AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, FEBRUARY 14, 2022

2:30 PM, STATE CAPITOL, ROOM 126

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. Please check the Assembly or committee website for updates regarding the free toll-free number to provide comment.

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LIST OF PANELISTS IN ORDER OF PRESENTATION

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEDI-CAL EXPANSION TO INCOME-ELIGIBLE ADULTS, 26 – 49 YEARS OF AGE, REGARDLESS OF IMMIGRATION STATUS

PANEL 1 - PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 1 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: TELEHEALTH

- **PROTECTION OF PATIENT CHOICE IN TELEHEALTH PROVIDER ACT (AB 457) BUDGET CHANGE PROPOSAL**
- **MEDI-CAL TELEHEALTH TRAILER BILL**

PANEL 2 – PRESENTERS

- **Mary Watanabe**, Director, Department of Managed Health Care
- **Dan Southard**, Chief Deputy Director, Department of Managed Health Care
- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 2 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Katherine Clark**, Assistant Program Budget Manager, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 3: CALIFORNIA ELIGIBILITY, ENROLLMENT, AND RETENTION SYSTEM (CALHEERS) BUDGET CHANGE PROPOSAL

PANEL 3 – PRESENTERS

- **James Duckens**, CalHEERS Project Director, Office of Systems Integration
- **Brian Metzker**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 3 – Q&A ONLY

- **Nina Hoang**, Finance Budget Analyst, Department of Finance
- **Katherine Clark**, Assistant Program Budget Manager, Department of Finance
- **Rob Trojan**, Information Technology Manager, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 4: MEDI-CAL NOVEMBER 2021 ESTIMATE

PANEL 4 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 4 – Q&A ONLY

- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 5: FAMILY HEALTH NOVEMBER 2021 ESTIMATE

PANEL 5 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 5 – Q&A ONLY

- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 6: FAMILY PACT HUMAN PAPILLOMAVIRUS VACCINE COVERAGE AND REPRODUCTIVE HEALTH CARE ACCESS

PANEL 6 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 6 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 7: MATERNAL CARE AND SERVICES (SB 65) BUDGET CHANGE PROPOSAL

PANEL 7 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 7 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Palav Babaria**, Chief Quality Officer & Deputy Director, Quality and Population Health Management, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 8: MEDI-CAL PROVIDER RATES PROPOSALS (TRAILER BILL):

- **AB 97 (2011 REDUCTIONS)**
- **PROPOSITION 56 (SHIFT OF SUPPLEMENTAL PAYMENTS TO GENERAL FUND)**
- **MEDI-CAL EQUITY AND PRACTICE TRANSFORMATION PROVIDER PAYMENTS PROPOSAL**

PANEL 8 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 8 – Q&A ONLY

- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Palav Babaria**, Chief Quality Officer & Deputy Director, Quality and Population Health Management, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 9: FEDERALLY QUALIFIED HEALTH CENTER ALTERNATIVE PAYMENT MODEL PROJECT TRAILER BILL

PANEL 9 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 9 – Q&A ONLY

- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 10: DISCONTINUATION OF CHILD HEALTH AND DISABILITY PROGRAM AND CHILDREN'S PRESUMPTIVE ELIGIBILITY EXPANSION TRAILER BILL

PANEL 10 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 10 – Q&A ONLY

- **Susan Philip**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Autumn Boylan**, Deputy Director, Office of Strategic Partnerships, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 11: MEDI-CAL REDUCTIONS TO PREMIUMS AND COPAYMENTS PROPOSALS:

- **OPTIONAL TARGETED LOW-INCOME CHILDREN'S PROGRAM (OTLICP)**
- **250 PERCENT WORKING DISABLED PROGRAM**
- **CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) TRAILER BILL**
- **COPAYMENTS IN THE MEDI-CAL PROGRAM TRAILER BILL**

PANEL 11 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 11 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 12: HEARING AID COVERAGE FOR CHILDREN PROGRAM -- OVERSIGHT

PANEL 12 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 12 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 13: INDIAN HEALTH PROGRAM GRANT RESTORATION BUDGET CHANGE PROPOSAL

PANEL 13 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 13 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 14: TRANSFORMING QUALITY OUTCOMES AND HEALTH EQUITY IN MEDI-CAL BUDGET CHANGE PROPOSAL

PANEL 14 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 14 – Q&A ONLY

- **Palav Babaria**, Chief Quality Officer & Deputy Director, Quality and Population Health Management, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 15: DHCS BUDGET CHANGE PROPOSALS:

- **FURTHER STRENGTHEN FISCAL FUNCTIONS AND OUTCOMES**
- **MEDI-CAL ENTERPRISE SYSTEMS MODERNIZATION: FEDERAL DRAW AND REPORTING – OPERATIONS**
- **INCREASED PROGRAM WORKLOAD**

PANEL 15 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 16 – Q&A ONLY

- **Lori Walker**, Chief Financial Officer, Deputy Director of Fiscal, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 16: ALIGN MEDI-CAL REDETERMINATIONS WITH FEDERAL GUIDELINES TRAILER BILL

PANEL 16 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 16 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEDI-CAL EXPANSION TO INCOME-ELIGIBLE ADULTS, 26 – 49 YEARS OF AGE, REGARDLESS OF IMMIGRATION STATUS

PANEL 1 - PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 1 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

The Department of Health Care Services (DHCS) proposes to expand full-scope Medi-Cal coverage to an estimated over 700,000 undocumented adults aged 26 through 49, effective after the Director determines that systems have been programmed for implementation, and no sooner than January 1, 2024. This expansion is anticipated to result in costs of $819 million total funds ($614 million General Fund) in FY 2023-24 and $2.3 billion total funds ($1.8 billion General Fund) at full implementation. With this expansion, full-scope Medi-Cal coverage will be available to all otherwise eligible Californians regardless of immigration status. In order to effect these changes DHCS is proposing trailer bill language.

BACKGROUND

Under current federal law, full scope Medicaid is generally available with federal funding to eligible Qualified Non-Citizens who have been in the U.S. for five years or more (or who are exempt from the five-year bar) and eligible Lawfully Present immigrants who are under 21 years of age or who are pregnant. In addition, federal funding is limited to emergency and pregnancy-related services for immigrants without satisfactory immigration status.

California currently provides full scope Medi-Cal benefits to eligible individuals under 26 years of age, regardless of immigration status. As part of the 2021 budget package, no sooner than May 1, 2022, California will provide full scope Medi-Cal benefits to eligible individuals 50 years of age or older, regardless of immigration status, subject to system readiness.

The proposed trailer bill language leverages existing law that implements previous expansions for children, young adults and those 50 years of age or older including: system readiness, the transition of current restricted-scope beneficiaries to full scope Medi-Cal, federal financial participation requirements, legislative appropriation language and other technical changes.

The administration states: “By removing a barrier to health access due to immigration status, this proposal would provide all low-income Californians equitable access to comprehensive and affordable care.”

STAFF COMMENTS/QUESTIONS

Expanding eligibility in Medi-Cal to all “otherwise eligible” individuals, regardless of immigration status, has been a very high priority for several members of the legislature, starting with the Chair of Assembly Budget Sub 1, Assemblymember Arambula, and for the health advocacy community. Once fully implemented, this Medi-Cal expansion will represent a significant step towards universal health coverage in California.

The Subcommittee requests DHCS present this proposal, and provide a more detailed explanation of the need for a two-year delay in implementation.

Staff Recommendation: Strong recommendation for approval of this proposal later in the spring when the Subcommittee is taking final actions.

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: TELEHEALTH

- **PROTECTION OF PATIENT CHOICE IN TELEHEALTH PROVIDER ACT (AB 457) BUDGET CHANGE PROPOSAL**
- **MEDI-CAL TELEHEALTH TRAILER BILL**

PANEL 2 – PRESENTERS

- **Mary Watanabe**, Director, Department of Managed Health Care
- **Dan Southard**, Chief Deputy Director, Department of Managed Health Care
- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

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- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS

This issue covers two proposals on telehealth:

1) **Department of Managed Health Care (DMHC) budget change proposal (BCP) – Protection of Patient Choice in Telehealth Provider Act (AB 457)**

The DMHC requests 3.0 positions and limited term expenditure authority (equivalent to 1.0 position) and $1,130,000 from the Managed Care Fund in 2022-23, 3.0 positions and $957,000 in 2023-24, 3.0 positions and $614,000 in 2024-25 and ongoing to meet the requirements of AB 457 (Santiago, Chapter 439, Statutes of 2021).

This request includes $198,000 limited term expenditure authority (equivalent to 1.0 position) in 2022-23, $290,000 in 2022-23 for consulting funding to implement additional data collection and $343,000 in 2023-24 for consultant funding to enhance the Timely Access and Network Adequacy systems to collect telehealth data for annual network and timely access reviews. Additionally, funding of $2,000 is requested annually for software licensing costs beginning in 2022-23 for access to the Necessary Infrastructure Modernization for Business Unified Services (NIMBUS) platform. The request includes $290,000 for IT consulting costs in 2022-23 and $343,000 in 2023-24 available contingent upon the approval of Project Approval Lifecycle (PAL) documents.

2) **DHCS trailer bill proposal on telehealth in Medi-Cal**

DHCS plans to release proposed trailer bill to authorize Medi-Cal covered benefits and services to continue to be provided via telehealth across delivery systems when clinically appropriate. On February 4, 2022, DHCS released a concept paper outlining their proposal, which is described below.

BACKGROUND

DMHC BCP

AB 457 establishes the Protection of Patient Choice in Telehealth Provider Act, which requires health care service plans (health plans) to provide certain notices to enrollees when offering services through third-party corporate telehealth providers and requires health plans to file an array of reports with the DMHC regarding the utilization of corporate telehealth services. The bill also requires health plans to ensure that corporate telehealth providers send patient records to enrollees' primary care providers. The purpose of this bill was to encourage the use of local, in-network services where available, and ensure patient record continuity when health plan enrollees choose to seek services from corporate telehealth providers.

AB 457 establishes the following major requirements for health plans when they offer enrollees services through a third-party corporate telehealth provider:

- ***Disclosures to enrollees***. In any promotion or coordination of the service, health plans must disclose the availability of receiving services on an in-person (or telehealth, if available) basis with in-network providers meeting the existing, applicable timeliness and geographic access standards. If the enrollee has out -of-network benefits the health plan must remind the enrollee of the availability of these benefits, the cost-sharing differences between in and out-of-network benefits and balance billing protections that apply with in-network services. If the enrollee is currently receiving specialty telehealth services for a behavioral health condition with a contracted provider, the enrollee must be given the option of continuing with that individually contracted provider.

- ***Patient Records***. If the enrollee chooses to receive third-party corporate telehealth services after receiving the disclosures listed above, the health plan must notify the enrollee of their right to access their medical records, pursuant to existing law, and that their medical records from the third-party corporate telehealth provider would be shared with the enrollee's primary care provider unless the enrollee objects. The bill requires the health plan to ensure that the records are entered into a patient record system to which the primary care provider has access or are otherwise shared with the primary care provider, consistent with state and federal laws relating to medical records.

