AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 8, 2021

2:30 PM, STATE CAPITOL, ROOM 4202

Due to the regional stay-at-home order and guidance on physical distancing, seating for this hearing will be very limited for press and for the public. All are encouraged to watch the hearing from 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.

A moderated telephone line will be available to assist with public participation. After all witnesses on all panels and issues have concluded, and after the conclusion of member questions, the public may provide public comment by calling the toll-free number: ***877-692-8957,*** *access code:* ***131 54 202.***

ITEMS TO BE HEARD

NON-PRESENTATION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

4260 DEPARTMENT OF HEALTH CARE SERVICES
4800 COVERED CALIFORNIA

ISSUE 1: HEALTH4ALL, COVERAGE, CASELOADS, AND SUBSIDIES

PANEL 1 - PRESENTERS

Health4All Advocates
- **Jose Torres**, Legislative Advocate, Health Access
- **Orville Thomas**, Government Affairs Director, California Immigrant Policy Center
- **Lilian A. Serrano-Alamo**, Community Educator, Universidad Popular, and Member, San Diego Immigrant Rights Consortium

UC Berkeley Center for Labor Research and Education
- **Laurel Lucia**, Director, Health Care Program

Covered California
- **Katie Ravel**, Director, Policy, Eligibility and Research

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs and State Medicaid Director

Legislative Analyst's Office
- **Ned Resnikoff**, Fiscal & Policy Analyst

PANEL 1 – Q&A ONLY

Department of Health Care Services
- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility

Department of Finance
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst
- **Ryan Miller**, Assistant Program Budget Manager

Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal & Policy Analyst
- **Mark Newton**, Deputy Legislative Analyst

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: LONG-TERM CARE FACILITY PENALTIES FOR IMPROPER DISCHARGES TRAILER BILL

PANEL 2 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs and State Medicaid

California Association of Health Facilities (CAHF)
- **Amy Blumberg**, Director of legislative Affairs

PANEL 2 – Q&A ONLY

Department of Health Care Services
- **Pat Freeman**, Deputy Director, Office of Administrative Hearings and Appeals
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

Department of Finance
- **Alek Klimek**, Finance Budget Analyst
- **Tyler Woods**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Ned Resnikoff**, Fiscal & Policy Analyst

ISSUE 3: DELAY SUSPENSIONS OF PROPOSITION 56 AND MEDI-CAL ADULT OPTIONAL BENEFITS TRAILER BILLS

PANEL 3 – PRESENTERS

Department of Health Care Services

- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs and State Medicaid Director

Legislative Analyst's Office

- **Corey Hashida**, Fiscal & Policy Analyst

PANEL 3 – Q&A ONLY

Department of Health Care Services

- **Lindy Harrington**, Deputy Director, Health Care Financing
- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility

Department of Finance

- **Alek Klimek**, Finance Budget Analyst
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Tyler Woods**, Principal Program Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst

Legislative Analyst's Office

- **Ben Johnson**, Principal Fiscal & Policy Analyst
- **Mark Newton**, Deputy Legislative Analyst

ISSUE 4: CONTINUOUS GLUCOSE MONITORS COVERAGE PROPOSAL

PANEL 4 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs and State Medicaid Director

PANEL 4 – Q&A ONLY

Department of Health Care Services
- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility

Department of Finance
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal & Policy Analyst

ISSUE 5: RESTORATION OF ADULT OTC COUGH/COLD AND ACETAMINOPHEN DRUG BENEFIT TRAILER BILL

PANEL 5 – PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs and State Medicaid Director

PANEL 5 – Q&A ONLY

Department of Health Care Services
- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility

Department of Finance
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal & Policy Analyst

AGENDA OVERVIEW

This agenda covers issues and proposals that primarily relate to health care coverage. This includes: 1) one California Health and Human Services Agency budget change proposal (BCP) ; 2) both of the Department of Managed Health Care BCPs; 3) general information about the status of Covered California programs and coverage; 4) several Department of Health Care Services (DHCS) BCPs and proposed trailer bills (TBL) and other proposals contained in the Governor's January Budget related to Medi-Cal; and 5) a discussion of costs related to proposals to expand Medi-Cal eligibility to additional populations.

The DHCS budget also includes the following proposals that are not included in this agenda:

- ***Behavioral Health Proposals*** – the Subcommittee heard these at its hearing on February 22, 2021.

- ***CalAIM*** – the Subcommittee will hear CalAIM in two joint informational hearings with the Assembly Health Committee on March 9th (behavioral health) and March 16th.

- ***Medi-Cal and Family Health Estimates*** – the Subcommittee will evaluate the updated estimates at May Revise.

- ***Office of Medicare Integration and Innovation*** – the January budget announced an impending proposal to create this office to lead innovative models for dual-eligibles and Medicare-only individuals; however, the administration has yet to provide the Legislature with proposed trailer bill, and therefore the Subcommittee will evaluate the proposal once the full, detailed proposal has been received, contingent on sufficient time remaining to do so.

- ***Telehealth*** – the January budget includes a proposal to make various telehealth flexibilities, allowed during the public health emergency, permanent. This proposal may be heard at a future Subcommittee hearing.

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES
4800 COVERED CALIFORNIA

OVERVIEW

This issue covers: 1) information about insurance coverage rates and estimated costs of expansions to Medi-Cal; 2) an overview of Covered California programs and pandemic response; and 3) impacts of the pandemic on Medi-Cal, including caseload projections. In addition to this agenda, please also see slides provided by panelist Laurel Lucia.

ISSUE 1: HEALTH4ALL, COVERAGE, CASELOADS, AND SUBSIDIES

PANEL 1 – PRESENTERS AND QUESTIONS FOR PRESENTERS

Health4All Advocates
- **Jose Torres**, Legislative Advocate, Health Access
- **Orville Thomas**, Government Affairs Director, California Immigrant Policy Center
- **Lilian A. Serrano-Alamo**, Community Educator, Universidad Popular, and Member, San Diego Immigrant Rights Consortium

Questions for Health4All Advocates:
1. Please share any information you have about the impact of the pandemic on uninsured Californians.
2. Why is health insurance important, especially during a public health emergency?
3. What would be the main benefits of universal health coverage for California overall?

UC Berkeley Center for Labor Research and Education
- **Laurel Lucia**, Director, Health Care Program

Questions for Laurel Lucia:
1. Please provide an overview of data and demographics on uninsured Californians prior to the pandemic.
2. Please provide any information available on the impacts of the pandemic on uninsured rates.
3. Please provide any data on COVID-19 morbidity and mortality based on occupation, as a proxy for health coverage and immigration status.
4. Please share any data you have on the larger societal cost savings associated with insuring more people.

Covered California
- **Katie Ravel**, Director, Policy, Eligibility and Research

Questions for Covered California:

1. Please provide an overview of Covered California enrollment and how enrollment has been affected by the pandemic.
2. Please provide an overview of how Covered California has responded to the pandemic, and what strategies have been implemented to make coverage more accessible during the pandemic.
3. Please describe discussions and proposals at the federal level related to health benefit exchanges, and how they might affect California.
4. Specifically regarding the federal proposal to forgive the clawback of federal subsidies due to the pandemic, is this something that California could consider doing related to state-specific subsidies?

Department of Health Care Services

- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs and State Medicaid Director

Questions for DHCS:

1. Please provide an overview of how the Medi-Cal program has responded to the pandemic, and what strategies have been implemented to make Medi-Cal coverage more accessible during the pandemic.
2. Please describe the Medi-Cal caseload estimates and what major assumptions have influenced these estimates.

Legislative Analyst's Office

- **Ned Resnikoff**, Fiscal & Policy Analyst

Questions for LAO:

1. Please provide any analysis, concerns, or recommendations that the LAO has on any of the issues raised in this issue.

PANEL 1 – Q&A ONLY

Department of Health Care Services

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility

Department of Finance

- **Hinnaneh Qazi**, Finance Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst
- **Ryan Miller**, Assistant Program Budget Manager

Legislative Analyst's Office

- **Ben Johnson**, Principal Fiscal & Policy Analyst
- **Mark Newton**, Deputy Legislative Analyst

BACKGROUND

Expanded Coverage: Health4All Proposal

Many advocacy organizations, in coordination with members of both houses, prioritize the expansion of Medi-Cal to additional eligible populations, regardless of immigration status, prioritizing seniors. Even the Governor proposed an expansion to eligible seniors, regardless of immigration status, in his January 2020 budget. Health Access states that: "the proposal to expand Medi-Cal coverage to undocumented seniors is more urgent than ever. According to the Centers for Disease Control and Prevention, individuals who are above age 65 are susceptible to a higher risk of serious illness from COVID-19, including serious complications or even death. Undocumented immigrant seniors are the most at-risk population that is currently excluded from coverage, and so they are less likely to have a doctor or usual source of care to ask about symptoms or preventive care, and would be exposed to the significant costs of follow-up care after emergency coronavirus treatment."

According to data from the US Census Bureau, since the implementation of the Patient Protection and Affordable Care Act (ACA) in 2014, the rate of Californians without health insurance declined from 17.2% in 2013 to 7.2% in 2017. Undocumented immigrants represent 40% of California's remaining uninsured, according to the Legislative Analyst Office. The UC Berkeley Labor Center projected that 1.15 million undocumented adults would have been eligible for full-scope Medi-Cal in 2020, if coverage had been extended to all income-eligible individuals regardless of immigration status.

In May, 2018, the LAO published an analysis of the uninsured population including cost estimates for expanding Medi-Cal eligibility to cover this population. The LAO is currently working on updating this information and expects to have an updated version of this analysis this spring. In 2018, the LAO stated that:

> "The total population of undocumented adults that would be income-eligible for full-scope Medi-Cal is around 1.2 million individuals. (Income eligibility for full-scope Medi-Cal is generally a household income at or below 138 percent of the federal poverty level.) Figure 1 summarizes our estimate of the income-eligible undocumented adult population within six separate age bands."

Figure 1

Estimated Number of Undocumented Adults Eligible for Full-Scope Medi-Cal Coverage

Ages	Currently Enrolled in Restricted-Scope Medi-Cal	Currently Eligible but Not Enrolled in Restricted-Scope Medi-Cal	Total
19-25	92,000	19,000	111,000
26-35	310,000	64,000	374,000
36-49	440,000	91,000	531,000
50-54	61,000	13,000	74,000
55-64	56,000	12,000	68,000
65+	30,000	6,000	36,000
Totals	**989,000**	**205,000**	**1,194,000**

LAO: "Figure 2 summarizes the total costs of providing full-scope Medi-Cal coverage to undocumented adults within the six separate age bands, with an offset for the costs already covered for undocumented adults currently enrolled in restricted-scope Medi-Cal."

