AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

WEDNESDAY, MAY 16, 2018

3:30 P.M. - STATE CAPITOL, ROOM 437

ITEMS TO BE HEARD

ITEMS TO BE HEARD

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 1: TRIAGE FUNDING REAPPROPRIATIONS

PANEL

- Mental Health Services Oversight and Accountability Commission
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

The Mental Health Services Oversight & Accountability Commission (Commission) requests the reappropriation of $63.7 million of funds unspent in prior years, and the current year, for SB 82 triage grants, as follows:

FY 2013-14: $5,010,508.55
FY 2014-15: $5,903,251.42
FY 2015-16: $913,709.51
FY 2016-17: $19,843,657.79
FY 2017-18: $32,000,000

The Commission presented a request for reappropriation of just the prior-years funds, excluding the funds for 2017-18, at the Subcommittee's hearing on April 9, 2018. This request reflects their original request, expanded to include the $32 million 2017-18 funds.

BACKGROUND

The Investment in Mental Health Wellness Act of 2013 provides counties with funds for crisis programs through a competitive grant process. The Commission awarded the grants in FY 2013-14, however, counties had challenges in hiring triage personnel which resulted in delayed implementation. These challenges were due to hard-to-fill positions, complexity in developing partnerships with other organizations in the community and turnover in staffing. Due to these delays, counties were not able to spend all of the funds they received during the term of their grants, resulting in unspent funds that were returned to the Commission in 2018.

In FY 2017-18, the Commission requested that the counties return the funds that they were unable to spend during the four-year grant cycle. The Commission would like to reappropriate all of the unencumbered and unspent funds from FY 2013-14 through 2017-18 to support Triage Grant programs during FY 2018-19, 2019-2020, and 2020-

2021. The Commission awarded grants for the second competitive grant process early this year and the reappropriated funds will provide more counties an opportunity to operate Triage programs. The Commission has until June 30, 2018 to encumber or expend the funds listed above and is in the process executing these grants.

The Department of Finance (DOF) explains that if the $32 million in prior years' triage funds are reappropriated in this year's budget, this action would reduce the available Prop 63 State Admin Cap funds by $21 million (from $51 million to $30 million). According to DOF, reappropriating the $32 million in 2017-18 funds would have no impact on the $51 million Prop 63 State Admin Cap. DOF provided the following chart that shows the status of Proposition 63 State Administration funds:

Mental Health Services Fund State Directed Purposes - 2018-19 May Revision
(dollars in thousands)

Fiscal Year	Monthly Cash Transfers	Accruals	Interest	Total Revenue	Admin Cap[4]	Expenditures & Appropriations[3]	Available Cap	Comments
				(A+B+C=D)	(D[.035 or .05])		(E - F = G)	
	A	B	C	D	E	F	G	
2012-13[1]	$1,204,444	$479,780	$721	$1,684,945	$58,973	$31,572	$27,401	Item 4265-001-3085 ($15m appropriated w/o regard to FY in 2012 BA, but not spent, reflected in FY 16/17 and beyond) Item 6440-001-3085 ($12.3m appropriated in 2014 BA but not spent).
2013-14	$1,187,411	$94,253	$548	$1,282,212	$64,111	$39,474	$24,637	Item 4265-001-3085 ($15m appropriated w/o regard to FY in 2013 BA, reflected in FY 16/17 and beyond)
2014-15	$1,366,501	$464,136	$844	$1,831,481	$91,574	$78,989	$12,585	**2014-15 Budget Act** Item 4265-001-3085 ($15m approp. w/o regard to FY in 2014 BA, but not spent, reflected in FY 16/17 and beyond) Items 4560-491 and 6440-001-3085 (subject to available funds through June 30, 2017).
2015-16	$1,423,508	$446,046	$1,196	$1,870,750	$93,538	$78,246	$15,292	**2015-16 Budget Act** Item 4265-001-3085 ($15m appropriated w/o regard to FY in 2015 BA, but not spent, reflected in FY 16/17 and beyond). Chapter 6, Statutes of 2016 (AB 847) appropriated $1 million.
2016-17	$1,484,054	$272,547	$2,599	$1,759,200	$87,960	$94,037	($6,077)	**2016-17 Budget Act** Of the $60m appropriated for the CA Reducing Disparities Project in the 2012, 2013, 2014, and 2015 BA, $9.94m was spent for the CA Reducing Disparities Project (4265). Of the remaining CA Reducing Disparities Project funds, $9.56m will be spent in FY 17/18, and $40.5 is anticipated to be spent in FY 18/19. $500k for MHSA performance contracts (per AB 1622). Reappropriation $1.043m from Budget Acts of 2013, 2014 and 2015 to continue funding triage personnel grants through June 30, 2018. $1.952m for data contracts (reflected as savings in GB) One-Time Funding DHCD (2240) - $6.2m for No Place Like Home Housing Program CHFFA (0977) - $11m for Children's Crisis Services Grant Program (Subject to availability of funds) Funds released May 8, 2017. MHSOAC (4560) - $3m for Children Crisis Services (Subject to availability of funds) Funds Released May 8, 2017. DHCS (4260) - $4m for Suicide Hotlines (Subject to availability of funds) Funds released May 8, 2017.
2017-18/e[2,5]	$1,653,842	$397,989	$5,101	$2,056,932	$102,847	$120,389	($17,542)	**2017-18 Budget Act** MHSOAC (4560) - includes $157k (ongoing) for MH advocacy contract admin and $309k (ongoing) for prevention and early intervention plan reviews Reappropriation MHSOAC(4560) - $5.6m for Triage, Advocacy, and Evaluation Grants One-Time Funding CHFFA (0977) - Includes $16.7m for Children's Mental Health Crisis Grants MHSOAC (4560) - Includes $100k for development of a Statewide Strategic Suicide Prevention Plan DHCS (4260) - Includes $4.3m for Suicide Hotlines (Subject to availability of funds).
2018-19/e[2,5]	$1,703,832	$521,057	$5,101	$2,229,990	$111,500	$116,922	($5,423)	**2018-19 Governor's Budget** MHSOAC (4560) - includes $2.5m in FY 18/19 and FY 19/20 for County Mental Health Innovation Planning Reappropriation UC (6440) - $1.83 million **2018-19 May Revision** OSPHD (4140) - $215k (one time) included to support close out of the WET Program DHCS (4260) - $725k (ongoing) to support MHSA fiscal oversight
TOTALS:					**$610,501**	**$559,629**	**$50,872**	

[1] The admin cap applicable in 11-12 and 12-13 was 3.5%. Display begins with 12-13 as this was the first year that funds were distributed monthly to counties based on unreserved funds. The cap was restored to 5% in 13-14.

[2] e/ = estimate

[3] Source: Expenditures per the 2018-19 Governor's Budget Fund Condition Statement for fund 3085 for FY 16/17, 17/18, 18/19

[4] Welfare and Institutions Code Section 5892(d) and 5892(e)(4)

[5] 2017-18 and 2018-19 interest is a sum of: 1) three quarters of actual 2017-18 interest receipts and 2) an average of those three quarters extrapolated for the fourth quarter.

Departments Funded in 2018-19: Judicial Branch (0250), CA State Treasurer (Health Facilities Financing Authority (0977), Office of Statewide Health Planning & Development (4140), Dept. of Health Care Services (4260), Dept. of Public Health (4265), Dept. of Developmental Services (4300), Mental Health Services Oversight & Accountability Commission (4560), