024. To preserve the existing CHDP Gateway newborn referral process, the CHDP Gateway online portal functionality, including the Newborn Hospital Gateway process, will transition and be renamed to the Children's Presumptive Eligibility (CPE) online portal effective July 1, 2024. Additionally, DHCS will be programming the Newborn Hospital Gateway functionality into the HPE and PE4PW online portals to open up more pathways for qualified PE providers to report the birth of Medi-Cal infants for whom they assist. Following the CHDP sunset, all qualified Medi-Cal PE providers will then have the ability to enroll newborns through the CPE, HPE, and PE4PW online portals.

This proposed requirement to report Medi-Cal infant births within 24 hours through the automated PE portals pertains to all birthing facility-based PE providers, including those working outside the traditional hospital or birthing center setting. This is a cost neutral proposal. The CHDP sunset was authorized in SB 184 (Committee on Budget and Fiscal Review, Chapter 47, Statutes of 2022).

DHCS provides the following justifications for this proposed language:

1. Requiring all qualified PE Providers to report deemed infants born in their facilities, including hospitals, birthing centers, and other birthing settings, would help improve access for eligible infants to receive the full 12 months of deemed eligibility to which they are entitled.
2. The proposal will reduce delays in establishing the infant's eligibility and expedite access to Medi-Cal benefits and necessary medical care.

STAFF COMMENTS/QUESTIONS

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

1. Please provide a status update of the stakeholder process and transition plan for the Child Health and Disability Program (CHDP)?

2. Does the administration plan to include the transition plan in its 2024-25 proposed budget for consideration by the Legislature, prior to commencing the transition?

Staff Recommendation: Staff is unaware of any significant concerns with this proposal and therefore recommends approval at a future hearing.

ISSUE 15: ACUTE INPATIENT INTENSIVE REHABILITATION SERVICES TRAILER BILL

PANEL

- **Jacey Cooper**, State Medicaid Director, Chief Deputy Director, Health Care Programs, DHCS
- **Kendra Tully**, Finance Budget Analyst, DOF
- **Jason Constantouros**, Principal Fiscal and Policy Analyst, LAO

PROPOSAL

DHCS proposes trailer bill to eliminate the statutory provisions related to initial evaluation (7-10 days) and 14-day trial program for acute inpatient intensive rehabilitation (AIIR) services.

The full language can be found here:
Acute Inpatient Intensive Rehabilitation Services

BACKGROUND

The administration provided the following background information:

AIIR is an intensive set of services in an inpatient setting to rehabilitate a physically or cognitively impaired patient to achieve or regain their maximum potential for mobility, self-care and independent living. This is accomplished by restoring maximum independent function, resulting in a sustained higher level of self-care with a discharge to home or other community setting, or to a lower level of care, in the shortest possible time. Established in 1976, the statute describing AIIR services is partially outdated and misaligned with evidence-based practice and current policy delineated by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program. Specifically, existing law states a typical program provides an initial evaluation of 7-10 days followed by a 14-day trial program as needed. However, in 2010, CMS determined that trial periods such as these are "no longer considered reasonable and necessary" for purposes of Medicare coverage. Instead, each admission decision must be evaluated and based on a thorough preadmission screening. In 2021, DHCS updated the relevant treatment authorization request criteria for AIIR, accordingly, to align with this evidence-based practice and Medicare policy, given a lack of clinical justification for the trial period.

DHCS proposes to update state law to conform with evidence-based practice, federal Medicare policy and current DHCS policy on medical necessity by removing the provision that describes the "trial period" as detailed in Welfare & Institutions (W&I) Code Section 14064 (C). DHCS also proposes non-substantive technical changes to update the section with contemporary numbering (W&I Code Section 14064(a) and (b)).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to any questions raised in the hearing.

Staff Recommendation: Staff is unaware of any significant concerns with this proposal and therefore recommends approval at a future hearing.