Figure 2

Estimated Cost of Providing Full-Scope Medi-Cal Coverage to Undocumented Adults

(In Millions)

Ages	Total Costs	Offset for Cost Already Covered[a]	Net Cost
19-25	$330	$190	$140
26-35	1,210	570	640
36-49	1,800	560	1,240
50-54	360	120	240
55-64	580	180	400
65+	460	130	330
Totals	**$4,740**	**$1,750**	**$2,990**

[a]Estimated costs primarily for emergency- and pregnancy-related services already covered for undocumented adults enrolled in restricted-scope Medi-Cal.

These cost estimates do not reflect the savings that would occur within our overall health care system when more people become insured. Nor do they reflect the overall improvements to public health that occur the closer any society gets to universal coverage. Finally, if you assume costs of $3 billion to insure all undocumented adults, and divide that cost equally among 40 million Californians, it would cost each of us only about $6.25 a month.

Governor's 2020 Proposal. The Governor's proposed 2020 January budget included a proposal to expand Medi-Cal eligibility to eligible seniors, regardless of immigration status. Specifically, the budget proposed to expand full-scope Medi-Cal to all income-eligible persons 65 years and older, regardless of immigration status, no sooner than January 1, 2021, including $80.5 million ($64.2 million General Fund) to cover costs, including for In-Home Supportive Services, for an estimated enrollment in the first year of 27,000 individuals. The January budget assumed full implementation (out-year) costs of $350 million ($320 million General Fund). The 2020 May Revise, post the start of the pandemic, dropped this proposal and therefore it was not considered for inclusion in the final 2020 Budget Act.

Covered California

The Affordable Care Act (ACA) implemented market reforms and required establishment of health benefit exchanges, which provide federally subsidized health care coverage to individuals with incomes between 138 and 400 percent of the federal poverty level (FPL). California established its own health benefit exchange, Covered California, funded by assessments on health plan premiums. Covered California offers several options for individual health care coverage negotiated for cost and quality with health plans. Enrollment occurs during an annual open enrollment period that begins November 1 and ends January 31.

Advance Premium Tax Credit Subsidies. The ACA subsidizes health care coverage purchased in health benefit exchanges, such as Covered California, for individuals between 138 and 400 percent of the FPL. The subsidies are provided in the form of advance premium tax credits (APTC), which reduce the amount of premium paid by income-eligible consumers purchasing coverage on the exchange. The amount of the APTC is linked to the cost of the second-lowest cost Silver plan in a consumer's coverage region. The APTC is meant to ensure that consumers are required to spend no more than two percent to 9.6 percent of their income for Silver plan premiums. Consumers may use the APTC subsidy amount to purchase other metal tiers of coverage that may be less expensive (e.g. Bronze) or more expensive (e.g. Gold or Platinum). According to Covered California, as of June 2020, approximately 1.5 million individuals had enrolled in coverage in the exchange. Approximately 1.4 million individuals covered by exchange products received an average of $454 per month in federal APTC subsidies. Approximately 103,000 individuals received exchange-based coverage, but were not eligible for APTC subsidies.

Individual Mandate Penalty and Cost-Sharing Reductions. In addition to individual market reforms and new coverage options, the ACA eliminated pre-existing condition exclusions for adults beginning in 2014, and imposed a requirement that individuals enroll in health plans that offer minimum essential coverage or pay a penalty, known as the individual mandate penalty. The individual mandate penalty was designed to stabilize premiums by encouraging healthy individuals to enroll in health coverage and reduce the overall acuity of health insurance risk pools. Because health plans cannot deny coverage based on a pre-existing condition, in the absence of a mandate penalty, individuals may delay enrolling in coverage until they are diagnosed with a high-cost health condition, resulting in higher overall plan expenditures, which lead to higher premiums. The ACA also limited the amount of cost-sharing that could be required of plan beneficiaries with incomes under 250 percent of the FPL. These cost-sharing reductions result in savings to beneficiaries on deductibles, copayments, coinsurance, and maximum out-of-pocket costs. Until 2017, the federal government provided cost-sharing reduction subsidies to health plans to help mitigate the costs of limiting cost-sharing amounts for these beneficiaries. These subsidies were designed to maintain those cost-sharing limits while reducing higher premium costs that would otherwise be required.

Elimination of Cost Sharing Reduction Subsidies and Repeal of Individual Mandate. In October 2017, the federal Administration eliminated cost-sharing reduction subsidies that prevented premium growth due to ACA requirements that limited cost-sharing for health plan beneficiaries with incomes under 250 percent of the FPL. According to Covered California, the loss of these subsidies will result in an annual reduction of approximately $750 million of federal funds available to reduce premiums. According to the Kaiser Family Foundation, health plans imposed resulting cost-sharing reduction surcharges ranging from seven to 38 percent on premiums beginning in 2018. In addition, recently enacted federal tax legislation included a reduction to zero of the individual mandate penalty for failing to purchase health care coverage. The reduction took effect for coverage in the 2019 calendar year.

State Subsidy Program and State Individual Mandate Penalty. The 2019 Budget Act included General Fund expenditure authority of $428.6 million in 2019-20, $479.8 million in 2020-21, and $547.2 million in 2021-22 to provide state premium subsidies for individuals up to 600 percent of the FPL purchasing health care coverage in Covered California. Approximately 17 percent of the funds supplement federal APTC subsidies for individuals with incomes between 200 and 400 percent of the FPL (between $51,500 and $103,000 for a family of four) and approximately 83 percent for individuals with incomes between 400 and 600 percent of the FPL (between $103,000 and $154,500 for a family of four). The funding also covers full premium costs for individuals below 138 percent of the FPL ($35,500 for a family of four). In addition, the 2019 Budget Act included trailer bill language to implement a penalty on individuals that fail to maintain minimum essential coverage during a coverage year, to encourage enrollment in the absence of the federal

individual mandate penalty. The minimum penalty is $695 for adults in a household and $347.50 for each child. The revenue from the penalty offsets General Fund expenditures for the state subsidy program. According to Covered California, as of June 2020, approximately 598,000 individuals received state subsidies, with 546,000 under 400 percent of the FPL receiving an average of $14 per month and 42,000 between 400 and 500 percent of the FPL receiving an average of $301 per month.

The state subsidy program design is based on the funding available through the budget appropriation and the provisional language governing the division of the funds: 17 percent for individuals 200 to 400 percent of the FPL and 83 percent for individuals 400 to 600 percent of the FPL.

***Covered California Response to the COVID-19 Pandemic*.** Covered California had already implemented a Special Enrollment Period (SEP) beginning on February 18th, designed to allow consumers whose annual tax filings made them aware of the state mandate penalty to enroll in coverage. The SEP was originally scheduled to end on April 30th, but due to the COVID-19 emergency Covered California extended the enrollment period until June 30th. In June, the deadline was extended again until July 31st, and extended again in July until August 31st.

According to Covered California, 289,000 individuals signed up for coverage during the COVID-19 SEP, including 21 percent who were previously uninsured and likely ineligible to enroll under federal rules. More than half previously had job-based coverage, while one in four left the marketplace to become uninsured, raising concerns about the affordability of coverage.

Open Enrollment for 2021 Plan Year. Covered California began Open Enrollment for the 2021 Plan Year on November 1st, 2020, reporting a record-low weighted average premium rate increase of 0.5 percent. Covered California also reported all 11 carriers would continue offering products in 2021, with two expanding their coverage areas. Nearly all Californians (99.8 percent) have two or more choices for coverage and 77 percent have four or more choices.

On January 12th, 2021, Covered California reported a record 1.6 million Californians had either renewed coverage or selected a plan during open enrollment, an increase of nearly 200,000 or 14 percent over the same time period in 2020. Over 640,000 are eligible for the state subsidy program, including 44,500 middle-income consumers between 400 and 600 percent of the FPL.

Impacts of Federal Executive Actions and Legislative Proposals. On January 28th, 2021, President Biden signed an Executive Order directing HealthCare.gov, the federally facilitated health insurance exchange serving 36 states without their own state-based exchange, to provide a special enrollment period between February 15th and May 15th,

2021, to allow individuals in need of health care coverage during the pandemic the opportunity to sign up. On the same day, Covered California announced that it would also extend its Open Enrollment period, previously scheduled to end on January 31st, 2021, until May 15th, 2021, to match the federal extension.

In addition to the executive actions, the Biden Administration has proposed to substantially increase federal support for APTC subsidies for individuals purchasing health care coverage in a state or federal exchange. The proposal would limit the required contribution towards health care premiums to 8.5 percent of household income and base the subsidy amount on the cost of a gold plan rather than a silver plan. If this proposal were to be adopted, the federal APTC subsidies would be significantly more generous than Covered California's current combined federal and state program design, which requires contributions up to 18 percent of household income for those near 600 percent of the FPL, based on the cost of the second lowest cost silver plan. The state subsidy program devotes the vast majority of resources to subsidize individuals between 400 and 600 percent of the FPL, due to their current ineligibility for any federal subsidy. However, if one or both of the subsidy-related components of the Biden Administration proposal is adopted, the state may need to reevaluate the program design of the state subsidy program.

Medi-Cal Response to the COVID-19 Pandemic:
DHCS, as the single state agency for Medi-Cal, is responsible for administration of the program's COVID-19 response to ensure Medi-Cal beneficiaries are able to receive necessary health, oral health, behavioral health, long-term care, and home- and community-based services while maintaining appropriate public health interventions to protect against transmission of COVID-19. The Medi-Cal response to the COVID-19 pandemic has been comprised of new federal requirements contained in various Congressional relief packages, as well as waivers and other flexibilities sought by DHCS to address the delivery of care during the pandemic.

Families First Coronavirus Response Act (FFCRA) – Increased FMAP and Continuous Coverage. The federal Families First Coronavirus Response Act (FFCRA) provided an increase in the federal medical assistance percentage (FMAP) for state Medicaid programs, including Medi-Cal, of 6.2 percent for Medi-Cal expenditures and 4.34 percent for Children's Health Insurance Program (CHIP) expenditures. According to DHCS, this increase in FMAP will offset General Fund expenditures in the Medi-Cal program by $2.9 billion in 2020-21 and $2.2 billion in 2021-22. DHCS assumes the enhanced FMAP will be available until December 31, 2021.

As a condition of the enhanced FMAP in the FFCRA, Medi-Cal beneficiaries may not be dis-enrolled from the program, except under limited circumstances, during the public health emergency. As a result, DHCS expects caseload impacts from the continuous coverage requirement to result in additional Medi-Cal costs of $5.2 billion ($1.7 billion

General Fund and $3.6 billion federal funds) in 2020-21 and $12 billion ($3.9 billion General Fund and $8.1 billion federal funds in 2021-22.

Federal Flexibilities Approved for Medi-Cal Through Waivers and Other Authorities. Since the beginning of the public health emergency, DHCS has sought approval from the federal Centers for Medicare and Medicaid Services (CMS) for various program flexibilities to allow the continued delivery of Medi-Cal services while maintaining appropriate public health interventions to prevent the transmission of COVID-19. DHCS has sought these flexibilities through State Plan Amendments, as well as under Sections 1115 and 1135 of the Social Security Act, and Appendix K amendments to 1915(c) home- and community-based waiver programs.

State Plan Amendments. The Medicaid State Plan is a comprehensive written document that describes the nature and scope of the Medi-Cal program. The State plan is a contractual agreement between California and CMS and requires administration of the Medi-Cal program in conformity with federal Medicaid laws and regulations. States may request changes to a State Plan through State Plan Amendments (SPAs). During the pandemic, California received CMS approval, or approval is pending, for the following SPAs:

- Child and Pregnancy Coverage Rules (SPA 17-0043) – Under a previously approved SPA (17-0043), DHCS used its existing authority to waive monthly premiums and other cost-sharing, such as co-pays, and to implement temporary adjustments to enrollment, eligibility determination, or determination policies for the following programs: Lower-Income Unborn Option, Medi-Cal Access Program (MCAP), Medi-Cal Access Infant Program (MCAIP), and the County Children's Health Initiative Program (CCHIP). Allows self-attestation of eligibility for application or renewal and waives monthly premiums.

- Clinical Laboratory and Long-Term Care Reimbursement (20-0024) - Allows Medi-Cal to do the following: 1) reimburse all COVID-19 related laboratory testing and collection procedures at 100 percent of Medicare reimbursement; and 2) allow a 10 percent per diem rate increase for certain long-term care facilities.

- COVID-19 Vaccination Coverage and Reimbursement (20-0040, pending CMS approval) - Seeks to add coverage for COVID-19 vaccine administration for Medi-Cal beneficiaries, and establish Medicare reimbursement rates for COVID-19 vaccine administration for all providers when furnished within their scope of practice in accordance with California state law, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Service Memorandum of Agreement (IHS-MOA) providers. FQHCs, RHCs, and IHS-MOA providers would receive the payment outside their all-inclusive, per-visit reimbursement.

- Crisis Stabilization Units (21-0003, pending CMS approval) - Seeks to allow Medi-Cal beneficiaries to receive crisis stabilization services for up to four days (96 hours), rather than the current limit of less than 24 hours per episode. Also seeks to reimburse crisis stabilization services providers up to 20 hours for each 24 hour period for up to four consecutive days, or 80 total hours in a 96 hour period.

- Durable Medical Equipment Reimbursement (21-0016, pending CMS approval) - Seeks to increase reimbursement rates for durable medical equipment (DME) oxygen and respiratory equipment to 100 percent of the corresponding Medicare rate, for dates of service on or after March 1, 2020.

Section 1115 Waivers. Section 1115 of the Social Security Act provides CMS broad authority to allow experimental, pilot, or demonstration projects likely to assist in promoting the objectives of Medicaid. California's 1115 Waiver, Medi-Cal 2020, recently extended by one year until December 31, 2021, provides authority for a broad array of Medi-Cal programs including its managed care delivery system, the Drug Medi-Cal Organized Delivery System, Community-Based Adult Services, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, the Global Payment Program (GPP), Whole Person Care (WPC) pilots, and the Dental Transformation Initiative (DTI). Changes to the 1115 Waiver may be made through waiver amendments. During the pandemic, California received approval, or approval is pending, for the following 1115 Waiver amendments:

- Drug Medi-Cal Organized Delivery System - Allows the following changes to the Drug Medi-Cal Organized Delivery System (DMC-ODS): 1) suspends limitations on two non-continuous 90 day residential treatment regimens per year during the public health emergency; 2) suspends current 30 day (for adolescents) and 90 day (for adults) maximums for a single residential treatment stay during the public health emergency; 3) modifies the rate-setting methodology of the DMC-ODS Certified Public Expenditure; 4) allows services to be provided in locations recognized as temporary extensions of qualified residential settings; and 5) suspends minimal clinical service hour and disallowance requirements for intensive outpatient and residential substance use disorder treatment.

- Public Hospital Redesign and Incentives in Medi-Cal and Global Payment Program - Allows modifications to the distribution of incentive payments under the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, and adjusts thresholds for the Global Payment Program (GPP).

- Community-Based Adult Services - Allows the following changes to community-based adult services (CBAS): 1) allows CBAS providers to provide limited in-center activities, as well as telephonic, telehealth, and in-home services; 2) expands settings where CBAS may be provided; and 3) allows assessments to be

conducted telephonically using self-reported information by participants or caregivers.

- COVID-19 Vaccines (pending CMS approval) - Seeks to extend coverage of COVID-19 vaccines and administration to the following limited-scope benefit populations in Medi-Cal: 1) individuals eligible for tuberculosis-related benefits; 2) individuals eligible for the optional COVID-19 testing group; 3) non-citizen individuals eligible for restricted-scope benefits; 4) individuals eligible for family planning benefits under the Family Planning Access, Care and Treatment (Family PACT) program. Also seeks to allow delivery of COVID-19 vaccines through the Medi-Cal fee-for-service delivery system, rather than managed care contracts, to standardize delivery of vaccines to beneficiaries.

- COVID-19 Testing in Schools - Extends coverage of COVID-19 testing in school settings under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening provisions for children in Transitional Kindergarten through 12th grade. Also allows delivery of COVID-19 testing through the Medi-Cal fee-for-service delivery system, rather than managed care contracts, to standardize delivery of the testing benefit.

Section 1135 Waivers. Section 1135 of the Social Security Act permits CMS to temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements during a federally declared public health emergency to ensure sufficient health care items and services are available to meet the needs of individuals enrolled in public programs in the emergency area and time periods, and providers who give such services in good faith can be reimbursed and exempted from sanctions. During the pandemic, California received CMS approval for the following 1135 Waivers:

- 1135 Waiver Approval (March 2020) - Allows Medi-Cal to do the following: 1) temporarily suspend Medicaid fee-for-service prior authorization and medical necessity processes; 2) extend pre-existing authorizations a beneficiary previously received until the end of the public health emergency; 3) modify timeframe for managed care entities to resolve appeals of adverse benefit determinations prior to a fair hearing process to no less than one day; 4) modify timeframe for beneficiaries to exercise appeal rights to allow an additional 120 days to request a fair hearing; 5) waive certain provider enrollment requirements for the duration of the public health emergency; and 6) allow facilities to be fully reimbursed for services rendered in an unlicensed alternative care setting, as long as the state determines it meets minimum reasonable standards in the context of the public health emergency.

- 1135 Waiver Approval – Telehealth (August 2020) - Allows Medi-Cal to waive clinic facility requirements to permit services via telehealth.

- 1135 Waiver Approval – Fair Hearings (December 2020) - Allows Medi-Cal to do the following: 1) temporarily extend the timeframe to reinstate services and benefits after a fair hearing beyond 10 days, but should reinstate the services and benefits as quickly as practicable, 2) allow managed care plans to continue benefits if requested within the current 10 day time frame or reinstate benefits for the beneficiary upon request between 11 and 30 days if the plan has not yet made a decision on the appeal and a fair hearing is pending.

Appendix K of 1915(c) Home- and Community-Based Services Waivers. Appendix K of the state's 1915(c) Home- and Community-Based Services Waivers allows states to request waiver amendments to respond to emergencies. Services provided under 1915(c) waivers include the Developmental Disabilities (DD) Waiver, the Home- and Community-Based Alternatives Waiver, the Assisted Living Waiver, the HIV/AIDS Waiver, and Multipurpose Senior Services Program. During the pandemic, California received CMS approval for the following Appendix K waiver amendments:

- Multi-purpose Senior Services Program - Allows Multi-purpose Senior Services Programs (MSSP) sites to conduct telephonic assessments, video conferencing, or live video interactions in lieu of face-to-face visits, in accordance with HIPAA requirements.

- HIV/AIDS Waiver – Allows the following for the HIV/AIDS Waiver: 1) telephonic or live virtual video conferencing in lieu of, or as an option for, face-to-face visits, in accordance with HIPAA requirements; 2) care management activities (level of care evaluations, home visits, and home environment assessments) to be conducted via telephonic or live video assessments in lieu of face-to-face visits; 3) digital signatures for forms that require participant or legal representatives' signatures; 4) waiver agencies to extend the time in which they have to complete level of care re-evaluations and ongoing comprehensive nursing and psychosocial reassessments by an additional 120 days beyond the current 180 day requirement.

- Assisted Living Waiver - Allows Assisted Living Waiver (ALW) Care Coordination Agencies (CCAs) to: 1) conduct telephonic or video conferencing interactions in lieu of, or as an option for, face-to-face visits for initial assessments or enrollments, in accordance with HIPAA requirements; 2) conduct telephonic or live video virtual assessments in lieu of face-to-face assessments for level of care; 3) temporarily modify incident reporting requirements for CCAs to allow facility staff to submit incident reports on non-standard forms as long as all elements of the form are present; 4) temporarily suspend the 60 day enrollment period for applicants unable to complete the application due to COVID-19 impacts; 5) temporarily allow for an

extension of the 31 to 60 day re-enrollment period of waiver participants who moved from assisted living for hospitalization to retain their slot or enrollment in the waiver; 6) temporarily allow digital signature for forms that require participant or legal representatives' signatures; and 7) allows prioritization of enrollment and intake processing for applicants in an inpatient facility stay within areas of the state designated as "hot spots", without having been in an institution for 60 days.

- Home- and Community-Based Alternatives Waiver – Allows the following changes for the Home- and Community-Based Alternatives Waiver: 1) permits payment for services rendered by family caregivers or legally responsible individuals; 2) modifies provider qualifications to permit unlicensed waiver personal care services providers as long as they are currently in-home supportive services providers; 3) modify provider types to allow certified nurse assistants to provide private duty nursing; 4) modify licensure or other requirements for settings where waiver services are furnished, allowing telehealth (including telephonic or virtual live video conferencing) as an alternative option to face-to-face interactions; 5) modify processes for waiver eligibility level of care evaluations and re-evaluations via telephonic or virtual live video conferencing as an alternative option to face-to-face interactions, in accordance with HIPAA requirements; 6) pause waiver dis-enrollments of participants who are re- institutionalized, beyond the 30 day limit, because a caregiver contracts COVID-19 or it is unsafe for them to return to the community; 7) temporarily allow digital signature for forms that require participant or legal representatives' signatures; 8) allows prioritization of enrollment and intake processing for applicants in an inpatient facility stay within areas of the state designated as "hot spots", without having been in an institution for 60 days; and 9) aligns rates with requirements in the FFCRA to allow two weeks of emergency paid sick leave when a waiver personal care service provider is unable to work due to the COVID-19 pandemic.

- Developmental Disabilities Waiver - Allows the following changes for Department of Developmental Services waiver programs: 1) temporarily changes service locations to allow services such as day services to be provided in the participant's home; 2) temporarily modify provider qualifications if a participant decides to self-direct to an individual to provide a service, as long as the individual is at least 18 years of age and possesses the skills and experience to provide the service; 3) temporarily modify service plan development requirements for in-person attendance of service plan development and monitoring meetings, allowing the option for telephonic or live virtual video conferencing; 4) temporarily allow retainer payments for habilitation, behavioral intervention services, and day services due to absences for the emergency; and 5) allows provision of technology, equipment, and training to assist waiver consumers in accessing services remotely.