- ***Direct access to third-party corporate telehealth providers***. AB 457 includes a provision stating that its terms do not apply when an enrollee seeks services directly from a third-party corporate telehealth provider.

- ***Reporting by health plans***. AB 457 requires health plans to include additional, specified data in annual reports already submitted to the DMHC under HSC section 1367.035. These reports relate to health plans' network adequacy and cover a variety of data points including provider location, specialization, number of patients assigned to primary care providers, and grievances regarding network adequacy and timely access to care.

As a result of the AB 457 requirements, plans will likely make revisions to advertisements, Evidence of Coverage, subscriber contracts, or other disclosure documents, to meet the new disclosure requirements. The health plans may also revise their provider contracts, administrative service agreements with telehealth vendors, or plan-to-plan agreements, to align with the notice and record-keeping requirements of AB 457. Finally, the health plans will likely revise existing, or create new, policies and procedures and/or consent forms regarding telehealth.

AB 457 requires the DMHC to do the following:

- Draft legal memorandums regarding the implementation of AB 457.
- Promulgate a regulation to clarify the requirements for health plans' reimbursement of telehealth in California.
- Implement AB 457's requirements for health plans' reimbursements of telehealth in California.
- Update network adequacy regulations pertaining to the required filings. Investigate and take enforcement action, as appropriate, against health plans that do not comply with the requirements of AB 457. This includes periodically evaluating contracts between health plans and third-party corporate telehealth providers to determine if any audit, evaluation, or enforcement actions should be undertaken
- Revise the Telehealth Checklist to include the new disclosure and notice requirements imposed by AB 457 and draft a summary and guidance for the annual All Plan Letter (APL) regarding new legislation.
- Enhance the Timely Access and Network Adequacy systems to collect telehealth data for annual network and timely access reviews.
- Review the additional data submitted by health plans to the DMHC under HSC Section 1367.035 for compliance with the Knox-Keene Act.
- Annually review health plan documents related to network access for services and timely access.

DHCS Medi-Cal Telehealth Trailer Bill

While Medi-Cal had an existing expansive telehealth policy given the changes implemented in 2019, as a result of the COVID-19 PHE, DHCS implemented additional broad flexibilities relative to telehealth modalities via blanket waivers and Disaster Relief state plan amendments (SPAs).

DHCS' temporary policy changes during the COVID-19 PHE include:

- Expanding the ability for providers to render all applicable Medi-Cal services that can be appropriately provided via telehealth modalities – including those historically not identified or regularly provided via telehealth such as home and community-based services, Local Education Agency Billing Option Program (LEA BOP) and the Targeted Case Management Program (TCM) services.
- Allowing most telehealth modalities to be provided for new and established patients.
- Allowing many covered services to be provided via audio-only for the first time.
- Allowing payment parity between services provided in-person face-to-face, by video, and by audio-only when the services met the requirements of the billing code by various provider types, including Federally Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) in both FFS and managed care.
- Waiving site limitations for both providers and patients for FQHC/RHCs, which allows providers and/or beneficiaries to be in locations outside of the clinic to render and/or receive care, respectively.

- Allowing for expanded access to telehealth through non-public technology platforms.

COVID-19 PHE flexibilities will continue for the duration of the PHE and until December 31, 2022.

Pursuant to Section 380 of Assembly Bill (AB) 133 (Committee on Budget, Chapter 143, Statutes of 2021), DHCS convened a Telehealth Advisory Workgroup for the purposes of informing the 2022 – 2023 Governor's Budget and the development of post-PHE telehealth policies. The Workgroup met three times from September to October 2021 to advise DHCS on proposed policy options, review telehealth utilization data and insights, and discuss future telehealth research and evaluation objectives.

In December 2021, DHCS published its Telehealth Workgroup Report that reviewed the policy approaches and workgroup deliberations. This Workgroup Report and deliberations from each Workgroup Session can be found on DHCS's Telehealth Advisory Workgroup Webpage:
https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthAdvisoryWorkgroup.aspx

All post-PHE policy changes envisioned and recommended by DHCS were guided by the following principles, which were also updated to reflect Advisory Workgroup input: equity, access, standard of care, patient choice, confidentiality, stewardship, and payment appropriateness.

DHCS intends for many policies first introduced during the COVID-19 pandemic to be continued after 2022. DHCS has also developed and refined proposed policy approaches for establishing and adopting billing and utilization management protocols for telehealth. The DHCS telehealth framework includes the following:

A. Policy Area: Baseline coverage of synchronous telehealth
Continue coverage of synchronous video and audio-only telehealth coverage across multiple services and delivery systems, as covered during the PHE.

B. Policy Area: Baseline coverage of asynchronous telehealth
Continue coverage of asynchronous telehealth across many services and delivery systems. Continue, post-PHE, coverage of asynchronous telehealth to 1915(c) waivers, TCM and LEA-BOP.

C. Policy Area: Payment Parity

- Continue parity in reimbursement levels between in-person services and select telehealth modalities (synchronous video, synchronous audio-only, or asynchronous store and forward, as applicable) across delivery systems. Payment parity will continue to exclude virtual communications (e.g., web-based modalities, such as web-based interfaces, live chats, econsult, etc.).

- Continue the use of cost-based reimbursement for TCM and LEA BOP telehealth services. All county-administered behavioral health reimbursements will be cost-based until BH Payment Reform via CalAIM (anticipated July 2023).

D. Policy Area: Virtual Communications & Check-Ins

Continue coverage of brief virtual communications in physical health. Add coverage of virtual communications (specifically e-visits) to 1915(c) waivers, TCM and LEA-BOP.

E. Policy Area: Telehealth in FQHCs & RHCs

Continue to reimburse FQHCs/RHCs at PPS rate for otherwise billable visits delivered via telehealth, including visits delivered via (1) synchronous video, (2) synchronous audio-only, and (3) store and forward. Continue exemption from site limitations for patient or provider.

F. Policy Area: Establish New Patients via Telehealth

- Clarify providers may only establish a relationship with new patients in-person or via synchronous video telehealth visits, subject to certain protections.
- Prohibit establishment of a new patient relationship using telehealth modalities other than video, and allow the Department to provide for specific exceptions to this prohibition, which shall be developed in consultation with stakeholders.
    - For FQHCs and RHCs, an exception to this prohibition will allow FQHCs and RHCs to establish new patient/provider relationships via asynchronous telehealth when certain conditions are met, including that the patient is present at an originating site that is a licensed or intermittent site of the FQHC or RHC.

G. Policy Area: Telehealth Modifiers

Use specific modifiers to delineate visits by telehealth modality, with alignment of requirements across delivery systems. Adopt new nationally-recognized audio-only visit 93 modifier announced by the American Medical Association's (AMA) Common Procedural Terminology (CPT) Editorial Board as soon as possible.

H. Policy Area: Patient Consent

Enhance existing consent requirements to require additional information be shared with beneficiaries regarding:

- Right to in-person services
- Voluntary nature of consent
- Availability of transportation to access in-person services when other available resources have been reasonably exhausted
- Limitations/risks of receiving services via telehealth, if applicable
- Availability of translation services

I.Policy Area: Telephonic Evaluation & Management (E&M) and Assessment & Management (A&M) CPT Codes

Activate CPT codes for capture of telephonic evaluation and management and assessment and management visits in Medi-Cal by July 1, 2022. Add use of telephonic E&M codes (99441-3) and A&M codes (98966-8).

J. Policy Area: Third Party Corporate Telehealth Providers

- Consider methods to identify third-party corporate telehealth providers and examine data related to services provided by these providers.
- Further evaluate requirements set forth by AB 457 to determine potential benefit in light of complimentary policy approaches in Medi-Cal, level of effort needed to apply to Medi-Cal, necessity for alignment with commercial plans and across Medi-Cal delivery systems, and potential implementation design applicable to providers outside of Knox-Keene licensed plan networks.

K. Policy Area: Utilization Review

Continue to expand analytics and algorithm development to effectively identify suspect telehealth activity to be investigated. Potential risks include, but are not limited to, the following:

- Up-coding time and complexity of services provided.
- Misrepresenting the virtual service provided.
- Billing for services not rendered.
- Kickbacks.

L. Policy Area: Patient Choice of Telehealth Modality

Over time, but no sooner than January 1, 2024, phase in an approach that provides patients the choice of a video telehealth modality when care is provided via telehealth. Specifically, if a provider offers audio-only telehealth services, the provider will also be required to provide the option for video services to preserve beneficiary choice.

M. Policy Area: Right to In-Person Services

Over time, but no sooner than January 1, 2024, phase in an approach that requires any provider furnishing services through telehealth to also either offer services via in-person face-to-face contact, or link the beneficiary to in-person care. If the provider chooses to link the beneficiary to in-person care to satisfy this requirement, they must provide for a referral to and a facilitation of in-person care that does not require a patient to independently contact a different provider to arrange for such care.

N. Policy Area: Network Adequacy

Currently five out of twenty-six Medi-Cal managed care plans have utilized telehealth as an alternative access standard; twenty-nine Specialty Mental Health Plans and twenty-four Drug Medi-Cal Organized Delivery Systems use telehealth to count towards network adequacy access to care standards.

Allow Medi-Cal managed care plans, county Mental Health Plans and county Drug Medi-Cal Organized Delivery System plans to use clinically appropriate video synchronous

interaction as a means of demonstrating compliance with the network adequacy time or distance standards.

Telehealth Research and Evaluation Plan

The plan will lay out how DHCS will monitor and report on telehealth utilization, assess provider and plan compliance with telehealth policies, and evaluate the impact of telehealth on access, quality and specific populations of interest. DHCS will leverage existing internal capacity for telehealth monitoring, reporting and compliance assessment. In addition, DHCS will collaborate with external research partners, such as UCLA for the California Health Interview Survey, and the California Health Care Foundation on their interests in Californians' experiences with telehealth.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC present the BCP and requests DHCS provide an overview of the issue of telehealth in Medi-Cal, summarize the work and report from the Telehealth Advisory Workgroup, and respond to the following questions:

1. When do you expect to release proposed trailer bill?

2. How are the challenges associated with telehealth in the commercial managed care market the same or different to those in Medi-Cal?

3. How do you intend to expand utilization review and ongoing monitoring of providers?

4. Please describe the evaluation plan? When will this begin? Will the Advisory Workgroup and other stakeholders be involved in its development?

5. What is the rationale for limiting the establishment of new patients to video only?

6. Providers state that a requirement to offer both video and audio services without any new funding for providers to acquire, or have access to, the needed technology and infrastructure, makes it difficult for providers to be fully video-capable in many areas of the state. How should the state seek to address these challenges? Wouldn't this requirement need to have accommodations for physicians practicing in very rural/underserved areas where the internet service may not support video.

7. How can the state ensure that managed care plans continue to prioritize network adequacy to support in-person health care as much as possible, particularly in provider-shortage areas?

Staff Recommendation: Hold open to allow for additional review and discussion, and to receive the proposed trailer bill.