NON-PRESENTATION ITEMS

There are no panels for non-presentation items, however any item can be moved to Presentation at any time before or during the hearing by any Member. At the end of the hearing, public comment is welcome on all items on the agenda, including the non-presentation items.

ISSUE 16: MEDI-CAL ENTERPRISE SYSTEM MODERNIZATION BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS requests 7.0 permanent positions, two-year limited-term (LT) resources equivalent to 6.0 positions; the Office of the Agency Information Officer is requesting 1.0 permanent position, and contract expenditure (LT) authority of $7,797,000 ($1,379,000 General Fund (GF); $6,418,000 Federal Fund (FF)) in fiscal year (FY) 2023-24, $4,509,000 ($716,000 GF; $3,793,000 FF) in FY 2024-25, and $1,580,000 ($337,000 GF; $1,243,000 FF) in FY 2025-26 for ongoing support of the DHCS Medi-Cal Enterprise Systems (MES) modernization efforts.

This request supports ongoing activities for the following approved projects and efforts: 1) Behavioral Health Modernization (BHM) - Project Approval Lifecycle (PAL) Stage 4 and data migration and conversion planning activities, 2) state staff DevOps activities to continuously support the Federal, Draw and Reporting system, 3) California Accounts Receivable Management (CalARM) enterprise shared services support, and (4) MES Modernization Strategy and Architecture Planning. This funding request will provide resources in FY 2023-24 to continue the strategy development effort and continued development/refinement of the MES Modernization roadmap based on DHCS business priorities. This will build upon the information provided in the modernization approach (IT Product Delivery Strategy Development Approach) document delivered on June 15, 2022 and the modernization strategy deliverables, including a roadmap, to be delivered in June 2023.

BACKGROUND

The administration provided the following background information:

DHCS and its partners use a myriad of often patchwork and outdated systems to administer more than $144.2 billion annually to deliver vital health care services to approximately 14.5 million, or one in three Californians in Medi-Cal.

To improve outcomes and resource efficiencies, DHCS has changed its approach from focusing on individual information technology (IT) systems to focusing on the entire MES, where Medicaid Management Information Systems and Eligibility and Enrollment systems

efforts are handled in coordination as MES. This approach aligns with CMS' Medicaid IT Architecture (MITA) framework.

In implementing the new enterprise-wide approach, DHCS has initially focused on modernizing the Federal Draw Reporting (FDR) system, CalARM, and the systems which support the Behavioral Health program. The FDR system entered its Operations phase in July 2022 and will solely be supported by contracted resources. These resources are responsible for maintaining day-to-day operations of the system, resolving any technical issues, and ensuring the Department is able to use the system to meet its mandated responsibilities today and over time.

The CalARM system finalized PAL Stage 4 requirements, and received California Department of Technology (CDT) approval to exit PAL Stage 4 on June 28th, 2022. Upon entering PAL Stage 4, the envisioned solution was a Software as a Service (SaaS) product. However, the procurement for the CalARM Prime Solution vendor resulted in procuring a modified off the shelf solution (MOTS). This MOTS solution presents new challenges and opportunities for DHCS in that it requires the Department to independently purchase additional software products to meet CalARM's full business needs, and provide and maintain the development and production environments to support the solution. The development environment consists of a set of shared enterprise services some of which can be leveraged from the recently completed FDR solution to serve both CalARM and future modernization efforts.

The BHM project is proceeding through the state's PAL process and is currently scheduled to complete Stage 3 and will begin Stage 4 in fall 2023. DHCS will be working with CDT and project stakeholders to explore methods for expediting the development and delivery of the highest priority Behavioral Health modernized functionality. This will be conducted in advance of completing Stage 4, in order for the BHM effort to more timely meet the most critical modernization business needs of the state's Behavioral Health program.

