

AGENDA**ASSEMBLY BUDGET SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES****ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR****MONDAY, MARCH 27, 2017****1:30 P.M. - STATE CAPITOL ROOM 437**

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LIST OF PANELISTS IN ORDER OF PRESENTATION**4260 DEPARTMENT OF HEALTH CARE SERVICES****ISSUE 1: SKILLED NURSING FACILITIES' NURSE STAFFING RATIOS STAKEHOLDER PROPOSAL****PANEL**

- **Samantha Contreras**, Legislative Advocate, SEIU Local 2015
- **Nora Garcia**, Member, SEIU Local 2015
- **Jennifer Snyder**, Lobbyist, California Association of Health Facilities
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment**ISSUE 2: PALLIATIVE CARE PROGRAM DELAY****PANELISTS**

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment**ISSUE 3: CHILD HEALTH AND DISABILITY STATE-ONLY PROGRAM ESTIMATE AND SUNSET TRAILER BILL****PANELISTS**

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 4: EVERY WOMAN COUNTS PROGRAM ESTIMATE AND ACCRUAL TO CASH BUDGET TRAILER BILL**PANELISTS**

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment**ISSUE 5: CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM ESTIMATE AND DELAY OF WHOLE CHILD MODEL****PANELISTS**

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment**ISSUE 6: GENETICALLY HANDICAPPED PERSONS PROGRAM ESTIMATE****PANELISTS**

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment**ISSUE 7: NEWBORN HEARING SCREENING PROGRAM OVERSIGHT****PANELISTS**

- **Jennifer Kent**, Director, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: SKILLED NURSING FACILITIES' NURSE STAFFING RATIOS STAKEHOLDER PROPOSAL

PANELISTS

- **Samantha Contreras**, Legislative Advocate, SEIU Local 2015
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- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

At a cost of approximately \$35.1 million General Fund in 2017-18, and \$141.2 million General Fund with full implementation in three years, SEIU proposes to increase the minimum number of required nursing hours per patient in a skilled nursing facility from 3.2 hours to 4.1 hours incrementally beginning on January 1, 2018, with full implementation on January 1, 2020. The proposal specifies that within the required minimum of 4.1 nursing hours when fully implemented, SNFs would be required to have a minimum of 2.8 hours per patient day for certified nursing assistants, and 1.3 hours per patient day for licensed nurses.

This proposal is very similar to AB 2079 (Calderon, 2016) for which the Department of Finance provided the following fiscal analysis:

- 2018-19: \$51.6 million total funds (\$25.8 million General Fund)
- 2019-20: \$198.9 million total funds (\$99.5 million General Fund)
- 2020-21: \$301.2 million total funds (\$150.6 million General Fund)
- 2021-22: \$312.0 million total funds (\$156 million General Fund)

BACKGROUND

Skilled Nursing Facility (SNF) funding. AB 1629 (Frommer, Chapter 875, Statutes of 2004), enacted the Medi-Cal Long Term Care Reimbursement Act of 2004, which established a reimbursement system that bases Medi-Cal reimbursements to SNFs on the actual cost of care. Prior to AB 1629, SNFs were paid a flat rate per Medi-Cal resident. This flat rate system provided no incentive for quality care and reimbursed SNFs for less than it cost to care for their residents. AB 1629 also allowed the state to leverage new federal Medicaid dollars by imposing a quality assurance fee (QAF) on SNFs. This new federal funding is used to increase nursing-home reimbursement rates. (Federal Medicaid law allows states to impose such fees on certain health-care service providers and in turn repay the providers through increased reimbursements. Because the costs of Medicaid reimbursements to health care providers are split between states and the federal government, this arrangement provides a method by which states can leverage additional federal funds for the support of their Medicaid programs and offset state costs.) AB 1629 contained a sunset date of July 1, 2008 and has been extended six times, and is currently scheduled to sunset on July 31, 2020. SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, established the Quality and Accountability Supplemental Payment (QASP) program. Under the QASP program, SNFs that meet minimum staffing standards can earn incentive payouts from a pool of supplemental funds. The payouts are awarded based on SNFs' performance on certain quality measures (including clinical indicators), as well as SNFs' improvement on these measures relative to the previous year. Under SB 853, a portion of each year's weighted average rate increase is to be set aside to fund the QASP payment pool. The set-aside amount was \$43 million in 2013-14, and \$90 million in the 2014-15 rate year. In 2013-14, about 477 out of 1,000 SNFs earned the QASP payouts. SB 853 is also scheduled to sunset on July 31, 2020.

Federal CMS Report. In December 2001, CMS released a congressionally-mandated report entitled, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes" (report). SEIU points to this report to support the increase staffing requirements included in this proposal. Congress requested this report to determine if there was an appropriate ratio of nursing staff to residents. The report analyzed data from 10 states with more than 5,000 facilities, and identified staffing thresholds that maximize quality outcome. These thresholds vary by nursing home category and whether the quality outcomes are related to the short stay or long stay nursing home population. The report states that for each quality measure, there was a pattern of incremental benefits of increased staffing until a threshold was reached, at which point there were no further significant benefits with respect to quality when additional staff were utilized. These thresholds for CNAs occurred at 2.4 hours per resident day for the short-stay quality measure, and 2.8 hours per resident day for the long-stay quality measures. For licensed staff (LVNs, registered nurses, etc.), the thresholds were 1.15 hours per resident day for short-stay measures, and 1.3 hours per resident day for the long-stay quality measures.