- Multiple Waiver Programs – Personal Care Services – Allows a waiver personal care service provider to exceed the maximum workday limit of 12 hours per day, without penalty, when necessary to reduce a waiver participant's potential exposure to COVID-19 or when providers are unavailable as a result of the public health emergency. Also allows retainer payments for services that provide support for personal care or activities of daily living including residential habilitation, behavior intervention and day services, which include personal care or components of personal care.

COVID-19 Uninsured Group. In response to the pandemic, DHCS also established a special category of Medi-Cal eligibility for individuals who do not qualify for Medi-Cal, but who are uninsured and diagnosed with COVID-19. This special eligibility category covers the costs of COVID-19 testing and treatment. DHCS reports that 94,000 individuals have enrolled in this coverage. As was raised in the form of a stakeholder request at the Subcommittee's hearing on February 8th, the application for this coverage includes a question about immigration status, which arguably has a chilling effect on precisely the population of people who would qualify and may need this coverage. DHCS states that CMS requires the inclusion of this question on the application, but are open to engaging with new CMS leadership on this issue as soon as possible.

Medi-Cal Caseload:
In 2020-21, the budget assumes annual Medi-Cal caseload of 14 million, a decrease of 1.9 percent compared to assumptions in the 2020 Budget Act. It is unclear what the reasons are that new enrollment during the pandemic has been lower than expected, however there are two dynamics that may have played a role: 1) many of the newly unemployed (as a result of the pandemic) were extremely low-wage workers, and therefore may have been eligible for, and already enrolled in, Medi-Cal prior to the pandemic when they were employed; and 2) the pandemic and its various impacts may have been such an anomaly for so many people, that some people have not perceived that they will be unemployed, and uninsured, for the long-term, and therefore do not believe that they need to seek out publicly-funded health insurance. DHCS points out that caseload continues to grow, despite the growth being slower than anticipated for this past year.

In 2021-22, the budget assumes annual Medi-Cal caseload of 15.6 million, an 11.7 percent increase compared to the revised caseload estimate for 2020-21. The administration attributes this significant increase in estimated caseload primarily to the fact that the increase in federal Medicaid reimbursements, that are part of the federal COVID-19 relief to states, prohibits states from dis-enrolling individuals during the public health emergency. Normally the Medi-Cal caseload experiences a substantial amount of churn as people cycle on and off the program as their eligibility fluctuates.

The January budget assumes increased caseload-driven costs in the Medi-Cal program of $5.4 billion ($1.7 billion General Fund) in 2020-21 and $13.5 billion ($4.3 billion General Fund) in 2021-22. Should these estimates turn out to be too high, savings will be scored in future Medi-Cal estimates (such as May 2021, November 2021, and May 2022).

STAFF COMMENTS/QUESTIONS

Prior to the pandemic, an abundance of evidence supported the public health benefits of universal health coverage. Subsequently, the pandemic itself has reinforced this and resulted in unequivocal clarity around the need for, and benefits of, universal health coverage. As with nearly all diseases and health threats, COVID-19 has inflicted its wrath most heavily on low-income communities of color; the disparities are stark. California cannot hope to achieve equity without universal access to health care. One cannot help but wonder how many lives may have been saved had the Governor's proposal to expand coverage to undocumented seniors been approved and included in the final budget. Moreover, just as we were with over-the-counter medications (discussed in issue 5), are we being penny-wise and pound foolish? The evidence says yes.

Finally, as described above, both DHCS and Covered California have engaged in super-human efforts, jumping through endless hoops and doing stunning acrobatics, to successfully push for a dizzying array of policy changes, all of which are simply for the purpose of making health care accessible to all Californians. Unfortunately, these efforts are temporary in nature, and most of them will disappear once the public health emergency is declared over. Imagine if California instituted all of these changes, as well as expansions to cover the remaining uninsured, on a permanent basis; when the next pandemic arrives, we would have nothing to do (except stay home).

Staff Recommendation: Subcommittee staff strongly recommends that the Legislature and Administration prioritize expanding health insurance coverage in order to get as close to universal health insurance coverage in California as soon as possible.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: LONG-TERM CARE FACILITY PENALTIES FOR IMPROPER DISCHARGES TRAILER BILL

PANEL 2 – PRESENTERS AND QUESTIONS FOR PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs and State Medicaid

Questions for DHCS:
1. How often does this occur? I.e., how often would these penalties be assessed (assuming they don't act as a deterrent), and therefore how much revenue would be raised?
2. What are the reasons that facilities do not comply with DHCS orders to not discharge patients?
3. Please describe the actual hearing process, and how the facilities are represented in these hearings.
4. Does CDPH have authority to levy fines against facilities for these same violations? If so, how much are the fines and what is the justification for having two different departments issue fines for the same violations?

California Association of Health Facilities (CAHF)
- **Amy Blumberg**, Director of legislative Affairs

Questions for CAHF
1. Please describe the most common situations that cause facilities to violate DHCS orders to admit or re-admit a patient.
2. Please describe the ways in which you believe the hearing process at DHCS should be changed.
3. Do you believe that there is any "patient dumping" that goes on in the SNF industry that needs to be addressed?

PANEL 2 – Q&A ONLY

Department of Health Care Services
- **Pat Freeman**, Deputy Director, Office of Administrative Hearings and Appeals
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support

Department of Finance
- **Alek Klimek**, Finance Budget Analyst
- **Tyler Woods**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Ned Resnikoff**, Fiscal & Policy Analyst

REQUEST

DHCS proposes trailer bill language to assess monetary penalties against a long-term health care facility for noncompliance with a hearing decision issued by DHCS that orders the readmission of a resident after a finding that the facility improperly transferred, discharged, or failed to readmit a resident.

This propose trailer bill language would authorize the department to assess penalties of up to $1,000 for each calendar day the facility fails to comply with a hearing decision, beginning on the sixth calendar day after the date of service of the decision. Penalties would not exceed a total of $100,000 for each hearing decision noncompliance episode. The language would authorize DHCS to waive a portion of penalties upon a facility's successful demonstration of hardship. Penalty revenue would be deposited in the state's General Fund.

BACKGROUND

Federal law requires states to provide a long-term health care facility resident with a fair hearing if the resident has been refused readmission to the facility from a hospital. The hearing process, meant to protect against improper resident discharge, known as "patient dumping," is administered by the DHCS Office of Administrative Hearings and Appeals (OAHA), which conducts the hearing and issues decisions and orders related to improper discharges, transfers, or refusals to readmit. According to DHCS, once OAHA issues a decision and order, it no longer has jurisdiction or authority for enforcement, but refers the issue to the California Department of Public Health (CDPH). CDPH handles these referrals as complaints, investigates the improper discharge, and may issue a citation to the facility.

DHCS indicates the hearing process for improper discharges, followed by an investigation by CDPH, can lead to delays in returning residents to their facility of origin in a timely manner. In addition, DHCS reports its OAHA findings occasionally do not align with CDPH findings in its investigative process. Since DHCS has no enforcement authority, it must defer to CDPH to ensure a resident is readmitted to their facility of origin, and to impose penalties on noncompliant facilities.

The California Association of Health Facilities (CAHF), which is an association of skilled nursing facilities (SNFs), opposes this proposed trailer bill for several reasons. CAHF raises the following concerns:

- Sometimes the patient who has been discharged is considered a threat to other patients and staff;

- The DHCS hearing process does not consider the perspective of the SNF; and
- The California Department of Public Health already has authority to impose fines on facilities in these situations of $50 per day.

STAFF COMMENTS/QUESTIONS

If inappropriate, harmful "patient dumping" from SNFs is a real problem, then clearly the state is justified in seeking to increase its enforcement authorities. However, it is incumbent upon DHCS to provide more evidence that this is a problem, as well as more detail on the nature of their hearing process, proving that it is in fact a fair process that considers the views and needs of all stakeholders. The state should explore how it helps facilities address the challenges they are facing with these patients, rather than utilizing only a punitive approach that ignores the source of the problem.

Staff Recommendation: Subcommittee staff recommends that the Subcommittee have more conversations with DHCS, stakeholders, and advocates during the spring prior to deciding whether or not to approve of the proposal.

ISSUE 3: DELAY SUSPENSIONS OF PROPOSITION 56 AND MEDI-CAL ADULT OPTIONAL BENEFITS TRAILER BILLS

PANEL 3 – PRESENTERS AND QUESTIONS FOR PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs and State Medicaid Director

Questions for DHCS:
1. Please present these proposals to delay the suspensions on Prop 56 supplemental payments and Medi-Cal optional benefits.
2. Please explain the rationale and justification for having any suspension requirements, particularly given the concerns raised by the LAO and Subcommittee staff in this agenda.

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

Questions for LAO:
1. Please present an overview of the LAO's analysis, concerns and recommendations related to suspensions to health programs.

PANEL 3 – Q&A ONLY

Department of Health Care Services
- **Lindy Harrington**, Deputy Director, Health Care Financing
- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility

Department of Finance
- **Alek Klimek**, Finance Budget Analyst
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Tyler Woods**, Principal Program Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal & Policy Analyst
- **Mark Newton**, Deputy Legislative Analyst

PROPOSALS

The administration proposes budget bill and trailer bill language to either delay or repeal the requirement to conduct a fiscal analysis potentially leading to suspensions of various programs throughout the budget, including for various health-related programs. Trailer bill to delay the suspensions of Medi-Cal maternal mental health benefits and for the screenings, brief intervention, and referral for treatments (SBIRT) expansion were included on the Subcommittee's February 22 agenda (focused on behavioral health). This issue covers proposed trailer bill to delay the suspensions for Proposition 56-funded Medi-Cal provider supplemental payments and for various Medi-Cal adult "optional benefits."

Specifically, the proposed language would make the following changes to the suspensions framework:

1. ***Proposition 56 Supplemental Provider Payments*** – DHCS proposes provisional budget bill language and trailer bill language that would delay the suspension of most Proposition 56 supplemental provider payments until July 1, 2022, or one year after the current suspension date. The language would suspend supplemental payments for intermediate care facilities-developmental disabilities (ICF-DDs), freestanding pediatric subacute facilities, and community-based adult services on December 31, 2022, or 18 months after the current suspension dates. The language would also repeal the suspension for supplemental payments for the AIDS waiver, home health, and pediatric day health care facilities, as DHCS does not expect federal approval for these suspensions.

2. ***Optional Benefits*** - DHCS proposes trailer bill language to delay the suspension of specified Medi-Cal optional benefits until January 1, 2023, or one year after the current suspension date. These benefits would include podiatric services, audiology services, speech therapy, optician and optical services, and incontinence creams and washes.

BACKGROUND

The 2019 Budget Act included language to suspend expenditures for certain health and human services programs on December 31, 2021. The statute requires that if the Director of Finance determines that projected annual General Fund revenues exceed projected annual General Fund expenditures sufficient to fund all suspended programs, the suspensions would not take effect. These suspensions were intended to address an expected General Fund shortfall in subsequent fiscal years due to a recessionary forecast. The health related programs subject to suspension included: 1) Proposition 56 supplemental provider payments, 2) Medi-Cal optional benefits, 3) provisional post-

partum care Medi-Cal eligibility expansion, 4) SBIRT expansion to opioids and other drugs, 5) comprehensive HIV prevention grants, 6) sexually transmitted disease (STD) prevention grants, and 7) hepatitis C prevention grants.

The 2020 Budget Act maintained the structure of the suspensions, but accelerated suspensions of Proposition 56 supplemental provider payments to July 1, 2021 (except family planning, women's health, and the physician and dentist loan repayment program), and repealed the suspensions for the HIV, STD, and hepatitis C prevention grant programs.

The 2009 Budget Act and related bills eliminated many Medi-Cal optional benefits, including: adult dental services, acupuncture, audiology, speech therapy, chiropractic services, optician and optical lab services, podiatric services, psychology services, and incontinence creams and washes. These benefits were not eliminated for beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program, beneficiaries in a skilled nursing facility or intermediate care facility, or pregnant beneficiaries. Over the course of several years, budget and legislative actions have restored nearly all of the eliminated benefits as of January 1, 2020, including full adult dental benefits, optical benefits, acupuncture, audiology, incontinence creams/washes, podiatry, and speech therapy.

Legislative Analyst's Office (LAO)

The LAO analyzed the suspensions across state government and published a report that can be accessed on their website and via this link:
https://lao.ca.gov/Publications/Report/4328

The LAO's analysis raises these key concerns:

> "***Maintaining Suspensions Treats Ongoing Programs as Temporary***. The suspension language treats policies that are fundamentally ongoing in nature as temporary. For example, health and developmental services-related spending amounts subject to suspension generally support core programmatic funding intended to improve consumer access to an entitlement program. Some reductions—such as the IHSS 7 percent service hour reduction—also could present legal risks in addition to being a reduction to a core service. Treating ongoing program costs as temporary fundamentally understates the true ongoing cost of the state's policy commitments.
>
> ***Suspending Core Government Services Poses Programmatic Issues***. Many of the suspension items, particularly the larger ones, are related to core government services. The suspension language creates uncertainty in these programs, which can pose problems for providers and recipients of these services. The potential suspension of supplemental rate increases for developmental

services providers makes staffing and planning more difficult. For example, hiring permanent staff to work directly with program consumers is more challenging when the funding is uncertain. Similarly, retaining staff may be more difficult if a provider cannot assure employees that any pay increase will remain intact. More staff turnover means less stability for consumers. In some cases, this uncertainty can work against the Legislature's objectives for the spending.

Suspensions Were Not Originally Proposed as an Annual Calculation. The suspension language enacted into law in 2019-20 was framed as a one-time determination made in May 2021. By proposing a new suspension calculation, however, the administration appears to intend to make this calculation ongoing. This is not consistent with our understanding of what the Legislature envisioned."

LAO makes the following two recommendations with regard to suspensions:

"Recommend Legislature Reject Suspension Language… We recommend the Legislature reject the Governor's proposal to create new budget bill suspension language. Considering that most of the costs of the suspension items directly fund core state services, including those costs in multiyear fiscal projections is appropriate. Given the state's multiyear deficits, however, the state likely will need to make changes to its budget within the next few years. As it stands, the state probably cannot afford existing programs, avoid the suspensions, and fund the Governor's proposals over the next few years. The Governor's proposal to include new suspension language simply papers over a portion of a larger structural problem.

…But Evaluate the Merits of Some Suspension Items. Some of the suspension items are recently created programs. As part of the broader effort to address the ongoing budget problem, evaluating whether these newer programs are achieving their intended goals would be worthwhile. To this end, the Legislature could take a look at reporting and oversight to ensure programmatic design aligns with its policy objectives and that the programs are resulting in the intended outcomes."

STAFF COMMENTS/QUESTIONS

As reflected in the Assembly's *2021-22 Blueprint For A Responsible Budget,* which prioritizes elimination of the suspensions, the Assembly generally concurs with the concerns raised by the LAO about suspensions. Particularly in the Medi-Cal program, the suspensions destabilize the program and undermine the very goals of the benefits and payments to which they apply. The uncertainty created by the suspension requirements results in challenges for both patients and providers, ultimately resulting in a weaker program overall, rather than a stronger one. Moreover, given that the state adopts an

annual budget, the Legislature and Governor have the opportunity to evaluate and change spending priorities every year; if the state's fiscal condition requires reductions to current spending, the Governor can propose reduced funding to these same programs and negotiate those choices with the Legislature. Suspensions simply remove the Legislature from these decisions in the future.

Staff Recommendation: Subcommittee staff recommends that the Subcommittee seriously consider rejecting the Governor's proposals to delay the suspensions, and instead approve of eliminating the suspensions altogether.

ISSUE 4: CONTINUOUS GLUCOSE MONITORS COVERAGE PROPOSAL

PANEL 4 – PRESENTERS AND QUESTIONS FOR PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs and State Medicaid Director

Questions for DHCS:
1. Please present this proposal.
2. Please explain the reasons that CGM is not necessarily an appropriate intervention for an adult with Type 2 diabetes.
3. Please explain the process of determining medical necessity for an adult with Type 1 diabetes.

PANEL 4 – Q&A ONLY

Department of Health Care Services
- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility

Department of Finance
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal & Policy Analyst

REQUEST

DHCS requests expenditure authority of $10.9 million ($3.8 million General Fund and $7.1 million federal funds) to add continuous glucose monitoring (CGM) systems as a Medi-Cal benefit for beneficiaries with Type 1 diabetes who demonstrate medical necessity. The implementation of the benefit would begin January 1, 2022.

The benefit would include two physician visits for sensor placement and calibration, patient training, and a follow-up; an external CGM receiver for three years; and monthly supplies of sensors and transmitters. The CGM systems would be reimbursed as durable medical equipment. DHCS plans to enter into rebate agreements with CGM system manufacturers to offset General Fund costs for the new benefit. In addition, DHCS estimates beneficiaries' transition from self-monitoring of blood glucose to CGM systems would result in offsetting savings to the Medi-Cal program due to a reduction in use of traditional blood glucose monitoring supplies.

BACKGROUND

Continuous glucose monitoring (CGM) systems use small sensors located just under a patient's skin to provide near real-time glucose data, which facilitates monitoring of time spent in the desirable target glucose range, warns users if glucose is trending toward hypoglycemia or hyperglycemia, and leads to improved glycemic control and outcomes compared to traditional self-monitoring of blood glucose for patients with Type 1 diabetes. In particular, use of CGM systems demonstrates sustained improvement in glycemic indicators and a reduction in adverse events such as severe hypoglycemia and episodes of ketoacidosis. Currently, the California Children's Services (CCS) program and the Genetically Handicapped Persons Program (GHPP) provide coverage of medically necessary CGM devices for program participants.

Adults with Type 2 diabetes can sometimes access CGM through Medi-Cal, but requires an approved treatment-authorization request. DHCS indicates that the medical literature and research does not support this intervention for individuals with Type 2 diabetes to the degree that it does for individuals with Type 1.

STAFF COMMENTS/QUESTIONS

Several policy bills and budget requests over the past several years have proposed to make CGM a covered benefit for adults, just as it is for children, in the Medi-Cal program. Generally, these proposals received considerable support in the Legislature. Given that CGM coverage represents a higher quality of care, and more effective preventive care, it is worthy of support. Moreover, the administration identifies this proposal as a component of their equity strategies.

Staff Recommendation: Subcommittee staff recommends approval of this proposal later in the spring.

ISSUE 5: RESTORATION OF ADULT OTC COUGH/COLD AND ACETAMINOPHEN DRUG BENEFIT TRAILER BILL

PANEL 5 – PRESENTERS AND QUESTIONS FOR PRESENTERS

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs and State Medicaid Director

Questions for DHCS:
1. Please present this proposal and explain how the proposal is expected to result in cost savings to the state.
2. Please provide any information known about how eliminating this benefit may have contributed to increased prescription substance abuse.

PANEL 6 – Q&A ONLY

Department of Health Care Services
- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility

Department of Finance
- **Hinnaneh Qazi**, Finance Budget Analyst
- **Laura Ayala**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal & Policy Analyst

REQUEST

DHCS proposes trailer bill language to restore over-the-counter acetaminophen and cough and cold products as Medi-Cal benefits. DHCS expects a reduction in annual Medi-Cal expenditures of $21 million ($7.8 million General Fund and $13.2 million federal funds) due to the replacement of more costly opioids, prescription pain relievers, and other prescription cough treatments with these less costly over-the-counter options.

BACKGROUND

Federal Medicaid law provides states the option to provide coverage for over-the-counter acetaminophen and cough and cold products. Prior to 2010, Medi-Cal covered these products as an inexpensive alternative to prescription pain relievers and other drugs. SB 853 (Committee on Budget and Fiscal Review, Chapter 717, Statutes of 2010), eliminated Medi-Cal coverage for over-the-counter (OTC) acetaminophen products as part of a package of General Fund reductions to address recessionary budget shortfalls. The 2010

Budget Act assumed an annual General Fund savings of $3.1 million from eliminating the OTC acetaminophen benefit. AB 97 (Committee on Budget, Chapter 3, Statutes of 2011), eliminated OTC cough and cold products, also to address recessionary budget shortfalls. The 2011 Budget Act assumed annual General Fund savings of $2.2 million from elimination of the OTC cough and cold product benefit.

During the COVID-19 pandemic, Medi-Cal temporarily reinstated coverage of OTC acetaminophen and cough and cold products for beneficiaries. The primary symptoms of COVID-19 include pain, aches, fever, cough, and congestion. As the preferred treatment for these symptoms are OTC fever reducers, analgesics and cough and cold products, DHCS reinstated coverage for these products.

This proposed trailer bill would permanently reinstate coverage of OTC acetaminophen and cough and cold products. According to DHCS, this policy change would result in savings for the Medi-Cal program, as these products are less costly than prescription opioids, analgesics, and cough treatments currently covered for beneficiaries. The budget assumes General Fund savings of $21 million ($7.8 million General Fund and $13.2 million federal funds) annually from implementation of this proposal. The department's current estimate that restoration of these benefits would result in savings to the Medi-Cal program suggests that the General Fund savings estimates included in the 2010 and 2011 Budget Acts for elimination of these benefits were likely erroneous.

STAFF COMMENTS/QUESTIONS

It appears that the elimination of OTC cough/cold and acetaminophen products, as a budget solution during difficult economic years, failed as both health and fiscal policy. It is important that the state recognize and acknowledge failed solutions like this in order to learn from our mistakes, lest we repeat them in the next economic downturn.

Staff Recommendation: Subcommittee staff recommends approval of this proposal later in the spring.

NON-PRESENTATION ITEMS

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

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 6: ADMINISTRATIVE RESOURCES FOR SB 852 IMPLEMENTATION BUDGET CHANGE PROPOSAL

REQUEST

The California Health and Human Services Agency (CHHSA) requests a one-time appropriation of $2 million General Fund in Fiscal Year 2021-22 for consulting services, with expenditure authority until Fiscal Year 2022-23, and position authority for one FTE position ($197,000 General Fund in 2021-22 and $184,000 General Fund ongoing) to support implementation of the California Affordable Drug Manufacturing Act of 2020, SB 852 (Pan, Chapter 207, Statutes of 2020).

CHHSA states that implementation of SB 852 involves a multitude of complex issues related to the pharmaceutical sector, including legal, market, policy, and regulatory considerations, as well as strategic and operational issues. CHHSA further explains that the concept of state-led generic manufacturing of essential medicines is ambitious as there are no active efforts by state governments to directly contract with generic drug manufacturers, although nationally there is an existing nonprofit effort to manufacture hospital-administered drugs experiencing shortages and select outpatient drugs (Civica Rx).

The in-depth research and analysis required for SB 852 implementation is organized into the following three interrelated work streams:

1. Identifying Top Drugs for Generic Manufacturing

2. Assessing Legal, Market, Policy, and Regulatory Factors

3. Strategic and Operational Issues

BACKGROUND

The generic drug market as a whole is competitive and represents a small share of total prescription spending. However, in recent years there have been troubling exceptions,

with significant price increases for some longstanding and often essential medications. In many cases, these price increases are driven by a market dominated by monopolies or oligopolies.

Last year, the 2020-21 Governor's Budget included a proposal for the State to use its purchasing power to offer more generic drug alternatives in the marketplace. SB 852 advances this work by charging CHHSA to enter into partnerships that result in the production or distribution of generic prescription drugs. SB 852 directs CHHSA to consult with public and private payers, including health plans, health insurers, hospitals, and pharmacy benefit managers. The intent of partnerships that involve public and private payers is to leverage combined purchasing power to increase access to affordable medications, target failures in the market for generic drugs, and produce savings.

SB 852 requires CHHSA to report progress to the Legislature by July 1, 2022, and subject to appropriation of funds, submit a legislative report by July 1, 2023 on the feasibility of the State directly manufacturing and selling prescription drugs at a fair price.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 7: HEALTH COVERAGE: MENTAL HEALTH OR SUBSTANCE USE DISORDERS (SB 855) BUDGET CHANGE PROPOSAL

REQUEST

The Department of Managed Health Care (DMHC) requests five positions and expenditure authority from the Managed Care Fund of $1.5 million in 2021-22, and 5.5 positions and $1.3 million annually thereafter. If approved, these positions and resources would allow DMHC to enforce mental health and substance use disorder treatment coverage mandates on health plans pursuant to SB 855 (Wiener, Chapter 151, Statutes of 2020), as well as respond to complaints from consumers and providers regarding compliance. These positions and resources include the following:

Office of Plan Licensing - The Office of Plan Licensing would need to promulgate regulations to implement SB 855 provisions and review 53 full service commercial plans' documents for compliance. DMHC is requesting temporary resources equivalent to one Attorney III, effective between July 1, 2021 and June 30, 2022, to conduct legal research and promulgate the regulations package. Effective July 1, 2022, DMHC is requesting 0.5 Attorney III position ongoing to review evidence of coverage documents, provider contracts, plan-to-pan contracts, and other health plan documents for annual compliance with SB 855.

Help Center – According to DMHC, the Help Center received an average of 180 complaints about coverage of substance use disorder treatment annually over the past three years. DMHC expects the volume of these complaints to double due to the expansion of covered mental health disorders and the new out-of-network treatment requirements. DMHC is requesting 0.5 Attorney III position for enforcement referrals and independent medical reviews due to the increased volume of complaints.

Office of Plan Monitoring – According to DMHC, the expansion of coverage requirements for behavioral health services will require additional review of 14 health plans annually for compliance. DMHC is requesting two 0.5 Attorney III positions to provide legal guidance, review health plan documents, review annual network filings, participate in the evaluation of network availability issues, and provide assistance with enforcement actions and referrals. DMHC is also requesting expenditure authority of $284,000 from the Managed Care Fund annually to support clinical expert consultants to assist with the clinical review and analysis of health plan documents.

Office of Enforcement – DMHC expects its Office of Enforcement to experience an additional 39 referrals for investigation or litigation related to health plan compliance with

SB 855. DMHC is requesting two Attorney III positions and 1.5 Legal Assistant positions. The attorneys would provide legal support to investigations or litigation of compliance issues, perform complex legal review and analysis, conduct legal research, respond to legal questions, develop strategies to respond to difficult and sensitive matters, and serve as lead counsel during litigation. The legal assistant positions would assist the attorneys with these responsibilities.

Office of Technology and Innovation – DMHC requests expenditure authority of $6,000 from the Managed Care Fund annually to support additional user licenses and managed services costs for the information technology applications that facilitate the processing of consumer complaints.

BACKGROUND

Under existing law, the coverage of mental health and substance use disorder treatment by health plans is subject to both federal and state law. Congress enacted the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, prohibiting health plans in the large group market from imposing financial coverage limits on mental health benefits that were less favorable than those for medical and surgical benefits. In 2010, the Affordable Care Act (ACA) extended MHPAEA's requirements to the small group and individual markets. MHPAEA requires health care service plans that provide mental health and substance use disorder benefits to provide those benefits at the same level as the health plan's medical and surgical benefits. MHPAEA does not require a health plan to cover mental health and substance use disorder benefits, but if the plan does so, it must offer the benefits on par with medical and surgical benefits. Current MHPAEA requirements have been in effect since mid-2014.

In 1999, California enacted its own law requiring parity in mental health benefits, Health and Safety Code Section 1374.72. Unlike the federal law, California's mental health parity law requires full service health plans to provide treatment for specified mental health conditions as a covered benefit. Like federal law, it states that these benefits must be provided under the same terms and conditions as other medical conditions. Prior to SB 855, the coverage requirement in Section 1374.72 applied to health plans in the large group, small group, and individual markets and included (1) "severe mental illnesses" for individuals of any age, including nine specified condition categories, and (2) "serious emotional disturbances" of a child, but did not include treatment for substance use disorders.

The ACA further expanded coverage requirements for mental health and substance use disorders. The ACA required health plans in the small group and individual markets to cover "Essential Health Benefits" (EHBs), which include coverage for "mental health and substance use disorder" services. Thus, between the EHB requirement and Section 1374.72, all full service health plans must cover mental health treatment, and all health

plans in the small group and individual markets must cover treatment for substance use disorders.

SB 855 amends California's mental health parity statute, requiring commercial health plans in all markets to cover treatment for all medically necessary mental health and substance use disorder conditions. This bill amended Section 1374.72 to add a new express coverage requirement of substance use disorder treatment for health plans in the large group market. The bill also expanded the mental health treatment coverage requirement for all plans, including those in the small group and individual markets, by replacing the nine enumerated mental health categories and expanding the coverage mandate and parity requirements to all recognized mental health disorders.

In addition, SB 855 revised utilization management requirements for mental health and substance abuse treatment and expands the plan's responsibility to help enrollees obtain out-of-network care when required, within geographic and timely access standards.

SB 855 requires the DMHC to do the following:

1. Annually review health care service plan documents, including evidence of coverage documents, provider contracts, and plan-to-plan contracts for compliance with the mental health and substance use disorder treatment requirements in Section 1374.72.

2. Review health plan documents related to utilization management, including utilization review criteria documents provided by health plans.

3. Review health plan documents related to network access for services.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 8: RISK-BASED OR GLOBAL RISK PROVIDER ARRANGEMENT PILOTS (AB 1124) BUDGET CHANGE PROPOSAL

REQUEST

DMHC requests expenditure authority from the Managed Care Fund of $413,000 in 2021-22, $401,000 in 2022-23 through 2024-25, $322,000 in 2025-26, and $342,000 in 2026-27. If approved, these resources would allow DMHC to create two pilot programs to permit a qualifying voluntary employees' beneficiary association (VEBA) or trust fund to enter into capitation payment agreements with qualified providers while being exempt from licensure under the Knox-Keene Health Care Service Plan Act of 1975 for no more than four years, pursuant to AB 1124 (Maienschein, Chapter 266, Statutes of 2020).

This request includes $163,000 annually through 2026-27 for clinical consultant services to review clinical patient outcomes reported by pilot participants, and $80,000 in 2026-27 to assist in preparing the report to the Legislature. Additionally, funding of $4,000 in 2021-22 through 2025-26 is requested for software licensing and cloud service costs to process the additional applications, consumer complaints and pilot participant reports following the passage of AB 1124.

This request also includes limited-term resources of $246,000 (equivalent to 1.5 positions) in 2021-22, $234,000 (equivalent to 1.5 positions) in 2022-23 through 2024-25, $165,000 (equivalent to 1 position) in 2025-26, and $99,000 (equivalent to 0.5 position) in 2026-27 to implement the provisions of AB 1124.

DMHC expects the pilots will begin no earlier than January 1, 2022, and end no later than December 31, 2025. These resources include the following:

Office of Financial Review – DMHC expects the Northern California pilot participant would contract with five health care providers and the Southern California participant with 10 health care providers. Including the two pilot participants, DMHC expects its Office of Financial Review would be required to review report submissions and statements for 17 additional entities. DMHC is requesting limited-term resources equivalent to 0.5 Corporation Examiner IV to review the submissions, review financial solvency standards for RBOs, review financial statements of new licensees, and assist in preparing the report to the Legislature. In addition, DMHC requests expenditure authority from the Managed Care Fund of $163,000 until 2026-27 for clinical consultant services to review patient outcomes in the pilots, and an additional $80,000 in 2026-27 for preparation of the report to the Legislature.

Help Center – DMHC assumes there would be a total of 300,000 lives covered under the two pilot programs, which would lead to an estimated increase of 120 complaints per year to its Help Center. DMHC requests limited-term resources equivalent to one Associate

Governmental Program Analyst (AGPA) until 2024-25 and equivalent to 0.5 AGPA in 2025-26 to review and process the increased volume of consumer complaints, review and analyze Independent Medical Review requests and health plan responses.

Office of Technology and Innovation – DMHC requests expenditure authority of $4,000 from the Managed Care Fund until 2025-26 to support additional user licenses and managed services costs for the information technology applications that facilitate the processing of consumer complaints.

BACKGROUND

In addition to its role regulating health plans under the Knox-Keene Health Care Service Plan Act of 1975, DMHC is responsible for monitoring the financial solvency of risk-bearing organizations (RBOs). An RBO is a provider group that, in its contracts with a health plan, pays claims and assumes financial risk for the cost of professional health care services by accepting a fixed monthly payment for each plan member it is assigned. DMHC monitors financial solvency through analysis of financial filings, financial examinations, review of claims payment practices, and development and monitoring of corrective action plans.

AB 1124 (Maienschein, Chapter 266, Statutes of 2020), requires DMHC to authorize two pilot programs, one in Northern California and one in Southern California, no later than May 1, 2021, allowing a voluntary employees' beneficiary association (VEBA) or trust fund to undertake a risk-bearing arrangement with approved providers without being subject to licensure under the Knox-Keene Act. To be eligible, VEBAs must cover more than 100,000 lives, while trust funds must cover more than 25,000 lives, and both would be required to comply with federal requirements and contract with a health care provider who is a RBO, limited licensee, or restricted licensee regulated by DMHC. The health care provider is required to comply with financial solvency standards and audit requirements, including financial reporting on a quarterly basis during the pilot. The VEBA or trust fund must also appoint an ombudsperson to monitor and respond to complaints, including referral to DMHC's grievance and appeals process if the enrollee is unsatisfied with the result, and report on complaints to DMHC on a quarterly basis.

According to DMHC, AB 1124 requires the department to do the following:

- Create two pilot programs for VEBAs or trust funds, one in Northern California and one in Southern California
- Review annual cost savings, clinical patient outcomes, enrollee satisfaction reports, and quarterly reporting of any complaints lodged by an enrollee during the pilot
- Review quarterly financial reports submitted by the participating health care providers
- Report pilot program findings to the Legislature by January 1, 2027.

AB 1124 also requires pilot participants to reimburse DMHC up to $500,000 for commissioning the legislative report, developing the application process for the pilot programs, and monitoring compliance with AB 1124.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

4160 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 9: STRENGTHENING COORDINATION OF BENEFITS AND POST-PAYMENT RECOVERY TRAILER BILL

REQUEST

DHCS proposes trailer bill language to clarify requirements for third-party commercial health insurance carriers to share data with the department of post-payment recovery and coordination of benefits. DHCS considers this to be technical, non-controversial, clean-up trailer bill.

BACKGROUND

Federal and state law requires Medi-Cal to be the payer of last resort for the provision of health care services. If a Medi-Cal beneficiary has other health coverage, DHCS identifies these other coverage entities and maintains that information in the department's eligibility data system. Medi-Cal providers are able to access this information when they provide services to Medi-Cal beneficiaries and are required to seek reimbursement from a beneficiary's other health coverage before they may bill Medi-Cal for any remaining balance. DHCS refers to this process as "cost avoidance." If DHCS identifies other health coverage for a Medi-Cal beneficiary after the delivery of a health care service, Medi-Cal reimburses the provider for the service and recoups allowable costs from the other health coverage entity. DHCS refers to this process as "pay and chase".

For both "cost avoidance" and "pay and chase," DHCS obtains commercial health insurance eligibility files through electronic data exchanges. Other health coverage carriers are required by existing law to provide this information to DHCS through cooperative agreements. DHCS must negotiate these agreements with each individual carrier and has limited ability to request a comprehensive data set from each carrier. DHCS reports verification of this information is also a labor-intensive process.

DHCS proposes trailer bill language that would do the following:

1. Update and clarify the list of other health coverage carriers required to enter into cooperative agreements with DHCS to include all health care entities licensed by the California Department of Insurance, third party administrators, and union trusts.
2. Remove requirements that carriers be paid at the same rate paid to the Department of Motor Vehicles for providing information.
3. Establish the specific beneficiary data required to be submitted to DHCS from third-party entities.
4. Establish other data required when available about other persons' covered under the member's policy.

5. Require entities to provide DHCS with access to real-time electronic eligibility verification, at no cost to DHCS and in a form and manner specified by DHCS as is necessary to conduct its coordination of benefits responsibilities.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 10: MEDI-CAL ENTERPRISE SYSTEM MODERNIZATION BUDGET CHANGE PROPOSAL

REQUEST

DHCS requests expenditure authority of $22.3 million ($4 million General Fund and $18.3 million federal funds) in 2021-22 and $1.3 million ($128,000 General Fund and $1.1 million federal funds) in 2022-23 to continue support of critical information technology (IT) modernization efforts under the Medi-Cal Enterprise System (MES). Specifically, DHCS requests the following contract resources for the following projects and components:

California Automated Recovery Management (CalARM) – DHCS requests expenditure authority of $3 million ($297,000 General Fund and $2.7 million federal funds) to contract with a Software-as-a-Service vendor in 2021-22 for design and implementation activities for the California Automated Recovery Management (CalARM) module, which provides support for third-party liability and recovery activities, and was previously part of the CA-MMIS modernization project. This contract would be part of the CalARM project's Project Approval Lifecycle Stage 4 submission.

Comprehensive Behavioral Health Data Systems Modernization (CBHDSM) – DHCS requests expenditure authority of $1.3 million ($128,000 General Fund and $1.1 million federal funds) in 2021-22 and 2022-23 for a contract to support completion of the Project Approval Lifecycle Stage 2 Alternatives Analysis, Stage 3 Preliminary Assessment, and the federal Implementation Advanced Planning Document (IAPD) for the Comprehensive Behavioral Health Data System Modernization (CBHDSM). This project would modernize required data collection from county behavioral health programs as part of the department's oversight of these programs.

Federal Draw and Reporting (FDR) System – DHCS requests expenditure authority of $9.8 million ($2.5 million General Fund and $7.4 million federal funds) for an engineering services contract to build on existing functionality delivered in 2020-21 for the Federal Draw and Reporting (FDR) System, which replaces functionality currently provided by the CMS-64 system and other manual processes for reporting Medi-Cal expenditure information to the federal Centers for Medicare and Medicaid Services for the purpose of federal matching funds.

Modernization Strategy Planning and Support – DHCS requests expenditure authority of $8.2 million ($1.1 million General Fund and $7.1 million federal funds) in 2021-22 to implement its consolidation of IT projects under the MES. According to DHCS, MES Modernization would implement an agile organization, capable of delivering modern technology solutions that have design, technology, and development procedure consistency. To support the transformation to a modern, enterprise approach, DHCS specifically requests the following contract services:

- *Digital Support Services (DSS)*
  $2 million ($200,000 General Fund and $1.8 million federal funds)
  This contract would provide the MES Modernization effort the capability to bring resources with specialized skills to meet the project and business objectives across the comprehensive set of IT projects.

- *Modern Development Environment*
  $1 million ($100,000 General Fund and $900,000 federal funds)
  This contract would provide engineering support for the development and operations, and licensing costs for platform and tools.

- *Architecture Planning and Governance Support*
  $3.4 million ($340,000 General Fund and $3.1 million federal funds)
  This contract would enable development of the MES Modernization strategy including development of an MES Modernization approach, MES Modernization roadmap, MES Modernization product and module portfolio, MES Modernization governance structure, initial understanding of cost and timeframes, and related MES Modernization management functions.

- *Organizational Change Management*
  $735,000 ($74,000 General Fund and $662,000 federal funds)
  This contract would plan, execute, and support the transformation DHCS program and IT staff, knowledge, skills, and abilities, including the transition of culture, process, and organizational approach.

- *Independent Validation and Verification (IV&V)*
  $375,000 ($38,000 General Fund and $338,000 federal funds)
  This contract would provide oversight for all MES Modernization work efforts, to assess these efforts as a whole, rather than as individual modules.

BACKGROUND

Over the past several years, DHCS has undertaken several IT projects to upgrade systems for payment processing, eligibility, and other functions. These projects have been managed either directly by DHCS or in partnership with the California Health and Human Services Agency and other state partners. Beginning with the 2020 Budget Act, DHCS has changed its approach from focusing on individual IT systems to focusing on a comprehensive Medi-Cal Enterprise System (MES), which coordinates these efforts. The MES would combine the following previously separate modernization efforts: 1) the California Medicaid Management Information System (CA-MMIS) Modernization project; 2) the Medi-Cal Eligibility System (MEDS) Modernization project; and 3) the Comprehensive Behavioral Health Data System Modernization (CBHDSM) project.

According to DHCS, the department has already begun the process of consolidating these efforts and requires additional resources to continue to build and manage its portfolio of IT projects.

Legislative Analyst's Office (LAO)

The LAO did an analysis of this proposal which can be found here:
https://lao.ca.gov/Publications/Report/4375

The LAO has no significant concerns with the proposed funding, although recommends that the Legislature have the ability to provide appropriate oversight on any future changes to the project. LAO provides the following recommendations:

> ***"Approve the Budget Proposal***. We recommend the Legislature approve the budget proposal for DHCS to continue existing Medi-Cal IT system modernization projects that leverage enhanced federal financial participation, and for the department to plan a strategy for the complex MES Modernization project portfolio.
>
> ***Direct the Administration to Work With the Legislature on Potential Changes to IT Project Processes***. To improve legislative oversight of the MES Modernization effort (and possibly other complex and costly efforts or projects), we recommend the Legislature direct the administration to keep the Legislature regularly informed of key changes to existing IT project processes that the administration is considering for the MES Modernization effort. (The Legislature could, for example, direct the administration to update our office at least quarterly on these changes.) We also recommend the Legislature adopt supplemental report language that directs the administration to report back before January 10, 2022 on (1) changes made to existing IT project processes for the MES Modernization effort; (2) new options for legislative oversight of MES Modernization; and (3) other potential improvements to current oversight processes for, in particular, complex and costly IT projects."

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it, and also consider taking actions consistent with the LAO recommendations.

ISSUE 11: CALIFORNIA COMMUNITY TRANSITIONS (SB 214) BUDGET CHANGE PROPOSAL

REQUEST

DHCS requests General Fund expenditure authority of $432,000 in 2021-22 and $405,000 in 2022-23 and 2023-24. If approved, these resources would allow DHCS to implement and operate a temporary, state-funded California Community Transitions (CCT) program, pursuant to the requirements of SB 214 (Dodd, Chapter 300, Statutes of 2020).

This expenditure authority would support the equivalent of one Associate Governmental Program Analyst, one Health Program Specialist I position, and one Research Data Analyst II position. These positions would coordinate implementation and operation of the program with CCT Lead Organizations (CCTLOs), DHCS administrative staff, and clinical staff. This workload would include processing applications and treatment authorization requests, providing enrollment packets, implementation of a separate tracking process for state-only participants, and overseeing program performance.

BACKGROUND

The Deficit Reduction Act of 2005 established the Money Follows the Person (MFP) rebalancing demonstration, which was designed to increase the use of home- and community-based, rather than institutional, long-term care services and eliminate barriers to enable beneficiaries to receive support for appropriate and necessary long-term services in the setting of their choice. In California, the MFP demonstration is known as CCT, which works with CCTLOs to identify eligible Medi-Cal beneficiaries who have continuously resided in state-licensed health care facilities for 90 consecutive days or longer. CCTLOs employ or contract with transition coordinators who work directly with eligible individuals, support networks, and providers to facilitate and monitor beneficiaries' transitions from facilities to the community settings of their choice. CCTLO staff meet with individuals to develop a transition plan and identify the individual's needs to safely live in the community, including skilled-nursing or in-home attendant care, medical equipment, transportation, and case management. After transition, a transition coordinator works with the individual for up to one year to address post-transition needs.

Transitions During COVID-19 Pandemic. During the pandemic, individuals over 65 years of age have been more likely to experience a more severe case of COVID-19 with 12,579 deaths occurring among skilled nursing facility residents, 27 percent of the state's total. As a result, several state efforts have been focused on reducing COVID-19 impacts on congregate care facilities, including skilled nursing facilities. Identifying eligible individuals that could transition from these facilities into a home- and community-based setting, including in the CCT program, helps decompress facilities and avoid exposure of

vulnerable seniors and persons with disabilities to COVID-19. However, as a condition of federal MFP demonstration funding, individuals are only eligible for CCT services if they have continuously resided in a facility for 90 days. This requirement would not allow individuals to receive transition services immediately when determining suitability for a home- and community-based placement, but rather would require a stay of 90 days or longer in facilities that have been a locus of morbidity and mortality for COVID-19.

SB 214 Establishes a State-Only CCT Program to Eliminate 90 Day Stay Requirement. To alleviate the impact of COVID-19 on facilities, residents, and staff, SB 214 establishes a state-only program to provide CCT services to individuals residing in facilities for less than 90 days. DHCS expects the program would transition 300 eligible individuals in 2021 and 420 in 2022 from facilities to home- and community- based settings of their choice. According to DHCS, these transitions would also result in long-term savings to the Medi-Cal program by providing lower-cost home- and community-based care to eligible individuals, rather than more costly long-term care in a facility. The state-only CCT program would sunset on January 1, 2023.

DHCS also provided an update on federal actions which is that federal legislation at the end of December changed the federal eligibility criteria for the program from patients who have been in the facility at least 90 days to those who have been in the facility at least 60 days. This allows for federal funding to be utilized on more of the patients than was originally projected as a part of SB 214. State-only funding will be used only for patients who have been in the facility under 60 days.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 12: EXTENSION, AND CONVERSION TO PERMANENT, OF LIMITED-TERM POSITIONS BUDGET CHANGE PROPOSALS

REQUEST

Extensions for Limited-Term Positions:

DHCS requests expenditure authority of $8.7 million ($3.1 million General Fund and $5.6 million federal funds) in 2021-22, $1.5 million ($222,000 General Fund and $1.3 million federal funds) in 2022-23, $1.3 million ($132,000 General Fund and $1.1 million federal funds) in 2023-24 and 2024-25, and General Fund expenditure authority of $132,000 in 2025-26. If approved, these resources would allow DHCS to extend previously approved limited-term resources equivalent to 38 positions for workload in various programs.

DHCS requests limited-term extension of previously approved limited-term resources equivalent to 38 positions that expire on June 30, 2021, and expenditure authority of $8.7 million ($3.1 million General Fund and $5.6 million federal funds). Specifically, DHCS is requesting the following resources in the following programs:

California Community Transitions Demonstration Project – The California Community Transitions (CCT) Demonstration Project is supported by a federal Money Follows the Person (MFP) Rebalancing Demonstration grant to assist Medi-Cal beneficiaries in an in-patient facility to return to a home- or community-based setting. Because the MFP grant is approved by Congress on a limited-term basis, resources for this program have also been approved on a limited-term basis. DHCS is requesting four-year extension of resources equivalent to eight positions until June 30, 2025.

Federal Managed Care Regulations and 1115 Waiver Extension – In 2015, the federal Centers for Medicare and Medicaid Services (CMS) released a final rule expanding state requirements for oversight and monitoring of managed care plans, mental health plans, prepaid inpatient hospital plans, and dental managed care plans. Also in 2015, CMS approved California's 1115 Waiver renewal titled Medi-Cal 2020. Because the waiver is only approved for five years, these resources were only approved for a limited-term. However, due to the public health emergency, this waiver was extended by an additional year. For both the federal managed care regulations and 1115 Waiver extension resources, DHCS is requesting one-year extension of resources equivalent to 25 positions and 15 month extension of resources equivalent to seven positions.

Medi-Cal Health Enrollment Navigators – The 2019 Budget Act included resources to support outreach and enrollment support for retaining and using health coverage and gaining access to necessary medical care. Because the resources were available for a limited time, resources to support program workload was also approved for a limited-term. DHCS is requesting one-year extension of resources equivalent to four positions, as the

grant program is continuing to provide funds to counties and organizations to contact hard-to-reach target populations to engage in outreach activities.

Robert F. Kennedy (RFK) Farm Workers Medical Plan – The RFK Medical Plan is a non-governmental, self-funded, self-insured health plan subject to collective bargaining agreements between the United Farm Workers and multiple agricultural employers. The 2017 Budget Act provided support to the RFK Medical Plan to ensure its financial viability through 2026. Because the funding was limited-term, the resources were only approved for a limited-term, as well. DHCS is requesting five year extension of resources equivalent to one positions to continue supporting the program until funding expires in 2026.

Conversion of Limited-Term Resources to Permanent:
DHCS requests 62.5 positions and expenditure authority of $9.5 million ($3.2 million General Fund, $5.6 million federal funds, and $676,000 Hospital Quality Assurance Revenue Fund) annually to allow DHCS to address ongoing workload in various programs. Specifically, DHCS is requesting the following positions and resources in the following programs:

Federal Managed Care Regulations - In 2015, the federal Centers for Medicare and Medicaid Services (CMS) released a final rule expanding state requirements for oversight and monitoring of managed care plans, mental health plans, prepaid inpatient hospital plans, and dental managed care plans. Much of this workload is permanent, as it is unlikely CMS is going to relax these standards. DHCS is requesting authority for 30 positions to convert these limited-term resources to permanent staff.

Legal Support for Ongoing Waiver Activities – The 1115 Waiver requires legal support and expertise for legislative, regulatory, contractual, and litigation support work. As the 1115 Waivers have been time-limited, the resources have been approved for limited-term. However, the workload is ongoing for the conclusion of this waiver and any successor programs. DHCS is requesting authority for two positions to convert these limited-term resources to permanent staff.

Health Care Reform Financial Reporting – The 2015 Budget Act provided limited-term resources equivalent to 18 positions to address increases in mandated reporting requirements related to the federal Affordable Care Act. This workload includes federal reporting of quarterly expense reports based on state plan amendments, waivers, and base provider payments. This workload is ongoing. DHCS is requesting authority for 18 positions to convert these limited-term resources to permanent staff.

Private Hospital Directed Payment Program – The Private Hospital Directed Payment program implements a uniform dollar increase in reimbursement to private hospitals that provide designated inpatient and outpatient services under contract with managed care plans. DHCS must annually submit adjustments to managed care rates to comply with

CMS requirements for this directed payment program. The 2018 Budget Act included three year limited-term resources equivalent to 9.5 positions to support the program. DHCS is requesting authority for 7.5 positions to convert some of these limited-term resources to permanent.

Medi-Cal Eligibility Systems Staffing – The 2016 Budget Act provided three-year limited-term resources to support enhancements to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), Medi-Cal Eligibility Data System (MEDS), and Statewide Automated Welfare Systems (SAWS). DHCS is requesting authority for seven positions to convert these limited-term resources to permanent staff.

BACKGROUND

Over the past several years, DHCS has received limited-term resources to support workload in the following programs:

- California Community Transitions (CCT) Demonstration Project
- Federal Managed Care Regulations
- 1115 Waiver Extension – Medi-Cal 2020
- Medi-Cal Health Enrollment Navigators
- Robert F. Kennedy Workers Medical Plan
- Legal Support for Ongoing Waiver Activities
- Health Care Reform Financial Reporting
- Private Hospital Directed Payment Program
- Medi-Cal Eligibility Systems Staffing

These resources were established as limited-term to provide support for new workload that was either seen as time-limited in scope, or to allow sufficient time to assess whether the workload was ongoing and required permanent positions and resources. DHCS is requesting resources for additional limited-term extension of resources for workload for which such a temporary extension is appropriate, and to convert limited-term resources to permanent for ongoing workload.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 13: AB 1705 GROUND EMERGENCY MEDICAL TRANSPORTATION PUBLIC PROVIDER INTERGOVERNMENTAL TRANSFER PROGRAM BUDGET CHANGE PROPOSAL

REQUEST

DHCS requests five positions and expenditure authority of $715,000 ($358,000 federal funds and $357,000 reimbursements) in 2021-22, and $670,000 ($335,000 federal funds and $335,000 reimbursements) annually thereafter. If approved, these positions and resources would allow DHCS to implement a new Ground Emergency Medical Transportation (GEMT) Public Provider Intergovernmental Transfer (IGT) program, pursuant to AB 1705 (Bonta, Chapter 544, Statutes of 2019).

According to DHCS, the new program would create new workload in the department's Capitated Rates Development Division (CRDD), which would require one Staff Services Manager I position and four Associate Governmental Program Analysts. These positions would work with the department's contracted actuary to develop managed care capitation rate adjustments for the program; manage the IGT agreements and revenue collections; serve as subject matter experts for the new program; oversee and develop appropriate tools and mechanisms to process GEMT public provider IGT information; research, develop, and recommend policies and standards; and communicate policies, processes, timelines, and other requirements to the GEMT public provider community.

BACKGROUND

SB 523 (Hernandez, Chapter 773, Statutes of 2017), established the Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) program, which assesses a fee on each emergency medical transport to support enhanced reimbursement to GEMT providers. For GEMT providers in the Medi-Cal fee-for-service delivery system, fee revenue serves as the non-federal share of a reimbursement rate add-on for transports. For GEMT providers in the Medi-Cal managed care delivery system, fee revenue serves as the non-federal share of increased capitation payments to Medi-Cal managed care plans to provide supplemental payments to noncontract providers of GEMT services. Under SB 523, the QAF program supports enhanced reimbursement for both public and private GEMT providers.

AB 1705, suspends the GEMT QAF program for public providers, and instead establishes a GEMT Public Provider Intergovernmental Transfer (IGT) program. Under this program, public providers would participate in a voluntary transfer of funding to DHCS, which would support the non-federal share of enhanced reimbursement to eligible GEMT providers. Similar to the GEMT QAF program, the GEMT Public Provider IGT program would provide a rate add-on in the fee-for-service delivery system, and would increase managed care capitation payments to provide supplemental payments to providers in the managed care delivery system. Managed care plans would be required to reimburse a noncontract

GEMT provider an amount equal to what the provider would have received under the fee-for-service delivery system.

Under the GEMT Public Provider IGT program, DHCS would assess a 10 percent fee on each voluntary IGT to support program operations, as well as the non-federal share of health care services expenditures in the Medi-Cal program. The 10 percent assessment is a feature of other IGT programs administered by DHCS, and supports administration of the program without an impact on the state's General Fund. According to DHCS, the IGT program would likely provide a higher reimbursement rate to providers than these providers currently receive under the QAF program. DHCS reports the GEMT public provider community has communicated strong support for the implementation of this program.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.