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 3: CALIFORNIA HEALTHCARE ELIGIBILITY, ENROLLMENT, AND RETENTION SYSTEM – BUDGET CHANGE PROPOSAL

PANEL 3 – PRESENTERS

- **James Duckens**, CalHEERS Project Director, Office of Systems Integration
- **Brian Metzker**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 3 – Q&A ONLY

- **Nina Hoang**, Finance Budget Analyst, Department of Finance
- **Katherine Clark**, Assistant Program Budget Manager, Department of Finance
- **Rob Trojan**, Information Technology Manager, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

The Office of Systems Integration (OSI) requests $1.3 million ($332,000 General Fund) in fiscal year (FY) 2022-23 and ongoing and 6.0 permanent positions to support the stabilization of critical services within the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS).

BACKGROUND

This proposal expands the CalHEERS team to successfully develop, test, and implement federal and state mandated system changes. This request also addresses the increased workload required to successfully manage the recent change in the Systems Integrator (SI) prime vendor contract. The goal is to ensure the most efficient automated system to apply for and obtain affordable health coverage through Covered California (C. CA) or Medi-Cal.

The state awarded a contract to a new SI, Deloitte, LLC, in September 2019. The contract with Deloitte included robust changes and new requirements across every functional area of the Project. The CalHEERS oversaw a one-year transition between the incumbent, Accenture, and Deloitte that ended in June 2020.

These program initiatives and the associated changes need to be planned, approved, managed, and monitored. In addition, with the maturity of the CalHEERS Project and the

maturity of Project resources, the new SI contract has placed more ownership and responsibility on the state as they work with their SI counterparts during the pre-Design and Design Phases and other Project teams where their historical system/business knowledge are leveraged. The number of change request (CR) releases have increased from 8 in 2019 to 21 in 2021 and will increase to 26 in 2022. This does not include emergency/priority releases, of which during 2020 there were 35. Due to increased federal and state funding for the ACA, more demand is placed on the CalHEERS state team as sponsors request more enhancements to align with newly implemented policy and legislations, including Senate Bill 260 and Assembly Bills 577, 174, 414, 1309, and 1130. The identified initiatives which have led to an increase in workload are resulting in the current resources of the OSI state team reaching capacity.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSI present this proposal, and provide an overview of CalHEERS and an update on the roadmap for addressing CalHEERS implementation challenges.

Staff Recommendation: Hold open to allow for additional review and discussion.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 4: MEDI-CAL NOVEMBER 2021 ESTIMATE

PANEL 4 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

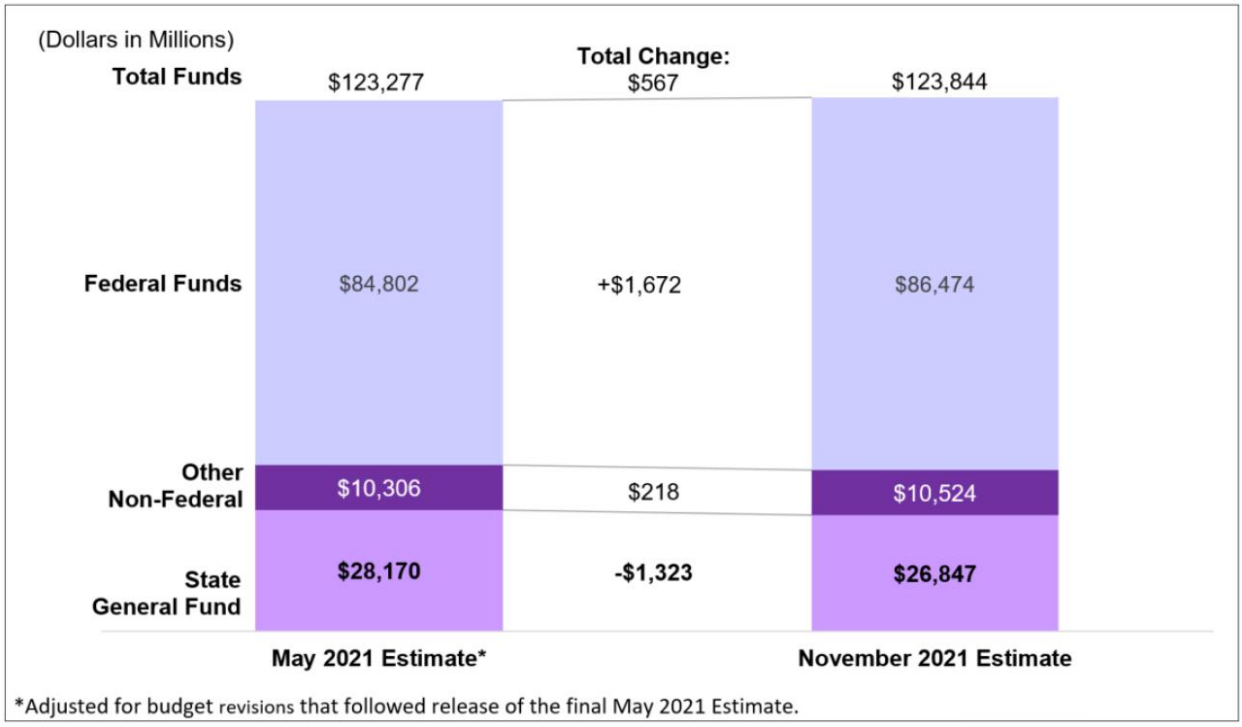
PANEL 4 – Q&A ONLY

- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

DHCS estimates Medi-Cal spending to be $123.8 billion total funds ($26.8 billion General Fund) in FY 2021-22 and $132.7 billion total funds ($34.9 billion General Fund) in FY 2022-23. This does not include Certified Public Expenditures of local governments or General Fund in other state departments.

FY 2021-22 Comparison

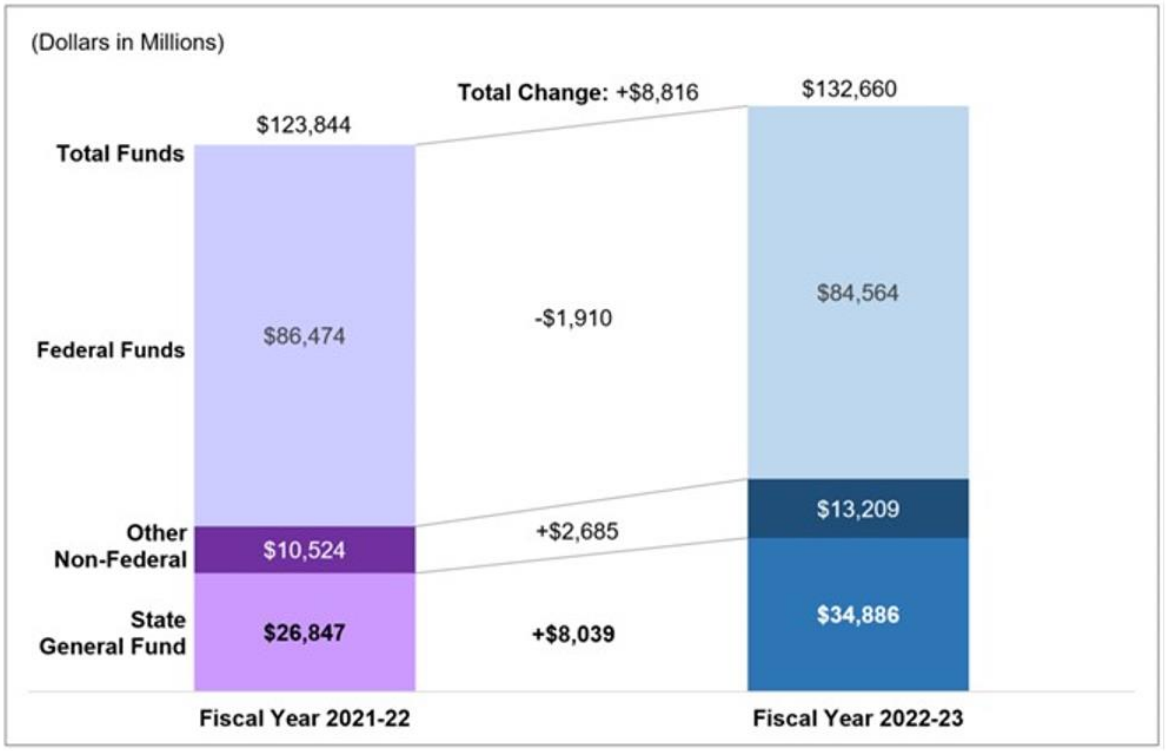


The November 2021 Medi-Cal Local Assistance Estimate for FY 2021-22 projects a $567 million increase in total spending and a $1.3 billion decrease in General Fund spending compared to the final FY 2021-22 Budget Act appropriation. Excluding revisions to the 2021-22 appropriation, the General Fund decrease is $1.1 billion. This reflects a 0.5 percent increase in estimated total spending and a 4.7 percent decrease in estimated the General Fund spending for FY 2021-22.

Following are the major drivers of the change in estimated General Fund spending in FY 2021-22 between the May 2021 and November 2021 Estimates:

- -$1 billion related to COVID-19 impacts.
- -$553 million related to the shift of multiyear spending into later years.
- -$189 million related to increased funding from the Hospital Quality Assurance Fee for children's health coverage.
- -$170 million related to reduced projected costs for CalAIM transitioning populations.
- $548 million related to state only claiming.

Year-Over-Year Change from FY 2021-22 to FY 2022-23



After the adjustments described previously, the November 2021 Medi-Cal Local Assistance Estimate projects that total spending will increase by $8.8 billion (7.1 percent) and General Fund spending will increase by $8 billion (30 percent) between FY 2021-22 and FY 2022-23.

After the adjustments described previously, the November 2021 Medi-Cal Local Assistance Estimate projects that total spending will increase by $8.8 billion (7.1 percent) and General Fund spending will increase by $8 billion (30 percent) between FY 2021-22 and FY 2022-23.

Following are the major drivers of changes in estimated General Fund spending in FY 2021-22 and FY 2022-23:

- -$478 million related additional drug rebates.
- -$415 million related to deferrals.
- -$327 million related to full implementation of Medi-Cal Rx.
- $5 million for HPV vaccine coverage in Family PACT.
- $9 million to eliminate certain AB 97 provider rate reductions.
- $13 million for Medi-Cal dental policy evidence-based practices
- $16 million to implement a mobile crisis benefit.
- $19 million to reduce Medi-Cal premiums to zero.
- $46 million to implement nursing facility financing reform.
- $77 million related to the expiration of the managed care organization (MCO) tax.
- $134 million for a full year of postpartum care extension costs.
- $176 million in General Fund support for Proposition 56 payments.
- $200 million for equity and practice transformation payments.

- $309 million to discontinue the end-of-year two-week checkwrite hold.
- $340 million related to normal growth in managed care costs.
- $348 million related to normal growth in Medicare costs.
- $454 million to reflect a full year of implementation of coverage for undocumented older Californians.
- $547 million for a full year of implementation of CalAIM.
- $813 million related to state only claiming.
- $1 billion for Behavioral Health Bridge Housing.
- $2.3 billion related to COVID-19 impacts.
- $2.4 billion related to the Children and Youth Behavioral Health Initiative and Behavioral Health Continuum Infrastructure Program.