Purpose of Proposal. According to SEIU, this proposal would raise the minimum number of direct care service hours, transforming the care and environment in nursing homes to provide a more patient centered level of care. Currently, SNFs are required to provide a minimum of 3.2 nursing hours per patient day – which includes certified nursing assistants, licensed vocational nurses, and registered nurses. However, SEIU states that this standard has not been evaluated in over a decade. Providing person-centered care in SNFs requires time, and when rushed, a resident’s quality of life and health suffer. Most importantly, this proposal would establish a minimum number of hours of care provided by CNAs. SEIU explains that CNAs are the primary providers serving the needs of seniors and people with disabilities in SNFs and this staffing ratio increase is necessary to meet the needs of seniors, persons with disabilities, and people recovering from illness and injury.

SEIU states that a recent analysis found that long-term care facilities are more segregated than the general state population. The analysis found that facilities in which the population is a majority non-white population, the residents are more likely to experience worse outcomes in terms of staffing and deficiencies in quality of care. Finally, SEIU explains that insufficient staffing ratios put workers at risk as well. Nurses are required to provide assistance with resident movement, including lifting and turning, and with an increase in the number of patients with psychiatric conditions, these activities can threaten a nurse’s safety in the absence of sufficient staff.

The proposal includes the following time-line:

- Commencing January 1, 2018, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state hospital, shall have a minimum number of direct care service hours of 3.5 per patient day, with 2.4 hours per patient day for certified nursing assistants (CNAs) and 1.1 hours per patient day for licensed nurses, except as set forth in Section 1276.9.
- Commencing January 1, 2019, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state hospital, shall have a minimum number of direct care service hours of 3.8 per patient day, with 2.6 hours per patient day for CNAs and 1.2 hours per patient day for licensed nurses, except as set forth in Section 1276.9.
- Commencing January 1, 2020, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state hospital, shall have a minimum number of direct care service hours of 4.1 per patient day, with 2.8 hours per patient day for CNAs and 1.3 hours per patient day for licensed nurses, except as set forth in Section 1276.9.

3-Year Implementation	2018	2019	2020
CNA Hours Per Resident Day (HPRD):	2.4	2.6	2.8
Licensed HPRD:	1.1	1.2	1.3
Total HPRD:	3.5	3.8	4.1
State Share:	\$35,149,721	\$80,147,905	\$141,208,329

Concerns with Proposal. The California Association of Health Facilities (CAHF), which represents SNFs, has shared the following concerns with the proposal with the Subcommittee:

1. *Increased Cost to SNFs.* According to CAHF, despite AB 1629, SNFs still are paid below cost (though closer) and therefore cannot absorb additional losses that would result from substantial increased staffing costs, especially in light of impending minimum wage increases. They also point out the challenge in adding substantial costs to the Medi-Cal program given the very uncertain future of the federal Medicaid program and federal funding at this point in time.
2. *Workforce Shortage.* CAHF states that AB 2079 would have required SNFs to employ an additional 10,300 CNA (once fully implemented) despite the hiring challenges SNFs already face today. CAHF is concerned about the liability for SNFs that cannot meet the new staffing mandate, and the possibility that SNFs might reduce their number of beds in response, thereby increasing the shortage of overall SNF capacity in the state.
3. *Lack of Evidence for an Increase in Care Quality Resulting from Increasing Staffing Ratios.* CAHF points out that there has never been a Federal Recommendation for a 4.1 minimum staffing ratio. CAHF states that the report was never adopted by CMS because "there was no empirical data to support quality outcomes for the blanket increase to 4.1 NHPPD or shift ratios." CAHF shared the following statement by CMS within their newly adopted Rules of Participation:

"We do not discount the relationship between staffing levels and quality. We disagree that this requires that we set minimum staffing ratios and that we know what that minimum staffing ratio should be. As discussed previously, we believe that there are concerns about utilizing a minimum staffing standard and we do not necessarily find that the 4.1 hours per resident day (hrpd) is the right standard for every facility. LTC facilities are varied in their structure and in their resident populations. Some facilities are Medicare-only SNFs that focus on short term rehabilitation services. Others are primarily Medicaid facilities that include primarily long-stay residents. Many are both. Some facilities specialize in dementia care. Some facilities have pediatric residents, young adult residents, or ventilator dependent residents. The care needs of each of these populations are different. Facilities range in size from the very small to the very large. The capabilities of these facilities are likely to be different. As noted above, we discuss our concerns with establishing a minimum staffing ratio in prior responses. As stated in the proposed rule, our intent is to require facilities to make thoughtful, informed staffing plans and decisions that are focused on meeting resident needs, including maintaining or improving resident function and quality of life."

Support for Proposal

The Subcommittee has received letters of support for this proposal from all of the following: Central Coast Alliance for Sustainable Economy (CAUSE); Democratic Party of Sacramento County; Jericho for Justice; California Partnership; Mi Familia Vota; 24/7 Miracle Center of Fresno; North Bay Jobs with Justice; Northern California and Northern Nevada Chapter of the Alzheimer's Association; Organize Sacramento; Sacramento Central Labor Council AFL-CIO; Inland Empire Immigration Coalition; Tri-County Central Labor Council (Ventura, Santa Barbara, Santa Maria, San Luis Obispo); Iglesia de Cristo; April Angel Youth Foundation; and Quality Tax Services.

STAFF COMMENTS/QUESTIONS

Subcommittee staff requests SEIU to present this proposal, requests CAHF to share their concerns with the proposal, and requests DHCS to provide reactions to this proposal.

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

ISSUE 2: PALLIATIVE CARE PROGRAM DELAY**PANELISTS**

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment**PROPOSAL**

Within the January budget, DHCS announced its intention to delay the start of the adult palliative care policies adopted through SB 1004 (Hernández, Chapter 574, Statutes of 2014) from July 1, 2017 to July 1, 2018. DHCS has administrative authority to delay implementation without additional legislative approval. This delay is expected to result in savings of \$2 million total funds (\$1 million General Fund).

BACKGROUND

SB 1004 requires DHCS to consult with interested stakeholders to establish standards and provide technical assistance for Medi-Cal managed plans to ensure delivery of palliative care services in a manner that is cost neutral on the General Fund. The bill requires covered services to include those that are available through the Medi-Cal hospice benefit including:

- Hospice services that are provided at the same time that curative treatment is available, to the extent that the services are not duplicative.
- Hospice services provided to individuals whose conditions may result in death, regardless of the estimated length of the individual's remaining period of life.
- Any other services that DHCS determines to be appropriate.

The bill requires DHCS, in consultation with interested stakeholders, to establish guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services.

According to the bill's author, as noted in the California State Health Care Innovation Plan (SHIP), an abundance of recent evidence suggests that an expansion of patient and family centered palliative care has the potential to change health outcomes for many Californians, while reducing costs associated with inpatient care. Palliative care is designed to better address patient preferences for patients facing advanced illness. California has already demonstrated success in Medi-Cal with pediatric palliative care where a preliminary analysis indicates that:

- The program improves quality of life for the child and family;
- Average days in the hospital fell by one-third; and
- Shifting care from the hospital to in-home community based care resulted in cost savings of \$1,677 per child per month on average.

DHCS explains that this planned delay reflects workload challenges at DHCS, primarily given the new federal Managed Care Final Rules that have created a substantial new workload for the Medi-Cal program. DHCS states that, per SB 1004 requirements, more training of providers and planning for the monitoring and oversight of health plans need to occur prior to implementation. All new contractual requirements in managed care require DHCS oversight. For comparison, the similar pediatric policy that has been implemented already primarily affects the California Children's Services (CCS) program which is a fee-for-service program, and therefore does not require managed care oversight. The savings associated with the delay occur due to the delay in workload, whereas the savings expected from the implementation of the policy are long-term in nature, according to DHCS. Finally, DHCS points out that some plans have implemented this on their own, and therefore some Medi-Cal beneficiaries already benefit from this policy.

Estimate

As stated above, the Medi-Cal estimate includes \$2 million in savings associated with the delay of this policy. DHCS provided the following explanation of what this funding is for: "The California HealthCare Foundation provided grants of up to \$50,000 to each participant in its Payer-Provider partnerships Initiative to start palliative care programs, including the Health Net and Partnership Health Plan palliative care programs. The funding proposed in the Medi-Cal estimate would provide that same amount to each Medi-Cal health plan, for provider network development, data analysis, and other palliative care program development costs."

STAFF COMMENTS/QUESTIONS

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

1. Roughly, what percentage of Medi-Cal beneficiaries are covered by managed care plans that have implemented this policy already?
2. Is DHCS willing to commit to not delaying the implementation beyond July 1, 2018?
3. What additional resources would DHCS need to be able to implement this July 1, 2017?

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

ISSUE 3: CHILD HEALTH AND DISABILITY STATE-ONLY PROGRAM ESTIMATE AND SUNSET TRAILER BILL**PANELISTS**

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment**PROPOSAL**

This issue covers the Child Health and Disability State-Only Program (CHDP) estimate and proposed trailer bill to eliminate the program.

Estimate:

Since the January Budget proposes to eliminate the CHDP state-only (non-Medi-Cal, state-only funding) program, the estimate includes just \$1,000, reduced from a proposed current year budget of \$32,000. Such a small budget represents the declining need and caseload in this program reflecting nearly 100 percent health insurance coverage for children in California. DHCS states that between July 2016 and February 2017, the state received 35 CHDP claims for services and that those 35 children are now enrolled in Medi-Cal. They also report that the state has received 0 claims in the past month.

Trailer Bill:

DHCS proposes to repeal the statutory provisions for eligibility for the state-only CHDP program. Caseload and expenditures have been close to eliminated as a result of the expansion of eligibility for full-scope Medi-Cal services to individuals under the age of 19, regardless of immigration status, that began in May 2016, pursuant to the provisions of SB 75 (Committee on Budget and Fiscal Review, Chapter 18, Statutes of 2015). All children who only had emergency Medi-Cal prior to the implementation of SB 75 now have full scope Medi-Cal, including the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. As such, DHCS states that CHDP state-only services are no longer needed as these services are now provided by Medi-Cal under the EPSDT benefit.

BACKGROUND

The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance,

and referral for any needed diagnosis and treatment. The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

In July 2003, the CHDP program began using the "CHDP Gateway," an automated pre-enrollment process for non Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal or formerly the Healthy Families program.

Historically, the CHDP program has provided state funded health assessments and immunizations to low income children and youth. In fiscal year (FY) 2003-04, the CHDP Gateway was implemented which shifted CHDP services costs to Medi-Cal and provided Medi-Cal Administrative funding to local CHDP Programs. The CHDP Gateway is an electronic enrollment system that operates at CHDP provider offices to enable the providers to electronically enroll children and youth in limited duration presumptive eligibility full scope Medi-Cal and encourages families to enroll their children in ongoing Medi-Cal coverage. When the Gateway was implemented, residual state-only CHDP services funding was retained to provide state funded health assessments and immunizations to children and youth with limited scope emergency Medi-Cal (e.g., children and youth with ineligible immigration status).

Currently, all children and youth under 21 years of age who are full scope Medi-Cal beneficiaries receive well child health assessments and immunizations under the EPSDT benefit. The majority of these beneficiaries are enrolled in Medi-Cal managed care health plans and receive capitated EPSDT services from their plan provider network. The residual CHDP Medi-Cal fee-for-service (FFS) population (e.g., foster care beneficiaries and presumptive eligibility beneficiaries) receive those same well-child health assessments and immunizations through Medi-Cal funded FFS CHDP providers. These services and populations would not be affected by this proposal. Prior to the SB 75 expansion of Medi-Cal, CHDP also provided state funded (state-only) health assessments to children/youth under age 19 from families under 200 percent of the federal poverty level (FPL) who had limited scope emergency Medi-Cal. With the implementation of the SB 75 Medi-Cal expansion, the repeal of the eligibility provisions for state-only CHDP services would have no negative impact on or loss of benefits for any child or youth, according to DHCS.

Advocates' Concerns

Children's health advocates oppose the proposed trailer bill and have significant concerns with statutorily eliminating this program. They claim that although 100 percent of low-income children in the state are eligible for Medi-Cal or other coverage, not 100 percent are enrolled for various reasons. Advocates state that approximately 80,000 children remain uninsured, a population of children who may need and benefit from CDHP services. Moreover, advocates are concerned about the near future in light of both the possible repeal of the Affordable Care Act and resulting increased uninsured rates, as well as new U.S. immigration policies and attitudes already having a chilling effect on public programs, leading to disenrollment by some families, at least per

anecdotal information. Generally, advocates argue that this is a highly inappropriate time to make substantial changes to the health care safety net, particularly for children.

STAFF COMMENTS/QUESTIONS

As advocates point out, the future of health care for low-income Americans, including Californians, is very uncertain at best. While it is nothing short of a triumph that California has achieved 100 percent coverage for children, that achievement is perilously fragile at this moment. Sadly, California may need this program in as little as a few months, making this an inappropriate time to statutorily eliminate the program, which if unused, does not incur costs for the state by just having it exist in statute.

The Subcommittee requests DHCS to present the CHDP estimate and proposed trailer bill, and respond to the following:

1. Are there negative impacts to the state of having this program continue to exist in statute even if no children are using its services and no claims are being submitted for reimbursement?
2. Is DHCS certain that this program will not be needed again in the near future?

Staff Recommendation: Subcommittee staff recommends that the Subcommittee deny the proposed trailer bill.

ISSUE 4: EVERY WOMAN COUNTS PROGRAM ESTIMATE AND ACCRUAL TO CASH BUDGET TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

This issue covers the Every Woman Counts (EWC) Program estimate and proposed trailer bill to convert the program's budget from accrual to cash.

Estimate:

The proposed 2017-18 budget includes \$26,936,000 total funds (\$0 General Fund) for EWC, a \$2.8 million (9.5%) decrease from the 2016-17 estimate of \$29,782,000 (\$1,190,000 General Fund). This significant decrease primarily reflects the proposal to convert the program to a cash budget, which creates a one-time cost shift to the next year. Additionally, the decrease also reflects the on-going decrease in caseload as a result of ACA implementation. It is presumed that much of the EWC caseload has obtained comprehensive coverage through either Covered California or Medi-Cal. Also as a result of this caseload reduction, the costs of the program now can be covered with the other sources of funding, and General Fund is no longer needed. As shown below, most of the funding is tobacco tax revenue.

Every Woman Counts Estimate			
Funding	2016-17 Estimate	2017-18 Proposed	CY to BY Change
General Fund	\$1,190,000	\$0	-\$1,190,000
Proposition 99	\$16,171,000	\$14,515,000	-\$1,656,000
Breast Cancer Control Account	\$7,912,000	\$7,912,000	\$0
Federal (CDC) Funds	\$4,509,000	\$4,509,000	\$0
TOTAL FUNDS	\$29,782,000	\$26,936,000	-\$2,846,000

Trailer Bill:

DHCS proposes to change the Every Woman Counts (EWC) Program budget from an accrual to a cash basis, beginning with services provided in Fiscal Year 2017-18. Additionally, this proposal would reduce the frequency of program reporting requirements from quarterly to biannually.

BACKGROUND

EWC provides breast cancer screening and diagnostic services to California's uninsured and underinsured women age 40 and older whose incomes are at or below 200 percent of the Federal Poverty Level (FPL). Women age 21 and older may receive cervical cancer screening and diagnostic services.

EWC also serves as one of the main gateways for enrollment into the Breast and Cervical Cancer Treatment Program (BCCTP). BCCTP provides cancer treatment and services for eligible California residents diagnosed with breast and/or cervical cancer. BCCTP applicants are required to be screened and enrolled by CDC providers authorized to participate in EWC. State law allows non-EWC providers, such as non-Medi-Cal providers, to diagnose cancer and make referrals to an enrolled EWC provider for the purpose of enrollment into BCCTP. This process is known as a "courtesy enrollment." The individual seeking cancer treatment through BCCTP must provide the pathology/biopsy report to an EWC provider to confirm diagnosis and request enrollment into BCCTP.

EWC also provides outreach and health education services to recruit and improve cancer screening and early cancer detection in underserved populations of African-American, Asian-Pacific Islander, American Indian, older, and rural women. EWC is expected to serve 177,800 women for fiscal year 2016-17.

EWC provides breast and cervical cancer screenings to Californians who do not qualify for Medi-Cal or other comprehensive coverage, and is funded through a combination of tobacco tax revenue, General Fund, and federal Centers for Disease Control (CDC) grant. The CDC grant requires the program to monitor the quality of screening procedures, and therefore the program collects recipient enrollment and outcome data from enrolled primary care providers through a web-based data portal. This recipient data is then reported to CDC biannually and assessed for outcomes to determine if outcomes meet performance indicators, such as the number of women rarely or never screened for cervical cancer and length of time from screening to diagnosis to treatment. EWC was transferred to DHCS from the Department of Public Health in 2012.

EWC covered benefits and categories of service include office visits, screening, diagnostic mammograms, and diagnostic breast procedures, such as ultrasound, fine needle and core biopsy, pap test and HPV co-testing, colposcopy and other cervical cancer diagnostic procedures and case management.

Currently, the EWC Program is funded with a combination of Cigarette and Tobacco Products Surtax Unallocated Fund, Breast Cancer Fund, Centers for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program Grant, and General Fund monies. EWC has been budgeted on an accrual basis since it transitioned from the Department of Public Health in 2012.

The accrual estimates in past fiscal years' data were used only after all services rendered in that fiscal year were paid. Thus, more recent payment data was not incorporated. This proposal would allow DHCS to use the most recent claims data to project expenditures; thereby incorporating recent changes in expenditure trends. This proposal would:

1. Change the budget for EWC to a cash budget effective July 1, 2017;
2. Continue to budget services prior to Fiscal Year 2017-18 on an accrual basis;
3. Make the EWC budget and caseload consistent with all other programs in the Family Health Estimate including California Children's Services and the Genetically Handicapped Persons Program; and
4. Modify EWC Program reporting requirements from quarterly to biannually.

DHCS explains that the budgets for all other "Family Health Programs" as well as for the Medi-Cal program are prepared on a cash budget, and that the EWC Program is the one exception still being done on an accrual basis. DHCS states that making it a cash budget will simplify their work, thereby increasing clarity and efficiencies.

STAFF COMMENTS/QUESTIONS

The Subcommittee request DHCS to present the EWC Program estimate and proposed trailer bill.

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

ISSUE 5: CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM ESTIMATE AND DELAY OF WHOLE CHILD MODEL
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PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Estimate:

Excluding Medi-Cal costs, the proposed 2017-18 CCS budget includes total funds of \$79.3 million (\$73.8 million General Fund), as compared to the current year (2016-17) estimate of \$78.6 million total funds (\$67.8 million General Fund). Caseload is expected to decrease in the state-only CCS program and increase in CCS-Medi-Cal reflecting the Medi-Cal expansion to cover all eligible children regardless of immigration status, adopted through SB 75 (2015 budget trailer bill). I.e., caseload is shifting from non-Medi-Cal CCS to Medi-Cal CCS. The net reduction of \$5.3 million in federal funds reflects a \$6.06 million loss in federal Safety Net Care Pool funding that the state received through the prior 1115 Medicaid Waiver ("Bridge to Reform"), which allowed for the use of certified public expenditures through various state-only programs. This funding is no longer available through the state's new 1115 Medicaid Waiver ("Medi-Cal 2020") and therefore is proposed to be replaced with General Fund.

CCS Budget (Non-Medi-Cal)			
	2016-17 Estimate	2017-18 Proposed	CY to BY Change
Federal Funds	\$10,784,000	\$5,453,000	-\$5,331,000
General Fund	\$67,805,400	\$73,877,200	\$6,071,800
*County Funds	\$78,684,700	\$79,443,700	\$759,000
TOTAL FUNDS	\$78,589,400	\$79,330,200	\$740,800
Non Medi-Cal Caseload	12,803	12,557	-246 (-2%)
Medi-Cal Caseload	174,178	177,396	3,218 (1.8%)

*County Funds are shown here, however the Total is the total in the state budget and therefore does not include county funds.

Whole Child Model Delay:

Through the January budget, DHCS announced a delay in the establishment of the Whole Child Model (WCM) from July 2017 to July 2018. SB 586 (Hernández, Chapter 625, Statutes of 2016) authorizes DHCS, no sooner than July 1, 2017, to establish a WCM for Medi-Cal enrolled children who are also enrolled in CCS in 21 counties served by four COHS plans. DHCS does not need additional legislative authority to delay implementation as they have proposed.

BACKGROUND

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to: chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, and cancer; traumatic injuries; and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

Historically, the CCS program has served children who fit into three categories: 1) children in Medi-Cal; 2) Children in Healthy Families; and 3) "State-only" children who are not eligible for either Healthy Families or Medi-Cal. The Family Health Estimate includes CCS costs only for children who are not in Medi-Cal. The largest category of children in CCS are in Medi-Cal, however these costs are contained separately, in the Medi-Cal estimate. State-only children, who are not eligible for Medi-Cal, qualify for CCS by being in a family for which their estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

The CCS program is administered as a partnership between county health departments and DHCS. For CCS-eligible children in Medi-Cal, their care is paid for with state-federal matching Medicaid funds. The cost of care for CCS-Only children is funded equally between the State and counties. The cost of care for CCS children who had been in the Healthy Families program was, and continues to be, funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds, despite the fact that these children have transitioned into Medi-Cal.

Whole Child Model Delay

SB 586 (Hernández, Chapter 625, Statutes of 2016) authorizes DHCS to establish a Whole Child Model for children enrolled in both Medi-Cal and CCS in 21 counties served by four county organized health systems, instead of the existing arrangement in most counties where CCS services are "carved out" from the Medi-Cal managed care plan. The bill continues the CCS carve out in the remaining 37 counties until January 1, 2022.

The bill authorizes DHCS, no sooner than July 1, 2017, to establish a "Whole Child Model" (WCM) program for Medi-Cal enrolled children who are also enrolled in CCS in 21 counties served by four COHS plans. Those counties are as follows: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo.

This bill contains a number of provisions to ensure the expertise and quality of care in CCS is preserved as part of the transition to the WCM, including requirements for plan readiness, time-limited continuity of care, ensuring CCS benefits are provided according to CCS program standards; requiring Medi-Cal managed care plans to facilitate timely access to services by CCS providers and facilities with clinical expertise in treating the

enrollee's specific CCS condition; requiring DHCS to pay plans participating in the WCM a new actuarially sound rate specifically for CCS children and youth; requiring a "rate floor" for CCS providers; and requiring an independent evaluation that compares CCS services in WCM counties before and after CCS services are carved into the plan, and that compares the WCM counties to other counties where CCS is not carved into the plan.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the CCS state-only program estimate and to explain the reason for the delay in the WCM.

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

ISSUE 6: GENETICALLY HANDICAPPED PERSONS PROGRAM ESTIMATE**PANELISTS**

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment**PROPOSAL**

The proposed 2017-18 Genetically Handicapped Persons Program (GHPP) budget includes total funds of \$160.6 million (\$144.2 million General Fund), compared to the 2016-17 estimate of \$142.6 million (\$106.2 million General Fund). The significant (\$16 million) reduction in rebate fund reflects an accumulation of rebates received in prior years that have been used, while the 2017-18 estimate reflects more recent rebate experience, according to DHCS. The cost increase in the program can be attributed to coverage of the drug Orkambi, as the uptake in use of the drug has been slower than anticipated resulting in lower costs in the current year and higher costs in the budget year.

Genetically Handicapped Persons Program Estimate			
	2016-17 Estimate	2017-18 Proposed	CY to BY Change
General Fund	\$106,186,300	\$144,205,700	\$38,019,400
Federal Funds	\$0	\$0	\$0
Enrollment Fees	\$425,400	\$425,400	\$0
Rebates Special Fund	\$36,000,000	\$16,000,000	-\$16,000,000
TOTAL FUNDS	\$142,611,700	\$160,631,100	\$18,019,400

BACKGROUND

The goal of the GHPP program is to help individuals ages 21 and older with an eligible inherited condition achieve the highest level of health and functioning through early identification and enrollment into GHPP, prevention and treatment services from highly-skilled Special Care Center teams, and ongoing care in the home community provided by qualified physicians and other health team members. Hemophilia was the first medical condition covered by the GHPP and legislation over the years have added other medical conditions including Cystic Fibrosis, Sickle Cell Disease, Phenylketonuria, and Huntington's disease. The last genetic condition added to the GHPP was Von Hippel-Lindau Disease.

Unlike other programs, GHPP covers services even when they are not directly related to the treatment of the GHPP eligible medical condition; the approval of these services is subject to individual review based on medical need. There is no income limit for GHPP, however, GHPP clients may be required to pay an annual enrollment fee based on the client's adjusted gross income.

The mission of GHPP is to promote high quality, coordinated medical care through case management services through:

- Centralized program administration;
- Case management services;
- Coordination of treatment services with managed care plans;
- Early identification and enrollment into the GHPP for persons with eligible conditions;
- Prevention and treatment services from highly-skilled Special Care Center teams; and,
- Ongoing care in the home community provided by qualified physicians and other health team members.

GHPP			
Average Monthly Caseload			
	2016-17	2017-18	CY to BY Change
GHPP State Only	931	936	5 (0.5%)
GHPP Medi-Cal	974	996	22 (2.3%)
TOTAL	1,905	1,932	27 (1.4%)

Orkambi Benefit

The FDA approved drug, Orkambi, helps people with cystic fibrosis ages 12 and older who have specific defective or missing proteins resulting from mutations in a specific gene and meet the required level of impaired lung function. As referred to above, this benefit has been revised based on a 24-month phase-in, rather than the previously assumed 15-month phase-in, and also now includes a Service Authorization Request requirement.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the GHPP estimate.

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

ISSUE 7: NEWBORN HEARING SCREENING PROGRAM OVERSIGHT**PANEL**

- **Jennifer Kent**, Director, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment**OVERSIGHT ISSUE**

This is an oversight issue in response to stakeholders who have raised concerns about the contract for automation services ending in December 2016, and the potential impacts of losing an automated system on infants and families.

BACKGROUND

As per California State Law, the Newborn Hearing Screening Program (NHSP) provides a hearing screen to all newborns in the State of California. All data related to the screening results are managed by an automated system that was contracted to a California-based vendor (Natus). Any newborn that does not pass the initial screening test is referred to California Hearing Coordination Centers (HCCs) for follow-up and case management.

The NHSP has separate contracts for the automated database system and the Hearing Coordination Centers. Natus has provided the automated system since August, 2009 and the statewide Hearing Coordination Center Services since July, 2015. The State partnered with Natus to create the Infant Data Management Service (IDMS). The HCCs provide technical assistance and consultation to hospitals, parents and community service groups in the implementation and ongoing execution of facility hearing screening programs. The HCCs also track and monitor every infant who needs follow-up to ensure they receive the needed services and referrals.

The IDMS supports the reporting, tracking, monitoring and quality assurance activities of the NHSP. The IDMS provides information and data to effectively plan, establish, monitor, and evaluate the NHSP. This includes screening, follow-up, and the comprehensive system of services of newborns and infants who are deaf or hard-of-hearing and their families.

DHCS has had two contracts with Natus as follows:

- 1) The IDMS program started in August, 2009 and the initial contract expired on June 30, 2014. The department entered into a Non-Competitive Bid (NCB) from July 1, 2014 to November 30, 2014 due to procurement issues. The most recent contract began on December 1, 2014 and expired on November 30, 2016. Within

this contract, The State partnered with Natus to create the IDMS which allowed hospitals to enter NHSP program data for use by the HCC teams in the IDMS.

- 2) The second contract with Natus is to provide the services of the Hearing Coordination Centers for which the contract began July 1, 2015 and has a five-year term, expiring May 31, 2020.

NHSP Timeline - from birth to referral:

- Screening generally occurs within the first few days after birth
- Rescreening occurs within one month after non-pass
- Linked to diagnostic services within three months of birth
- Linked to treatment services within six months of birth

Newborn Hearing Screening Program Estimate		
	2016-17	2017-18
State Funds	\$3,850,000	\$3,850,000
Federal Funds	\$3,850,000	\$3,850,000
TOTAL FUNDS	\$7,700,000	\$7,700,000

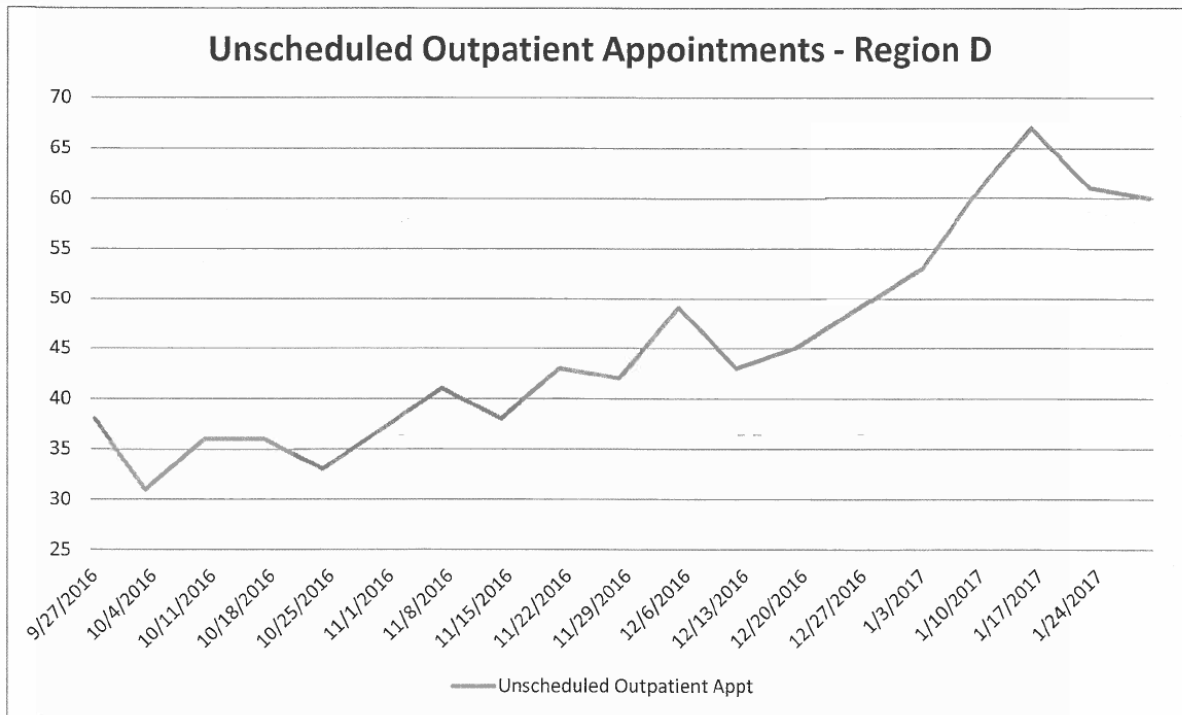
According to DHCS, the Natus contract for IDMS was set to expire in December 2016 and DHCS implemented an RFP process in order to enter into a new contract, either with Natus or another vendor, to continue an automated process for managing the hearing screening test results. DHCS explains that DHCS lawyers found errors in the RFP process thereby nullifying the process and requesting DHCS to re-do the process. In addition to redoing the RFP process, DHCS legal also indicated that the contract needs to be changed from a "service" contract to an "IT" contract. As a result, DHCS has not had an automated system to use for this program since this contract ended on November 30, 2016.