The S2AA analysis has determined there is a need for Data Migration and Conversion planning analysis, which will need to begin before the project's anticipated implementation start date in the 2024-25 fiscal year. The need to begin before the project implementation start date is due to the immense volume of data and extremely technical nature of determining how the data migration and conversion plan will work with the chosen solution.

The MES is an outdated patchwork of systems that struggles to meet business needs, react timely to changing State and Federal requirements, and is inefficient and unnecessarily costly to maintain. These issues hinder the Medi-Cal program from being able to deliver health services in modern ways that, for example, utilize data to understand local population needs and allow beneficiaries to have better access to services and their health care information. Much of the current systems were built during a time when the

main method used for delivering services was a fee-for-service model. However, during the last few decades, major shifts have occurred such that over 85 percent of the Medi-Cal beneficiary population is covered through the managed care plan service delivery model and we estimate that number will grow to 99 percent as of January 1, 2024. MES Modernization needs to consider these changes in the service delivery model and plan for such changes in the future.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 17: DENTAL PROGRAM PROCUREMENT BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS requests conversion of 4.0 limited-term (LT) funded resources to permanent positions, and the establishment of 2.0 new permanent positions, and expenditure authority of $1,766,000 ($443,000 General Fund (GF); $1,323,000 Federal Fund (FF)) in fiscal year (FY) 2023-24, $1,748,000 ($438,000 GF; $1,310,000 FF) in FY 2024-25 and ongoing.

The requested positions and funding for consulting services will oversee and support a major procurement effort, contract transition, and related efforts, to secure a new Fiscal Intermediary (FI) Dental Information Technology Maintenance and Operations (FI-DITMO) contract for the Medi-Cal Dental Fee-for-Service (FFS) delivery system.

BACKGROUND

The administration provided the following background information:

DHCS's Medi-Cal Dental Services Division (MDSD) administers the Medi-Cal dental benefit through two delivery systems: dental FFS and Dental Managed Care (DMC). The dental FFS delivery system (which is the delivery system for approximately 93 percent of Medi-Cal members, or 13.5 million members) is supported by two contracted vendors: a dental Administrative Services Organization (ASO), and an FI–DITMO. Through these contracts, millions of claims are processed and paid annually for services provided to Medi-Cal members.

The FI-DITMO vendor's primary role is to operate and maintain the California Dental Medicaid Management Information System (CD-MMIS), which is a decades-old, legacy system. CD-MMIS is the system in which dental claims and Treatment Authorization Requests (TARs) are processed, and payments are issued. The dental ASO contract provides administrative services supporting the provision of dental services for Medi-Cal providers and members, including adjudicating TARs and claims, and operation of a provider and member call center. The ASO works closely with, and is dependent upon, the FI-DITMO contract to support all of the operational processes for delivering Medi-Cal FFS dental services.

The base and extension years for these two contracts were strategically staggered to accommodate completion of a re-procurement of the ASO contract before a second FI-ITMO procurement would have to begin. The maximum term of the ASO contract runs through June 30, 2023. The FI-DITMO contract is a four-year contract with up to five optional one-year extensions. With all FI-DITMO extension years exercised, the maximum term of the FI-DITMO contract runs through June 30, 2026.

MDSD's remaining resources are fully dedicated to administering the Medi-Cal dental benefit, including meeting the current and ever-increasing demands associated with effective and efficient contract monitoring and oversight activities of two major contracts (current ASO and FI-DITMO contracts,) which together total over $3.8 billion (ASO - $280,422,892; FI-DITMO - $3,541,731,318).