COVID-19 Medi-Cal Expenditures

The budget continues to reflect significant fiscal impacts related to COVID-19. Based on an assumption that the federal PHE continues through June 2022, the budget includes $13.5 billion in total costs ($45 million General Fund costs) in FY 2021-22 and $11.1 billion total funds costs ($2.3 billion General Fund costs) in FY 2022-23. These amounts reflect the net impact of a variety of factors, including:

- *Caseload Impact*. The Medi-Cal caseload continues to increase because of the COVID19 pandemic. The federal Families First Coronavirus Response Act (FFCRA) requires that the state implement a "continuous coverage requirement" under which Medi-Cal beneficiaries may be disenrolled only under very limited circumstances. Reducing the number of disenrollments causes the caseload to grow. The budget includes $10.4 billion total funds ($2.9 billion General Fund) in FY 2021-22 and $10 billion total funds ($2.8 billion General Fund) in FY 2022-23 associated with these caseload costs. This is based on an assumption that cases will continue to grow through June 2022, then gradually decline over 12 months as annual redeterminations resume following the end of the federal PHE.

- *Testing in Schools*. The Budget Act of 2021 included $575 million total funds ($265 million General Fund) for COVID-19 testing in schools in FY 2021-22, not accounting for increased FMAP. However, to date, schools have relied on direct federal funding to support testing costs rather than billing Medi-Cal for eligible students. As a result, the proposed budget no longer assumes costs related to COVID-19 testing in FY 2021-22; however, $405 million total funds ($102 million General Fund) are included in FY 2022-23, coinciding with the projected end of direct federal funding.

- *Vaccine Administration Costs*. As part of ARP, the federal government assumed full responsibility to cover vaccine administration costs in Medi-Cal beginning April 1, 2021. Based on more recent information about vaccination take-up, claiming, and the payment timing, the budget includes $348 million total funds ($38 million General Fund) in FY 2021-22 and $155 million total funds ($1 million General

Fund) in FY 2022-23 to cover vaccine administration costs, not accounting for increased FMAP. These amounts are adjusted to avoid double counting the impact of increased FMAP available under the FFCRA. (Note that manual processes to claim 100 percent federal funding for vaccine administration will lag behind payments, such that some General Fund costs are budgeted in FY 2021-22 and FY 2022-23, to be recovered in the following fiscal year.)

- *Funding for County Redeterminations*. The budget continues to include $73 million total funds ($37 million General Fund) in both 2021-22 and 2022-23 to support increased county workload to redetermine eligibility for individuals that remained enrolled in Medi-Cal due to the continuous coverage requirement during the COVID-19 PHE. DHCS proposes trailer bill language to align Medi-Cal redeterminations with federal guidelines (included in issue #16 of this agenda).

- *Many COVID-19 Response Impacts Assumed to End*. Costs associated with a number of COVID-19 impacts are assumed to end in FY 2021-22 and not continue into FY 2022-23, as a result of the assumed end of the federal PHE. These include temporarily increased rates for various provider types, temporarily expanded sick leave benefits, and temporarily expanded eligibility. Finally, the COVID-19 Vaccination Incentive Program also does not continue into FY 2022-23. The budget includes $1.5 billion total funds ($763 million General Fund) in FY 2021-22 for these COVID-19 impacts, but only $10 million total funds ($2 million General Fund cost) in FY 2022-23, associated with payments from FY 2021-22 lagging into FY 2022-23.

- *Increased Federal Funding Under the FFCRA*. The FFCRA provides additional federal matching funds for Medi-Cal tied to the federal PHE, which offset what otherwise would be state General Fund costs. The budget now assumes this increased federal funding will be available through June 2022. The budget includes $5.3 billion in increased federal funding, with offsetting General Fund savings in the DHCS budget of $3.7 billion in FY 2021-22. For FY 2022-23, the budget includes significantly less impact from increased FMAP—$1.6 billion in increased federal funding, with offsetting General Fund savings in the DHCS budget of $641 million. (The difference between increased federal funding and General Fund savings reflects offsetting savings to special funds, local funds, and General Fund in other departments' budgets.)

MEDI-CAL CASELOAD UPDATES

The overall Medi-Cal caseload is projected to continue to grow steadily through June 2022, consistent with the Medi-Cal Local Assistance Estimate's (Estimate) assumption that the federal PHE, and related restrictions on disenrolling beneficiaries, continue through that time. Consistent with recent actuals, this growth is assumed to be concentrated among the Affordable Care Act (ACA) Optional Expansion population and families with children.

Estimated Average Monthly Certified Eligibles

November 2021 Estimate

				Year over Year Change	
	2020-21	2021-22	2022-23	2020-21 to 2021-22	2021-22 to 2022-23
Seniors	1,056,400	1,130,700	1,168,500	7.03%	3.34%
Persons with Disabilities	1,109,300	1,103,400	1,113,500	-0.53%	0.92%
Families and Children	7,137,300	7,689,400	7,479,900	7.74%	-2.72%
Optional Expansion	4,131,100	4,703,200	4,445,100	13.85%	-5.49%
Miscellaneous	56,900	60,700	60,900	6.68%	0.33%
Total	**13,491,000**	**14,687,400**	**14,267,900**	**8.87%**	**-2.86%**

Change from May 2021 Estimate

	Eligibles		Percent	
	2020-21	2021-22	2020-21	2021-22
Seniors	(6,800)	16,600	-0.64%	1.49%
Persons with Disabilities	(1,600)	400	-0.14%	0.04%
Families and Children	(71,600)	83,400	-0.99%	1.10%
Optional Expansion	(28,100)	90,600	-0.68%	1.96%
Miscellaneous	(2,000)	(100)	-3.40%	-0.16%
Total	**(110,100)**	**190,900**	**-0.81%**	**1.32%**

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present an overview of the November 2021 Medi-Cal estimate, significant new cost trends and drivers, pandemic impacts, and caseload estimates, and respond to the following:

1. Please explain the caseload impacts that have, and will continue to, result from the suspension of disenrollments and redeterminations during the pandemic. Is this the explanation for the projected decrease in caseload from 2021-22 to 2022-23? Will this decrease not be offset by the increase in caseload that will occur as a result of the eligibility expansion for individuals over the age of 50, regardless of immigration status?

Staff Recommendation: Hold open to allow for additional review, discussion and May Revision updates.

ISSUE 5: FAMILY HEALTH NOVEMBER 2021 ESTIMATE

PANEL 5 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 5 – Q&A ONLY

- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

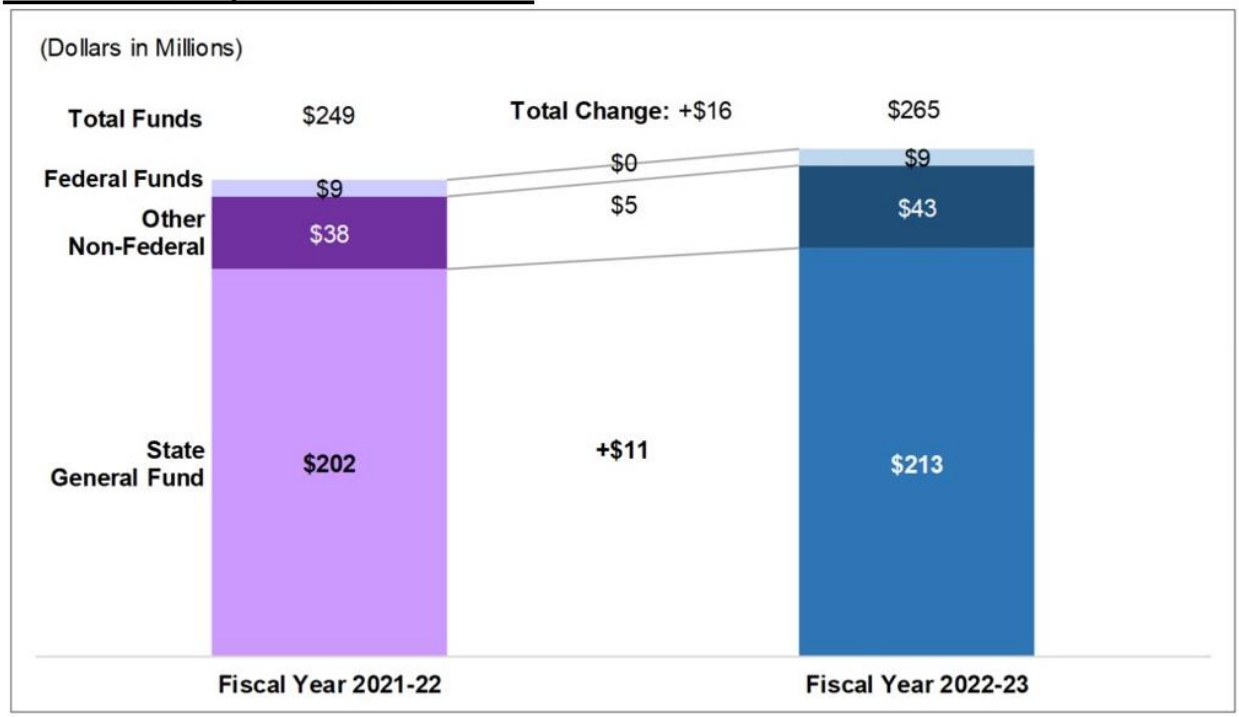
PROPOSAL

The Family Health Estimate reflects costs outside of the Medi-Cal program/estimate for the following programs: California Children's Services, Every Woman Counts, and the Genetically Handicapped Persons Program. DHCS estimates Family Health spending to be $249 million total funds ($202 million General Fund) in FY 2021-22 and $265 million total funds ($213 million General Fund) in FY 2022-23.

FY 2021-22 Comparison

As displayed above, the November 2021 Estimate for FY 2021-22 projects a $17 million decrease in total spending ($15 million General Fund) compared to the May 2021 Estimate. This reflects a 6.4 percent decrease in estimated total spending and a 6.9 percent decrease in estimated General Fund spending.

FY 2021-22 Comparison to FY 2022-23



Family Health spending is estimated to increase by $16 million total spending ($11 million General Fund) between FY 2021-22 and FY 2022-23. This reflects a 6.4 percent increase in total spending and a 5.4 percent increase in General Fund spending.

FAMILY HEALTH CASELOAD ESTIMATES

California Children's Services (CCS)

	PY	CY	BY	Change from	
CCS State Only	FY 2020-21	FY 2021-22	FY 2022-23	PY to CY	CY to BY
November 2021	10,032	9,311	11,687	-7.19%	25.52%
May 2021	12,569	14,601			
Change from May 2021	(2,537)	(5,290)			
% Change from May 2021	-20.18%	-36.23%			

- CCS caseload is based on average quarterly beneficiaries.

- Beneficiaries began shifting to Medi-Cal in late FY 2019-20 due to the economic impact of the COVID-19 PHE and have continued to shift through the most recent quarter of actual enrollment counts.

- Base caseload projections have been returned to pre-COVID-19 levels. The impact from the PHE is estimated in the COVID-19 Caseload Impact policy change and included in the average quarterly caseload in the table above.

Genetically Handicapped Persons Program (GHPP)

	PY	CY	BY	Change from	
GHPP State Only	FY 2020-21	FY 2021-22	FY 2022-23	PY to CY	CY to BY
November 2021	580	647	649	11.55%	0.31%
May 2021	598	670			
Change from May 2021	(18)	(23)			
% Change from May 2021	-3.01%	-3.43%			

- GHPP caseload is based on average monthly beneficiaries.

- In early FY 2020-21, GHPP cases were closed due to an effort on the part of the Department to address outstanding renewals and applications. The closed cases were subsequently re-opened and extended to the end of December 2021 or until the end of the PHE, whichever date is later. Beneficiaries will continue to receive coverage through the end of the PHE.

- Base caseload has returned to pre-COVID-19 levels and is estimated to remain relatively flat between fiscal years.

Every Woman Counts (EWC)

	PY	CY	BY	Change from	
EWC	FY 2020-21	FY 2021-22	FY 2022-23	PY to CY	CY to BY
November 2021	20,895	24,103	27,405	15.35%	13.70%
May 2021	21,409	24,602			
Change from May 2021	(514)	(499)			
% Change from May 2021	-2.40%	-2.03%			

- EWC caseload is based on average monthly users by date of payment.

- There is a slight increase in users from the May 2021 Estimate for FY 2021-22 due to actuals coming in higher than initially projected. The statewide stay at home order pursuant to Executive Order (N-33-20) triggered overall reductions in caseload estimates for the EWC program.

- The projected users for FY 2022-23 is estimated absent COVID-19 impact and retroactive reprocessing, as FY 2020-21 and FY 2021-22 include reprocessing of claims.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of the Family Health Estimate and explain the impacts of the pandemic on these programs.

Staff Recommendation: Hold open to allow for additional review and discussion, and for May Revision updates.

ISSUE 6: FAMILY PACT HUMAN PAPILLOMAVIRUS VACCINE COVERAGE AND REPRODUCTIVE HEALTH CARE ACCESS

PANEL 6 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 6 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS

HPV Covered in Family PACT
The budget includes $8 million total funds ($4.6 million General Fund) to add the Human Papillomavirus (HPV) vaccine as a covered benefit in the Family Planning, Access, Care, and Treatment (Family PACT) program for individuals age 19 through 45, effective July 1, 2022.

Medication Abortion Services
The budget summary also includes a proposal to increase flexibility for Medi-Cal providers to provide clinically appropriate medication abortion (MAB) services by removing requirements for in-person follow-up visits and ultrasounds when not clinically indicated.

Through the COVID-19 PHE, medication abortion providers have been able to provide visits through telehealth, including the post-abortion follow-up visit. During the PHE, DHCS also modified policies regarding use of ultrasounds and did not pursue reimbursement reductions. Specifically, during the PHE, providers have been able to provide visits through telehealth, including the post-abortion follow-up visit, and DHCS is allowing billing for the medication abortion "bundled rate" with no requirement for ultrasounds or in-person care.

In the past year, Planned Parenthood Affiliates of California and other reproductive advocates have made a number of requests to DHCS regarding the provision of MAB, including the requests to:

1. Acknowledge that while the type of care varies per Medi-Cal patient, the basic steps of medication abortion do not change.
2. Maintain PHE flexibility (not requiring pre-abortion ultrasounds).
3. Allow the billing of the S0199 code as soon as mifepristone is prescribed (S0190) and eliminate the "from-through" billing requirement.
4. Eliminate the use of modifier 52 for S0199 because it disproportionately reduces the reimbursement rate for medication abortion and only pays the full bundled rate if the patient returns for an abortion completion assessment (follow-up) visit and an ultrasound is performed.
5. Replace the term "follow-up visit" with "abortion completion assessment" and allow to be done remotely.
6. Clarify that the frequency limitation for one ultrasound per 180 days per provider would not apply for the provision of medication abortion.
7. Reimburse for the provision of medication abortion through 77 days gestational age.
8. Change the definition of the S0199 code for medication abortion services, per one of the following two options, with a preference for Option 1:
    a) Option 1. Provide flexibility within the bundle and maintain the current rate.
    b) Option 2. Provide flexibility within the bundle and reduce the bundled rate by the cost of one ultrasound.

In response, and as described in more detail below under Post PHE Proposal, DHCS proposes to maintain the base S0199 bundle rate but change the usage of the billing modifier ("Modifier 52") to reflect the reduced or eliminated services. This proposal will allow for more efficient allocation of clinical resources and increased convenience for beneficiaries seeking services, while maintaining sustainable reimbursement rates for these safety net services.

Current Policy (policy in place prior to PHE)

Medical abortion of intrauterine pregnancies through the 70th day from the first day of the recipient's last menstrual period is a Medi-Cal reimbursable benefit when billed with billing code S0199. The original construction of the bundled rate for S01999 assumed three visits and two to three ultrasounds, as well as other relevant services, and this billing code could only be used if these visits and services occurred. The bundle is currently reimbursed at $536.48 for Medi-Cal. There is also an adjusted payment called "Modifier 52" that is applied in a variety of situations where a service is modified or not provided and is currently a reduction of $230 to the base rate for S0199. 91% of claims in managed care and 84% of claims for billing code S0199 in FFS for MAB services are currently provided at the full bundled rate without the use of Modifier 52.

Post PHE Proposal

- Modify the S0199 code and medication abortion-related service codes as follows:
  - Improve flexibility for the use of the S0199 Code to be allowed when:
    - Pre-abortion ultrasounds are not required when not clinically indicated.
    - Post-abortion ultrasounds are not required when not clinically indicated.
    - Remote pregnancy completion assessment is allowable if clinically indicated and if patient prefers remote assessment; in-person visit must be offered but is not required to bill the bundled rate.
  - Adjust Modifier 52 payment reduction as it applies to the use of the S0199 Code.
    - Modifier 52 must be used in the following circumstances:
      - When fewer than two ultrasounds are provided, based on an assessment that one or more ultrasound is not clinically indicated. As noted above, providers will have the flexibility to assess whether ultrasounds are clinically indicated. If one or more ultrasounds are not performed based on lack of clinical necessity, providers may still bill the bundled rate. However, because the bundled rate reflects the costs of at least two ultrasounds, the modifier must be used when fewer than two ultrasounds are performed.
      - When a provider is unable to perform an abortion completion assessment or follow-up visit, which may include a patient not showing up for a visit or participating in the assessment.
    - Reduce the level of payment reduction associated with the use of Modifier 52 from $230 to $123.64 to account for the average cost of ultrasounds not provided based on clinical indications.
    - This reimbursement adjustment reflects that a lower intensity of services is needed to perform the service safely.
- Remove frequency limitations for ultrasounds
- Maintain the following (no change):
  - From-through billing (bundled rate is billed after all MAB services have been provided).
  - Provider discretion to bill the bundled rate or to bill for services individually.
  - Medication abortion remains through 70 days gestational age.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present these proposals and respond to the following:

- Will you be proposing trailer bill to implement the reproductive health proposal? If so, when?

Staff Recommendation: Hold open to allow for additional review and discussion.

ISSUE 7: MATERNAL CARE AND SERVICES (SB 65) BUDGET CHANGE PROPOSAL

PANEL 7 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 7 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Palav Babaria**, Chief Quality Officer & Deputy Director, Quality and Population Health Management, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

DHCS, Benefits Division (BD) and Office of the Medical Director (OMD), requests two-year limited-term (LT) resources equivalent to 2.0 positions and expenditure authority of $510,000 ($255,000 General Fund (GF); $255,000 Federal Fund (FF)) in fiscal year (FY) 2022-23 and $492,000 ($246,000 GF; $246,000 FF) in FY 2023-24. The request includes two-year contract authority of $215,000 ($108,000 GF; $107,000 FF) in FY 202223 through FY 2023-24 to implement the requirements as outlined in SB 65 (Skinner, Chapter 449, Statutes of 2021) and to track benefit implementation and manage the stakeholder process.

BACKGROUND

As part of the Budget Act of 2021 and as proposed by the Administration, doula services were established as a Medi-Cal benefit. DHCS will implement the doula benefit effective July 1, 2022. DHCS met with interested stakeholders throughout fall 2021 to receive their input on federal requirements, including qualifications to provide services, supervision requirements, and a description of doula services.

SB 65 requires DHCS to convene a workgroup by April 1, 2022, through December 31, 2023, to examine the implementation of doula services as a new benefit. SB 65 requires the workgroup to include doulas, health care providers, consumer and community advocates, health plans, county representatives, as well as others experienced with doula services as determined by DHCS. The workgroup will be tasked with the following:

- Ensuring that doula services are available to Medi-Cal beneficiaries who are eligible for and want doula services.

- Minimizing barriers and delays in payments to doulas or reimbursement to Medi-Cal beneficiaries for doula services received.

- Making recommendations for outreach efforts so that all eligible beneficiaries and other target populations are aware of the option to use doula services.

SB 65 requires DHCS to publish a report on its website by July 1, 2024, on the number of Medi-Cal recipients utilizing doula services, broken down by race, ethnicity, primary language, health plan, and county. The bill requires the report to identify any barriers that impede access to doula services in the prenatal, labor and delivery, and postpartum periods and make recommendations to the Legislature and DHCS to reduce any identified barriers.

The report will provide a numerical comparison of the birthing outcomes of Medi-Cal recipients who receive doula services with those who do not, including, but not limited to, rates of cesarean delivery births, maternal or infant mortality, other maternal morbidity, and, to the extent available through information voluntarily provided by the Medi-Cal recipient, breast and chest feeding outcomes. The report will utilize standard public health reporting practices for accurate dissemination of these data elements, especially to protect individuals' health information.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal, and provide an overview of the implementation of the new Medi-Cal doula benefit.

Staff Recommendation: Hold open to allow for additional review and discussion.

ISSUE 8: MEDI-CAL PROVIDER RATES PROPOSALS (TRAILER BILL):

- **AB 97 (2011 REDUCTIONS)**
- **PROPOSITION 56 (SHIFT OF SUPPLEMENTAL PAYMENTS TO GENERAL FUND)**
- **MEDI-CAL EQUITY AND PRACTICE TRANSFORMATION PROVIDER PAYMENTS PROPOSAL**

PANEL 8 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 8 – Q&A ONLY

- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Palav Babaria**, Chief Quality Officer & Deputy Director, Quality and Population Health Management, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS

The Governor's budget includes the following proposals that affect Medi-Cal provider rates in various ways:

Elimination of Certain AB 97 Provider Payment Reductions
The budget includes $20 million total funds ($9 million General Fund) in FY 2022-23 and $24 million total funds ($11 million General Fund) ongoing to eliminate AB 97 payment reductions for the following providers, in order to address the impacts of COVID-19 and to ensure access to services:

- Nurses (all types)
- Alternative birthing centers
- Audiologists/hearing aid dispensers
- Respiratory care providers
- Durable medical equipment, oxygen, and respiratory services
- Chronic dialysis clinics
- Non-emergency medical transportation
- Emergency air medical transportation

In order to effect these AB 97 changes, DHCS is proposing trailer bill language.

Certain Proposition 56 Payments to Transition to Ongoing General Fund Support
The budget proposes to fully transition the following payments, valued at $147 million, to ongoing rate increases supported by the General Fund, beginning in FY 2022-23:

- Adverse Childhood Experiences Screenings
- AIDS Waiver
- Community-Based Adult Services
- Developmental Screenings
- Freestanding Pediatric Subacute
- Home Health Services
- Intermediate Care Facilities for the Developmentally Disabled
- Non-Emergency Medical Transportation
- Pediatric Day Health Care

In addition, the budget includes an increase of $29 million from the General Fund to fully fund remaining Proposition 56 payments at their current level in FY 2022-23.

Proposition 56 revenues have declined over time and are insufficient to support current Proposition 56 payments beginning in FY 2022-23. In 2022-23, Medi-Cal supplemental payments funded by Proposition 56 are projected to exceed revenues by $176 million.

Equity and Practice Transformation Payments
The budget includes $400 million total funds ($200 million General Fund) in one-time funds to support practice transformation and COVID-19 recovery payments. This funding is proposed to be available until June 30, 2024.

Specifically, DHCS proposes to make equity and practice transformation payments to qualifying Medi-Cal providers, to close critical health equity gaps; address gaps in preventive, maternity, and behavioral health care measures; and address gaps in care arising out of the COVID-19 Public Health Emergency (PHE). Such payments are intended to promote patient-centered models of care in pediatric, primary care, obstetrics and gynecology, and behavioral health settings and to align with the goals of the Medi-Cal Comprehensive Quality and Equity Strategy.

During the PHE, DHCS has seen a significant reduction in preventive and routine chronic condition care. Furthermore, 55% of school aged children are enrolled in Medi-Cal, 50% of the state's births are in Medi-Cal, and 68% of the Medi-Cal population is Black, Latino or people of color. To align with the goals of the Medi-Cal Comprehensive Quality Strategy and Equity Roadmap, these funds would pay for delivery system transformation grants to pediatric, primary care, OB/GYN and behavioral health providers focused on advancing the following DHCS equity goals in the "50 by 2025: Bold Goals" Initiative:

- Ensure all health plans exceed 50th percentile for all children's preventive care measures;
- Close racial/ethnic disparities in well child visits and immunizations by 50% (state level);
- Close maternity care disparity for black, American Indian, Alaska Native, Native Hawaiian and Other Pacific Islander (AI/AN/NH/OP) individuals by 50% (state level);
  - Pre& Postpartum care
  - C-sections
- Improve maternal and adolescent screening and referral for depression by 50% (state level); and
- Improve follow up after ED visit for Mental Health/Substance Use Disorder by 50% (state level).

These funds would include both initial planning grants and practice transformation grants as follows:

- ***Initial Planning Grants*** would help small/medium independent practices apply for the Practice Transformation Grants. This grant funding could be used by each practice for staff time to prepare the grant application and/or the hiring of a consultant to help the practice conduct a needs assessment, assist with research, tools, strategies, and recommendations to include in the development of their grant proposal and with completing the grant application.

- ***Equity and Practice Transformation Grants*** would include but are not limited to case management and/or system mechanisms for identifying and addressing underutilization and closing care gaps, electronic medical record system updates, population health improvements, telehealth, remote patient monitoring, etc. and will help practices in their work to make it possible for DHCS to realize its 50% by 2025 Bold Goals. Full grant design details to be finalized.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present these three proposals and respond to the following questions:

1. What was the process or criteria for choosing which provider types would receive relief from AB 97 rate reductions? Various stakeholders are requesting relief for additional provider types not included in this proposal; will the administration consider expanding this proposal to encompass more provider types?

2. What was the process or criteria for choosing which provider types (or services) would be shifted from Proposition 56-funded supplemental payments to ongoing General Fund support?

3. Do you envision shifting all Proposition 56-funded supplemental payments to General Fund eventually?

4. Will the equity grantees reflect the geographic disparities in the state, particularly in regards to COVID-19?

Staff Recommendation: Hold open to allow for additional review and discussion.

ISSUE 9: FEDERALLY QUALIFIED HEALTH CENTER ALTERNATIVE PAYMENT MODEL PROJECT TRAILER BILL

PANEL 9 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 9 – Q&A ONLY

- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

DHCS is proposing trailer bill language to update existing law that authorizes the department to implement an Alternative Payment Model (APM) reimbursement methodology for Federally Qualified Health Centers (FQHCs) to incentivize delivery system and practice transformation at FQHCs through flexibilities available by moving away from a volume-based reimbursement methodology.

STAFF COMMENTS/QUESTIONS

The Subcommittee request DHCS present this proposal in detail, and respond to the following?

1. When will the proposed trailer bill be released?
2. Please describe the stakeholder involvement process utilized to develop this proposal.

Staff Recommendation: Hold open to allow for additional review and discussion, and for receipt of the proposal.

ISSUE 10: DISCONTINUATION OF CHILD HEALTH AND DISABILITY PROGRAM AND CHILDREN'S PRESUMPTIVE ELIGIBILITY EXPANSION TRAILER BILL

PANEL 10 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 10 – Q&A ONLY

- **Susan Philip**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Autumn Boylan**, Deputy Director, Office of Strategic Partnerships, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

DHCS is proposing to sunset the Child Health and Disability Program (CHDP) by July 1, 2023 via trailer bill language. The department's proposal preserves presumptive eligibility enrollment activities currently offered through the CHDP Gateway, as well as activities performed by CHDP counties under the Childhood Lead Poisoning Prevention Program (CLPP). Further, this proposal continues the Health Care Program for Children in Foster Care (HCPCFC). As part of this proposal, DHCS will launch the Children's Presumptive Eligibility Program to replace the CHDP Gateway. The Children's Presumptive Eligibility Program will increase the number of children presumptive eligibility providers to include all Medi-Cal providers. The majority of children and youth under the age of 21 will be enrolled into a MCP, through which they will receive all medically necessary services. This aligns with the Department's goal under CalAIM to reduce administrative complexities. The proposal will also enhance coordination of care and increase standardization of care across Medi-Cal by consolidating care responsibilities for children/youth under the Medi-Cal managed care plans.

STAFF COMMENTS/QUESTIONS

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

1. Will there be proposed trailer bill for this proposal? If so, when?

2. Which specific populations of children will be affected by this proposal?

3. Are there any CHDP services provided by counties that will be lost?

4. What are the estimated percentage of Medi-Cal-eligible children who are and are not enrolled in Medi-Cal?

Staff Recommendation: Hold open to allow for additional review and discussion, and for receipt of the proposal.

ISSUE 11: MEDI-CAL REDUCTIONS TO PREMIUMS AND COPAYMENTS PROPOSALS:

- **OPTIONAL TARGETED LOW-INCOME CHILDREN'S PROGRAM (OTLICP)**
- **250 PERCENT WORKING DISABLED PROGRAM**
- **CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) TRAILER BILL**
- **COPAYMENTS IN THE MEDI-CAL PROGRAM TRAILER BILL**

PANEL 11 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 11 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS

The proposed budget includes $53 million total funds ($19 million General Fund) in FY 2022-23 and $89 million total funds ($31 million General Fund) ongoing and trailer bill language to eliminate premiums for programs under the Children's Health Insurance Program (CHIP) and the 250 Percent of Federal Poverty Level Working Disabled Program.

The budget also proposes to reduce or eliminate copayments in the Medi-Cal program.

STAFF COMMENTS/QUESTIONS

The Subcommittee request DHCS present these proposals and respond to the following:

1. When will the trailer bill be finalized and released?

2. Please explain in detail which Medi-Cal populations currently pay premiums and/or copayments?

3. Should this proposal be included in the final budget, would there still be any Medi-Cal beneficiaries paying premiums and/or copayments?

Staff Recommendation: Hold open to allow for additional review and discussion, and for receipt of the proposals.

ISSUE 12: HEARING AID COVERAGE FOR CHILDREN PROGRAM -- OVERSIGHT

PANEL 12 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 12 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

OVERSIGHT ISSUE

The Hearing Aid Coverage for Children Program (HACCP) was funded in the FY 2020-21 budget and was officially launched by DHCS on July 1, 2021. HACCP is intended to provide access to hearing aids and related services to children living in families up to 600 percent of the federal poverty level who are not eligible for Medi-Cal coverage or California Children's Services (CCS) program.

Stakeholders have raised concerns about the implementation of this program, stating that various barriers to care exist in light of low provider reimbursement rates and other administrative challenges.

BACKGROUND

Stakeholders provided the following information:

- Leading up to the inclusion of HACCP in the state budget, legislation to mandate health plans cover pediatric hearing aids received unanimous bipartisan support.

- Early access to amplification is imperative to speech and language development, especially in very young children, where early amplification prevents significant language delays that can impede development.

- Ninety percent of children with private health insurance do not have coverage or access for hearing aids and related services, which is the gap HACCP was intended to close.

- Since the launch of the HACCP many stakeholder organizations have supported DHCS by providing and coordinating constructive feedback and suggestions, conducting additional research, and gathering experiences from families and providers to help inform the policies and operational decisions of HACCP.

- Policy decisions have left access to services and providers out of reach for the children the program is intended to serve.

- The biggest issue parents are facing is they are unable to find a pediatric provider in their county participating in the program. Top pediatric programs/centers of excellence, like UC Davis, USC Caruso Center for Childhood Communication, UCLA, Casa Colina, and Kaiser have not signed on to take the HACCP program to serve deaf and hard of hearing infants and children under the newly created program.

- The determining factors in qualified pediatric providers being slow to sign on is that essential codes specific to pediatrics have not been published (they currently do not exist in Medi-Cal), and that existing Medi-Cal rates for hearing loss do not cover their costs to provide time-intensive appropriate pediatric hearing care.

- Many components of the program have yet to be implemented, such as an online enrollment portal and FAQs for parents.

Stakeholders suggest the following to improve the quality of, and access to, HACCP:

- Extend HACCP eligibility to allow families with only partial coverage of hearing aids and high-deductible health plans to participate in HACCP to avoid one subset of deaf and hard of hearing children being excluded from hearing services.

- Build out pediatric audiology reimbursement rates for HACCP & Medi-Cal to align with CCS rate levels to consistently reimburse for the extensive professional time and resources needed to support infants and children to ensure equitable access to providers.

- Require DHCS to provide due process protections (appeal and hearing rights) for HACCP enrollees that align with Medi-Cal consumer protections.

- Apply the Medi-Cal and CCS standards for timely access of services (presumptive coverage during application review) to avoid delay in children receiving hearing aids and language access standards to HACCP to ensure access to providers.

- Require DHCS to hire a pediatric audiologist to serve as a technical expert to meaningfully consult on in the development and management of HACCP policies and to oversee and review appeals.

- Codify the Hearing Aid Coverage for Children Program (HACCP) into state statute.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of this program and any challenges associated with its implementation, and respond to the concerns, allegations, and questions (below) raised by stakeholders:

1. How many children have received services through this program? Stakeholders report that only two children of the 40 approved, out of an estimated 7,000 children, have benefited from services since this program was launched in July 2021. Is this accurate?

2. When will the pediatric codes be published and available for providers to bill for services rendered?

3. For what reasons has DHCS not based HACCP provider networks, billing and reimbursement on the CCS program that has enrolled and retained providers specialized in treating children with hearing needs?