In the absence of an automated system, DHCS reports that hospitals have been submitting the test results (to Natus, under the second contract they have with the state) via paper and fax. DHCS has heard from providers expressing concerns about the certainty of the faxes being received by Natus, as well as legibility issues of the faxes. DHCS asserts that they have not heard complaints about delays in the transmission of screening results or in services being provided to infants who need them. However, based on information received from stakeholders, DHCS held a meeting on February 3 of 2017 where complaints about delays in services being provided were expressed in verbal form; letters were submitted prior to this meeting in written form. In response to the provider concerns, the department has developed a pre-populated form, which can be accessed online and submitted via email, or printed and faxed, in an attempt to address the concerns about the delays in transmission. While this is a pre-populated form, this is not an automated, real-time system like IDMS.

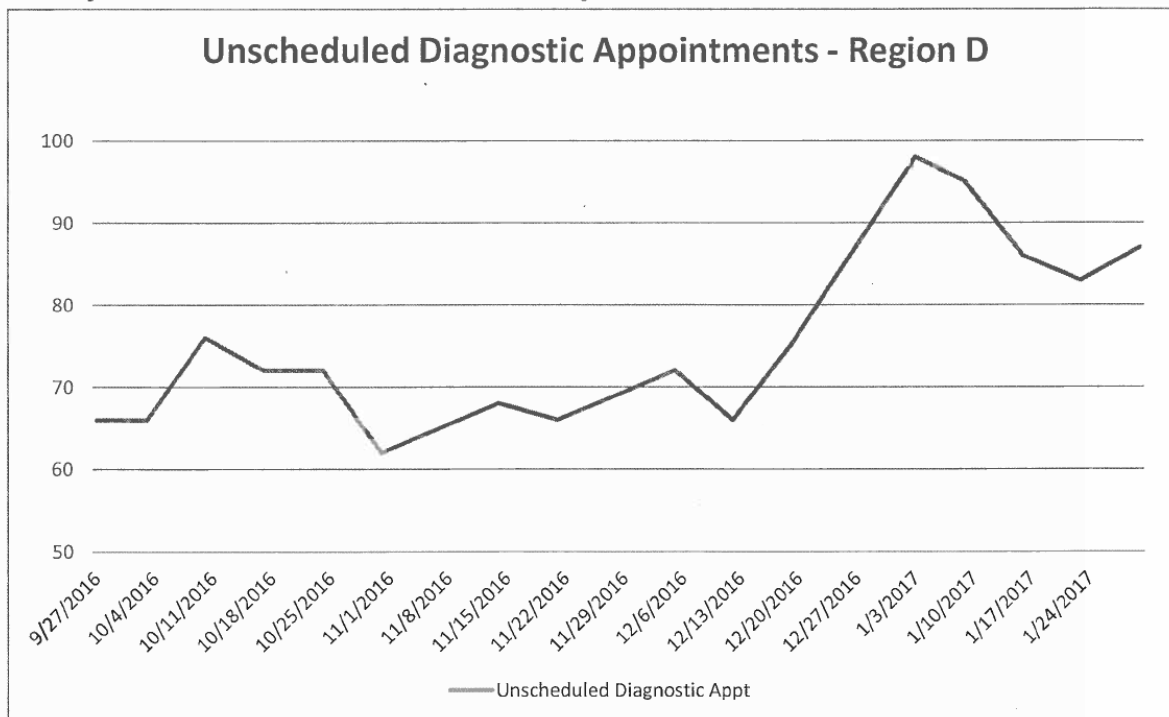
DHCS indicated to Subcommittee staff that they are planning to implement a new procurement process to enter into an IT contract with a vendor that can provide an automated system, such as IDMS, and expect this process to take up to a year from now.

Natus provided the following data to the Legislature showing a significant increase in "loss to follow-up" for California infants since the IDMS contract ended:

- Babies are being lost once they leave the hospital.
 Outpatient Appointments are not being scheduled



- Babies are not going to diagnostic appointments – they are lost to follow-up



STAFF COMMENTS/QUESTIONS

The NHSP has been a valued public service intervention for newborns across California who may have hearing challenges that could affect their cognitive ability. The consequences to newborns who have been identified with a potential hearing loss and do not receive intervention services, may be significant and life-long, as likely they will never fully recover from this loss of intervention services. It appears that the importance of moving quickly to reinstate the IDMS has not been heard by DHCS.

The Subcommittee requests DHCS to provide an explanation of this program, how it works, its budget and an explanation of what happened with the IDMS contract. Please also respond to the following:

- 1) For what reasons has DHCS discontinued use of the IDMS given its strong performance as recognized by the CDC and its ability to achieve a high success rate in terms of lowering the numbers of newborn children lost to follow up? In the absence of the IDMS, is it true that the rate of newborns lost to follow up has increased and continues to do so as of December 1, 2016 since the system was shut down?
- 2) Please share with this committee the reason for abandoning IDMS and options available to DHCS to resolve the problems created by discontinuing use of the IDMS. What is the intent of DHCS in terms of a new contract? Will DHCS issue

a noncompetitive bid (NCB) to get the system back up? Will DHCS put out a new RFP?

- 3) The funds for the IDMS contract are in the budget for FY 2016-2017, what is DHCS doing with these funds if there is no IDMS? Have staffing needs increased since there has been a manual system set into place?
- 4) What are the consequences to newborn children who have been identified with a potential hearing loss and do not receive intervention services?
- 5) In the original IDMS RFP from March 2008 DHCS stated that the manual system was "...susceptible to clerical error and does not support all essential functions of the program." What is DHCS's current position in terms of the efficiency in identifying and tracking NHSP statistics by using an automated system vs. a manual system?

Staff Recommendation: Subcommittee staff recommends directing DHCS to provide the Subcommittee with monthly updates on its progress on addressing the problems and changes to this program.