DHCS must procure a new FI-DITMO contract before the current contract, with extension years enacted, expires in June 2026. The procurement cycle for an FI contract is normally three years. Thus, resources will need to be allocated and in place to begin this procurement by July 2023.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 18: HEALTH CARE COVERAGE CONTRACEPTIVES (SB 523) BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS, Managed Care Quality and Monitoring Division (MCQMD), requests 3.0 permanent positions and expenditure authority of $455,000 ($228,000 General Fund (GF); $227,000 Federal Fund (FF)) in fiscal year (FY) 2023-24 and $428,000 ($214,000 GF; $214,000 FF) in FY 2024-25 and ongoing related to the requirements of SB 523 (Leyva, Chapter 630, Statutes of 2022) to lead policy development and implementation, conduct ongoing monitoring activities, analyze covered services to determine which contraceptive services may need to be carved out to the Fee-For-Service (FFS) delivery system due to federal impermissibility, and facilitate those carve outs.

DHCS states that these resources are needed to implement and maintain the new workload and distinguish between Federal Financial Participation (FFP)-ineligible services and FFP-eligible services to reduce the risk of providers billing Medi-Cal managed care health plans (MCPs) for services which are not FFP-eligible.

BACKGROUND

The administration provided the following background information:

MCPs must provide family planning services in a manner that protects and enables member freedom to choose the method of family planning to be used free from coercion or mental pressure consistent with Title 42 Code of Federal Regulations Section 441.20. MCPs are required to inform members in writing of their right to access any qualified family planning provider without prior authorization in the Model Member Handbook.

MCPs are contractually required to provide members of childbearing age with access to the following services from family planning providers, both in and out-of-network, without prior authorization, to temporarily or permanently prevent or delay pregnancy:

- Health education and counseling necessary to make informed choices and understand contraceptive methods;
- Limited history and physical examination;
- Laboratory tests if medically indicated as part of the decision-making process for choice of contraceptive methods;
- Diagnosis and treatment of a sexually transmitted disease (STD) episode, as defined by DHCS for each STD, if medically indicated;
- Screening, testing, and counseling of at-risk individuals for HIV and referral for treatment;
- Follow-up care for complications associated with contraceptive methods prescribed by the family planning provider;

- Provision of contraceptive pills, devices, and supplies;
- Tubal ligation;
- Vasectomies; and
- Pregnancy testing and counseling.

Existing state law establishes health care coverage requirements for contraceptives, including, but not limited to, requiring commercial plans and MCPs to cover up to a 12-month supply of federal Food and Drug Administration (FDA)-approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee by a provider or pharmacist, or at a location licensed to authorized to dispense drugs or supplies. Medi-Cal currently covers all FDA-approved drugs, devices, and products, including condoms, diaphragms, cervical caps, and Plan B emergency contraceptives without cost sharing, when provided by an authorized Medi-Cal provider acting under the scope of practicing authority for that provider type.

Federal law requires a providing health care professional to document the dispensing of the contraceptive device or product by keeping a prescription on file at the pharmacy. A providing pharmacist has the ability to self-generate a prescription or fill according to a prescription sent by a medical provider, pursuant to Business and Professions Code Section 4052.3. Prior authorization is only required for certain non-over-the-counter (OTC) contraceptives for quantities in excess of the quantity limitations. In addition, a pharmacist is authorized to furnish Plan B, and various forms of contraceptives such as oral, transdermal, vaginal, and depot injection, based on protocol from the Board of Pharmacy pursuant to 16 California Code of Regulations (CCR) Sections 1746.1 and 1746. Medi-Cal reimburses pharmacists for this service as providers pursuant to Welfare and Institutions Code Section 14132.968. Additionally, 22 CCR Section 51006 allows reimbursement for medically necessary emergency services that need to be provided by an out-of-state provider to members that are temporarily in another state.

The federal definition for sterilization means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. However, per federal law, FFP is only available for sterilization services if the individual is at least 21 years of age at the time consent is obtained; the individual is not mentally incompetent; the individual has given voluntary consent, as required; and at least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery. FFP is not available for a hysterectomy if it was performed solely for the purpose of rendering an individual permanently incapable of reproducing.