4. What is DHCS's plan to increase child enrollment and participation of qualified providers in HACCP and support timely access to appropriate pediatric care?

5. What is the scope of work DHCS has outlined for its vendor MAXIMUS to administer this program? What are the specific deadlines for these program components to be put in place? Is the state getting good value in spending $5.6 million to administer a $10 million program (as proposed by the Governor's budget)?

Staff Recommendation: Hold open to allow for additional review and discussion about potential solutions and improvements to this program.

ISSUE 13: INDIAN HEALTH PROGRAM GRANT RESTORATION BUDGET CHANGE PROPOSAL

PANEL 13 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 13 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

DHCS requests one-year limited-term (LT) resources equivalent to 3.0 positions and expenditure authority of $12,000,000 (General Fund (GF)) in fiscal year 2022-23. The requested funding is needed to restore local assistance grant funding in the Indian Health Program (IHP). The funds would be distributed to 45 Tribal and urban Indian health clinic corporations via a competitive grant program in accordance with a "need" and "performance" driven formula, as required by current law.

BACKGROUND

The State IHP was established in 1975, and is responsible for conducting studies, providing technical and financial assistance, staffing the mandated American Indian Policy Advisory Panel, and coordinating with other similar agencies. The IHP distributed local assistance grant funding annually starting in 1975-1976, until the IHP GF local assistance allocation of $6.46 million was eliminated in the FY 2009-2010 State budget. Prior to the elimination, funding from the IHP was allocated per a formula as required in regulation. Funds supported clinic infrastructure (i.e. provider salaries, operational costs, training, etc.) and two regional Traditional Health programs.

DHCS explains that significant health disparities for American Indians indicate the need to provide infrastructure support to Indian health programs. Recent data shows that American Indians continue to experience lower life expectancy and disproportionate

disease burden. In fact, the health status of California Indians is recognized as one of the lowest of any ethnic group in the state with higher prevalence of preterm births, suicide, substance use disorders, drug-induced death due, diabetes, and other chronic diseases than that of the general population.

STAFF COMMENTS/QUESTIONS

The information provided by DHCS in the paragraph above provides more than sufficient justification for the state to make a serious commitment (financially and otherwise) to improving the health and wellbeing of Tribal populations and communities in the state. The Subcommittee has received a substantial number of letters providing support for this proposal, but also requesting ongoing funding for this program, consistent with the first 35 years of the program, in place of the proposed one-time funding. Given the current heightened awareness of health equity and racial justice issues, restoring on-going funding, rather than one-time, would be the least the state can and should do.

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

1. What is the justification for proposing one-time, rather than ongoing, funding for this program?

2. What other programs or efforts is the state supporting to address health disparities among Tribal communities?

Staff Recommendation: Hold open until the Subcommittee takes final actions later in the spring, and urge support for an expanded version of this proposal with ongoing funding of some amount more than $12 million annually (should sufficient state resources exist).

ISSUE 14: TRANSFORMING QUALITY OUTCOMES AND HEALTH EQUITY IN MEDI-CAL BUDGET CHANGE PROPOSAL

PANEL 14 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 14 – Q&A ONLY

- **Palav Babaria**, Chief Quality Officer & Deputy Director, Quality and Population Health Management, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

DHCS, Quality and Population Health Management (QPHM), requests 19.0 permanent positions and expenditure authority of $4,689,000 ($2,345,000 General Fund (GF); $2,344,000 Federal Fund (FF)) in fiscal year (FY) 2022-23 and $4,463,000 ($2,232,000 GF; $2,231,000 FF) in FY 2023-24 and $4,083,000 ($2,042,000 GF; $2,041,000 FF) in FY 2024-25 through FY 2026-27 and $3,083,000 ($1,542,000 GF; $1,541,000 FF) in FY 2027-28 and ongoing to administer and lead quality improvement and health equity efforts for the Medi-Cal program.

BACKGROUND

In order to meet DHCS's goals of improving health care quality and health equity, DHCS proposes additional positions to lead quality and health equity work, to specifically improve quality and equity in the behavioral health, fee-for-service, and long term services and supports delivery systems, and to conduct data-driven program evaluation.

One of the challenges in improving quality and equity within Medi-Cal has been a lack of organizational structure and staff within DHCS to lead quality improvement and health equity efforts across programs. DHCS has recognized this gap and taken steps to address it by hiring a new Deputy Director of Quality and Population Health

Management/Chief Quality Officer (CQO) and initiating a reorganization of existing workload and staff focused on quality, health equity, and population health management throughout the organization, bringing them together under the new CQO.

However, in systematically examining federal requirements of DHCS around quality, current data on quality and health equity in Medi-Cal, and current program efforts as part of this reorganization, DHCS has identified numerous gaps, including program areas such as behavioral health, fee for service, and long term services and supports (LTSS) with little to no quality or health equity infrastructure. CMS has a clear interest in establishing measures and Medi-Cal currently has no such outcome-based clinical quality measures at all.

DHCS has never developed a comprehensive approach to facilitate program evaluation at DHCS. Such an approach would utilize internally-generated data and dashboards to assess program efficacy, often in collaboration with contracted external evaluators, and then use this analysis to focus quality improvement activities and program improvement. The comprehensive approach is intended to have a more coordinated set of metrics and quality improvement processes for providers and plans to work towards improving quality and equity to avoid different DHCS programs emphasizing different quality improvement metrics.

The QPHM program also aims to strengthen monitoring and compliance efforts to verify that all failures to meet standards are appropriately addressed. For example, within managed care, due to limited staffing and bandwidth, staff are not always able to follow up on every deficiency or plan which fails to meet minimum performance levels. In the current year, plans failed to meet minimum performance levels on more than 40 percent of measures, but given the high number of measures, an aggregated approach was used where only multiple deficiencies required a corrective action plan and possibly sanctions.

DHCS states that achieving its goal of transforming quality outcomes and health equity will require additional staff and contract resources to create a culture and program of data driven improvements that address the whole person, eliminate racial disparities through community-centered collaboration, and verify transparency and accountability of the Medi-Cal program.

STAFF COMMENTS/QUESTIONS

The Subcommittee request DHCS present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional review and discussion.

ISSUE 15: DHCS BUDGET CHANGE PROPOSALS:

- **FURTHER STRENGTHEN FISCAL FUNCTIONS AND OUTCOMES**
- **MEDI-CAL ENTERPRISE SYSTEMS MODERNIZATION: FEDERAL DRAW AND REPORTING – OPERATIONS**
- **INCREASED PROGRAM WORKLOAD**

PANEL 15 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 15 – Q&A ONLY

- **Lori Walker**, Chief Financial Officer, Deputy Director of Fiscal, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSALS

This issue covers the following three DHCS budget change proposals:

Further Strengthen Fiscal Functions and Outcomes BCP

DHCS requests 10.0 permanent positions, two-year limited-term (LT) resources equivalent to 5.0 positions, and expenditure authority of $2,362,000 ($1,181,000 General Fund (GF); $1,181,000 Federal Fund (FF)) in FY 2022-23, $2,227,000 ($1,114,000 GF; $1,113,000 FF) in FY 2023-24 and, $1,485,000 ($743,000 GF; $742,000 FF) in FY 2024-25 and ongoing to build upon the FY 2019-20 BCP relating to efforts to strengthen fiscal estimates and cash flow monitoring and to provide resources for increasing and complex workloads.

The 2019 Budget Act provided $3,587,000 ($1,706,000 GF) and 25.0 permanent positions on an ongoing basis related to efforts to strengthen fiscal estimates and cash flow monitoring. DHCS has delivered the following outcomes to date:

- Hired a deputy director-level Chief Financial Officer to oversee and coordinate accounting, budgets, and fiscal forecasting operations.
- Combined FMD and the FFD to create the Fiscal program.
- Reorganized the Accounting Section and Budget Branch under a newly-constituted FMD.
- Convened the first of several fiscal stakeholder workgroup meetings in August 2019.
- Established and fully staffed the Cash Management Section within FFD.
- Reorganized within FFD the BEB—which previously had responsibility for base projections and requesting federal funds based on the Medi-Cal Estimate and the newly-created cash management function—into two branches: the BEB and the RMB.
- Filled positions in FFD related to estimate enhancement.
- Introduced a number of initial enhancements to improve transparency and usability of the Medi-Cal Estimate.
- The Cash Flow Reporting Unit (CFRU) was created within the accounting section and is responsible for the accounting functions related to monitoring, tracking, and managing DHCS' cash flow.

Based on feedback from the external stakeholder workgroup, DHCS is pursuing a number of additional enhancements to the Medi-Cal Estimate, including updates to simplify aid categories used for developing projections, restructuring the Medi-Cal Estimate document to consolidate summary displays, and upgrading the Enhanced Medi-Cal Budget Estimate Redesign (EMBER)—the system FFD uses to develop the estimate—to make it more flexible and adaptable to a rapidly-changing program.

Medi-Cal Enterprise Systems Modernization Federal Draw and Reporting – Operations BCP

DHCS), Medi-Cal Enterprise Systems Modernization Division (MESMD), requests two-year limited term (LT) contract expenditure authority of $4,579,000 ($2,290,000 General Fund (GF); $2,289,000 Federal Fund (FF)) in fiscal year (FY) 202223 and $4,579,000 ($1,145,000 GF; $3,434,000 FF) in FY 2023-24 to support the Federal Draw and Reporting (FDR) system operations as part of its Medi-Cal Enterprise Systems (MES) Modernization. Funding request reflects 75/25 enhanced federal financial participation upon federal certification of system in FY 2022-23.

DHCS partners with counties to enroll Medi-Cal beneficiaries and works with other state departments on related programs for vulnerable Californians such as CalWORKs, CalFresh, Covered California, and In-Home Supportive Services. DHCS and its partners use myriad, often patchwork and outdated systems to administer more than $125 billion

annually to deliver vital health care services to about 14 million or one in three Californians in Medi-Cal.

FDR project has previously received funding through budget augmentations: 4260-501-BCP2017-MR, 4260-406-BCP-2018-MR, 4260-193-BCP-2020-MR, and 4260-052-BCP-2021-GB. The positions and expenditure authority approved in the prior budget change proposals (BCP) support the FDR project.

- 2017 Budget: approved 7.0 permanent positions and funding for consultants and hardware, software and hosting services for California Medicaid Management Information System (CA-MMIS) modernization efforts. The requested expenditure authority for FY 2017-18 and ongoing was $5,754,000 ($575,000 GF; $5,179,000 FF).

- 2018 Budget: approved 17.0 permanent positions for FY 2018-19, 2.0 limited term (LT) funded positions and multiyear funding for consultants and hardware, software and hosting services. 8.0 permanent positions were also approved to begin in FY 2019-20. Per 4260-406-BCP-2018-MR, $4,000,000 for FDR Project is available in FY 2020-21.

    - Additionally, provisional language that may augment the amount appropriated up to a maximum of $52,980,000, contingent on lessons learned or completion of milestones related to CA-MMIS modernization modules.