Effective January 1, 2022, DHCS transitioned Medi-Cal pharmacy services from the managed care delivery system to the FFS delivery system known as Medi-Cal Rx. Therefore, MCPs are no longer responsible for the provision of covered outpatient drugs when billed as a pharmacy claim. Medi-Cal Rx permits up to 18 cycles per dispensing without restrictions as stated on the Contract Drugs List.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 19: LOCAL EDUCATIONAL AGENCY MEDI-CAL BILLING OPTION PROGRAM RETURN OF OVER COLLECTED WITHHOLD BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS, Local Governmental Financing Division (LGFD), requests a one-time appropriation of $7,450,000 (Special Deposit Fund (SDF)) in fiscal year (FY) 2023-24 to reimburse local educational agencies for excess administrative withholds associated with the Local Educational Agency Medi-Cal Billing Option Program (LEA BOP).

BACKGROUND

The administration provided the following background information:

The LEA BOP was established in 1993 in conjunction with the California Department of Education and is authorized under Welfare and Institutions Code (WIC) sections 14132.06 and 14115.8. DHCS administers the LEA BOP which is a school-based, federal reimbursement, and certified public expenditure program. DHCS is responsible for implementing policies, regulations, and new legislation related to the LEA BOP and school-based health care.

The LEA BOP reimburses LEAs (school districts, county offices of education, charter schools, community college districts, California State Universities, and University of California campuses) the federal share of the maximum allowable rate for approved services. In order to be reimbursed under LEA BOP, services must be medically-necessary, provided by qualified health service practitioners to Medi-Cal enrolled students, and provided under an individualize plan for the student, such as an Individualized Education Program, Individualized Family Service Plan or an Individualized Health Service Plan.

The LEA BOP is an optional program in which the state's 1,039 LEAs can choose to participate in order to receive the federal share of reimbursement for the provision of direct medical services as allowed under the State Plan. Currently, 563 LEAs participate in LEA BOP and receive approximately $130 million in federal funding annually. The 563 participating LEAs account for over five million of the six million public school children in California.

An administrative withhold is levied against LEA claim reimbursements to cover DHCS administrative costs to run the program without an impact to the SDF. DHCS is seeking authority to use these funds to return the over collected funds back to the LEAs.

STATE FISCAL YEAR	TOTAL CLAIMS EXPENDITURES
2000-2001	$59.6 million
2001-2002	$67.9 million
2002-2003	$92.2 million
2003-2004	$90.9 million
2004-2005	$63.9 million
2005-2006	$63.6 million
2006-2007	$69.5 million
2007-2008	$81.2 million
2008-2009	$109.9 million
2009-2010	$130.4 million
2010-2011	$147.8 million
2011-2012	$137.9 million
2012-2013	$145.6 million
2013-2014	$148.7 million
2014-2015	$149.5 million
2015-2016	$143.9 million
2016-2017	$131.6 million
2017-2018	$133.7 million
2018-2019	$124.2 million

Original WIC statutory language implemented in 2002 by the approval of SB 2312 allows for a 1 percent withhold to claims submitted by participating LEAs in order to pay for a contract. Authority was established for an additional 1 percent withhold through SB 870, Budget Act of 2010, which stated that a 1 percent withhold will be retained by DHCS for work and related administrative costs associated with the audit resources and services conducted by the Audits and Investigation Division. This combined 2 percent withhold is collected by the Fiscal Intermediary through the claims submission process and is deposited into the special funds account designated for the Local Educational Agency Medi-Cal Recovery Fund. Therefore, DHCS is obligated by law to return unused funds to the LEAs.

Authority was given for the combined 2 percent withhold through the Budget Act of 2010 and in WIC 14115.8. Authority for the return of funds is stated in both statutes as well as in the October 2018 LEA BOP Provider Manual. Any remainder of unused funds should be returned to the LEAs. DHCS is out of compliance based upon this authority and therefore, the remainder of unused funds must be returned to the LEAs.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

ISSUE 20: PUBLIC SOCIAL SERVICES: HEARINGS (AB 1355) BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS Quality and Population Health Management (QPHM) and Office of Legal Services (OLS) request 2.0 permanent positions and expenditure authority of $523,000 ($193,000 General Funds (GF); $330,000 Federal Funds (FF)) in Fiscal Year (FY) 2023-24, $505,000 ($187,000 GF; $318,000 FF) in FY 2024-25 and ongoing to provide clinical and legal expertise in reviewing proposed State Fair Hearing (SFH) decisions and assisting the director, or their designee, in drafting alternative SFH decisions, as required by AB 1355 (Levine, Chapter 944, Statutes of 2022).

DHCS states that these resources are needed to implement and maintain the new workload resulting from the bill's requirements to review hearing transcripts or recordings; provide a detailed reasoning, including references to applicable sections of law and regulations, to support divergence from the Administrative Law Judge's (ALJ) proposed ruling; and review any additional SFH decisions resulting from the DHCS director, or their designee, choosing to take on additional evidence that was not available at the time of the original hearing.

BACKGROUND

The administration provided the following background information:

Medi-Cal beneficiaries have the right to request a SFH with the California Department of Social Services (CDSS) if they disagree with an action taken by a county, DHCS, or a Medi-Cal managed care health plan (MCP), such as a denial, termination, or reduction in services or benefits. DHCS has delegated the provision of SFHs to CDSS' State Hearings Division. Managed care enrollees must request a SFH within 120 days of receipt of the MCP's Notice of Appeal Resolution and for non-MCP related appeals, beneficiaries have 90 days from the date of the issued notice of action to request a SFH. Medi-Cal beneficiaries do not have to pay for a SFH.

SHFs are heard by Administrative Law Judges (ALJs) who are impartial parties employed by the state (i.e., CDSS). The hearing must afford beneficiaries and their representatives the chance to present evidence and witnesses, cross-examine adverse witnesses, and examine their case files. The adverse party must provide a written statement of position, if any, at least two days in advance of the hearing. Hearings must ordinarily be resolved within 90 days; however, beneficiaries may request an expedited hearing if waiting 90 days would put their health at risk, and CDSS must take final administrative action as expeditiously as the individual's health condition requires, but no later than the allowable timeframes prescribed in state and federal law. If the SFH decision is not favorable, the

beneficiary has 30 days to request a rehearing, which may be offered at the state's discretion, as prescribed in state law.

Under existing law, after an ALJ has held a SFH and issued a proposed hearing decision, the DHCS director (or the director's designee) has the option to adopt the proposed decision in its entirety; decide the matter themselves (i.e., alternate the decision) on the record, including the transcript, "with or without" taking additional evidence; or order a further hearing to be conducted by themselves, or another ALJ on their behalf. Failure of the director, or their designee, to take one of these actions within the allotted timeframes outlined in state and federal law, is deemed to be an affirmation of the ALJ's proposed decision. If a further hearing is ordered, it must be conducted in the same manner and within the same time limits specified for the original hearing.

AB 1355 amended existing law to require the DHCS director, when altering an ALJ's proposed SFH decision, to review either the hearing transcript or recording, and provide a detailed reasoning, including references to applicable sections of law and regulations, to support divergence from the ALJ's proposed ruling. The bill allows the DHCS director to alter a SFH decision "without" taking additional evidence, but requires the director to order a further hearing when choosing to take on additional evidence so that all parties are provided with the opportunity to present and respond to the additional evidence.

Staff Recommendation: Subcommittee staff is unaware of any significant concerns with this proposal and recommends approval at a future hearing.

PUBLIC COMMENT

(PUBLIC COMMENT WILL BE TAKEN ON ALL ITEMS ON THE AGENDA)

This agenda and other publications are available on the Assembly Budget Committee's website at: https://abgt.assebly.ca.gov/sub1hearingagendas. You may contact the Committee at (916) 319-2099. This agenda was prepared by Andrea Margolis.