- 2020 Budget: approved funding for the FDR project. The requested expenditure authority for FY 2020-21 was $11,152,000 ($1,115,000 GF; $10,037,000 FF).

- 2021 Budget: approved funding for the FDR project. The request was for LT expenditure authority for FDR project of $11,800,000 ($1,180,000 GF; $10,620,000 FF) in FY 2021-22.

Increased Program Workload BCP

DHCS) requests 31.5 permanent positions, 4.0 limited-term (LT) resources to permanent positions, and expenditure authority of $5,608,000 ($2,521,000 General Fund (GF); $2,783,000 Federal Fund (FF); $304,000 Reimbursement Fund (RF)) in fiscal year (FY) 2022-23 and $5,320,000 ($2,390,000 GF; $2,644,000 FF; $286,000 RF) in FY 2023-24 ongoing to address increased workloads in the following areas:

- Benefits Division
- Local Governmental Financing Division (Behavioral Health Financing Branch)
- Medi-Cal Dental Services Division
- Administration

Benefits Division (BD)

The BD is responsible for setting policy and covered services for health care services for the Medi-Cal program. BD works closely with the federal Centers for Medicare & Medicaid Services (CMS) to enable DHCS to provide eligible Californians with access to affordable, integrated, high-quality health care. BD also manages the uniform application of federal and state laws and regulations regarding Medi-Cal covered services and policies affecting fee-for-service and managed care beneficiaries as well as more than 240,000 providers. BD adds, limits, modifies, or eliminates services to increase patient safety, improve outcomes, reduce risks, and/or reduce cost of care. Recent additions to the BD's workload include:

- Telehealth policies prior to and during the COVID-19 Public Health Emergency (PHE) as well as in a post-PHE environment.
- Benefit policies for new provider types including doulas and Community Health Workers, and associated services.
- Addition of Dyadic/Family Therapy benefit.
- Coverage of Continuous Glucose Monitors.
- Development of COVID-19 Vaccine coverage policy and incentive efforts.
- Updates and clarifications to the non-benefit policy section of the provider manual.
- Increase in developing state-mandated regulations, including regulations for EPSDT services; behavioral health treatment; diabetes prevention program; and nonmedical transportation.
- Updating Interagency Agreements, reviewing expansion of services proposed by sister departments and processing invoices.
- Updating policies for long-term care facilities.
- Review benefit coverage questions in Life Care Plans and requests from the Department of Managed Health Care.
- Increase in the number of State Plan Amendments submitted to the Centers for Medicare and Medicaid services, including nine during a six-month period of 2021.
- Newly-redirected responsibilities for the coordination of policies related to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), previously managed by the former Primary Rural and Indian Health Division (PRIHD).
    - Staff provides assistance related to the implementation of Medi-Cal fiscal and programmatic policies, which require DHCS reimbursement. The recent policy and program initiatives related to telehealth and intersection with new benefits and provider types have increased the FQHC/RHC workload.

Local Governmental Financing Division

In September 2019, DHCS implemented a reorganization of the mental health and substance use disorder services programs. As part of this reorganization, DHCS created the Local Governmental Financing Division, and a new Branch, the Behavioral Health Financing Branch, to administer financing policies and provide support to the three Medi-Cal behavioral health delivery systems (i.e., Specialty Mental Health Services, Drug Medi-

Cal (DMC) State Plan services, and Drug Medi-Cal Organized Delivery System (DMC ODS) services). DHCS moved 20.0 permanent positions to this new branch to support its work of developing new financing policies and processes, as well as implementing existing policies and processes. The division was fully staffed beginning February 2020.

Medi-Cal Dental Services Division (MDSD)

MDSD administers the Medi-Cal dental benefit through two delivery systems: Dental Fee-for-Service (FFS) and dental managed care. The Dental FFS delivery system is supported by both a contracted dental Administrative Services Organization (ASO), Delta Dental of California, and Fiscal Intermediary (FI), Gainwell Technologies LLC. The dental managed care delivery system is supported by six contracted plans, three geographic managed care plans in Sacramento County and three Pre-Paid Health Plans in Los Angeles County. Jointly, FFS and dental managed care contracts approved over seven million claims totaling approximately $180,860,350 in calendar year 2020 for approximately 14 million members.

Administration

Program initiatives such as CalAIM, Quality Population Health Management, and Children and Youth Behavioral Health brought significant resources in the form of additional staff and contract dollars. For these DHCS programs, contract dollars related to the new initiatives have increased the number of high priority contract and procurement requests with short deadlines. In addition, the Contracts Division (CD) is managing an unprecedented number of Enterprise Technology Services contract requests in order to stand these initiatives up. As a result of these initiatives, CD received four analysts positions effective July 1, 2021 through prior BCPs. As DHCS moves forward to fully implement these initiatives to improve health care for Californians, resources are required to support the program resources requested for FY 2022-23.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present these three budget change proposals and respond to any questions raised by Subcommittee members.

Staff Recommendation: Hold open to allow for additional review and discussion.

ISSUE 16: ALIGN MEDI-CAL REDETERMINATIONS WITH FEDERAL GUIDELINES TRAILER BILL

PANEL 16 – PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper,** State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 16 – Q&A ONLY

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

DHCS is proposing trailer bill to align state law with federal guidelines related to the 90-Day Cure Period and processing Medi-Cal Change in Circumstance redeterminations.

BACKGROUND

County eligibility workers perform an annual renewal, which is a full eligibility redetermination that is conducted at least once every 12 months to redetermine eligibility for Medi-Cal beneficiaries. The annual renewal due month is generally set 12 months from the application month. However, if the applicant is not Medi-Cal eligible in the month of application, then the annual renewal is set 12 months from the first month in which the applicant meets all eligibility criteria. Counties must also conduct a change in circumstance redetermination between regular annual renewal redeterminations anytime there is a change in a beneficiary's circumstances that may affect eligibility, such as a new job or if a beneficiary gets married.

State law and federal guidelines for Medi-Cal redetermination processing are misaligned in two areas: the *90-day Cure Period* and *Change in Circumstance*. This conflict may lead to the potential loss of federal financial participation (FFP) and more burdensome processes for beneficiaries and county eligibility workers.

90-Day Cure Period

Beneficiaries who are discontinued from Medi-Cal as a result of not providing required information are given 90 days to submit their required information without needing to reapply for Medi-Cal. This is referred to as the 90-day Cure Period.

State law requires that if a discontinued beneficiary provides the necessary information during the 90-Day Cure Period and continues to be eligible for Medi-Cal, the beneficiary's eligibility can be reinstated back to the date of discontinuance and the annual renewal date remains the same. For example, a beneficiary discontinued at the end of their October 2021 annual renewal month (October 31, 2021), who provided the required information in January 2022 and is still eligible for Medi-Cal, would have eligibility reinstated with no break back to October 31, 2021, and the annual renewal due month would remain October, with the next annual renewal due October 2022.

However, on December 4, 2020, the Centers for Medicare and Medicaid Services (CMS) released an Informational Bulletin that clarifies that discontinued beneficiaries who return required information during the 90-Day Cure Period must be treated as new applicants, with eligibility only reinstated for any of the previous months if the individual requested retroactive eligibility and is found eligible for the requested months. Additionally, in a follow-up Webinar provided by CMS on January 13, 2020, CMS clarified that the annual renewal date would also be reset based on the new application date. For example, a beneficiary discontinued at the end of their October 2021 renewal month (October 31, 2021) would be sent a notice of action (NOA) with information about the 90-Day Cure Period, and an explanation regarding the ability to apply for retroactive coverage if needed. If the discontinued beneficiary provides the required information in January 2022, they would be treated as a new applicant with eligibility beginning in January 2022 and would have their annual renewal date set to 12 months later, in December 2022. The beneficiary would need to request retroactive coverage for November and December in order to have no break in coverage. However, beneficiaries have up to one year from the month they received services to request retroactive coverage for the retroactive month. Requesting retroactive coverage would not reset the renewal date.

Federal regulations require that an annual renewal redetermination occur "no more frequently" than once every 12 months. As CMS considers information received during the 90-Day Cure Period to be a new application with no automatic retroactive eligibility restoration and a new annual renewal date set for 12 months later, it is possible CMS's future audit of Medi-Cal cases could determine that FFP is unallowable and DHCS must return FFP due to improper retroactive eligibility determinations and annual renewals that occur too frequently. To date, DHCS has not received any audits with these findings. However, now that CMS has clarified their guidance on the 90-Day Cure Period, DHCS would not be able to argue an assumption that automatic reinstatement and keeping the original renewal date was the correct process. Prior to receiving this guidance from CMS, DHCS worked under the assumption that the DHCS policy and the CMS guidance were in alignment.

Change in Circumstance Redetermination Processing

The change in circumstance redetermination is an eligibility review that is conducted when a county receives information about a change in a beneficiary's circumstances that may affect eligibility, such as a new job or when a beneficiary gets married. This can occur when the beneficiary reports changes to their county eligibility worker, as is required within 10 days of the change, or when the county receives information about a change from other sources such as electronic databases or other public social services programs. Existing law requires the county to send a form to the beneficiary that is prepopulated with existing information obtained after the ex parte review process and that the beneficiary must sign under penalty of perjury. Federal regulation does not require a prepopulated form or the beneficiary to sign under penalty of perjury. As a result, the processes for Change in Circumstance in state law are far more restrictive and burdensome for beneficiaries and county eligibility workers and are not required by federal regulation.

Due to other priority assignments related to the Affordable Care Act (ACA) and higher priority forms and systems that needed to be implemented, DHCS never updated the change in circumstance form to be pre-populated or require a signature. Counties currently use the "Medi-Cal Request for Information" form (also known as MC 355) to request necessary information, which is not pre-populated and does not include a signature requirement. The current process, which is in alignment with the federal regulation, has been in place for years and is a proven and effective method for collecting such information.

During a change in circumstance redetermination, counties may only request information related to the specific change in circumstances that is reported. For example, if a beneficiary reports a change in income and the county is unable to verify the new income information electronically, the county may only ask the beneficiary for the income verification and may not ask for any additional information or verification. Sending a form to the beneficiary clearly requesting only the income verification is a simple and clear way to request the required information. Sending a form with pre-populated information for a change in circumstance redetermination would add a layer of complexity. Requiring the beneficiary to review the prepopulated information, agree to or update it before signing the form under penalty of perjury, and return the form to the county creates an extra burden for the beneficiary without adding any value as the county only needs the beneficiary's income verification.

In addition to repealing the provisions in law that do not comply with federal regulations, conforming changes in state statute will remove a duplicative statement regarding when to discontinue a beneficiary when there is no response to the change in circumstance form.

Aligning the state statute with federal guidelines eliminates potential loss of FFP, lessens administrative burdens and requirements for county eligibility workers, and ensures the integrity and accountability of DHCS' policy requirements. Updating the state statute will also align the current application and 90-Day Cure Period processes to ensure consistent policy and equal treatment of individuals requesting Medi-Cal coverage. Additionally, updating the state statute will allow the continuation of current Change in Circumstances business processes and eliminate the complexity and workload burden that the statutorily required process, including a prepopulated and signed form, would create for beneficiaries and county eligibility workers.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposed trailer bill and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional review and discussion.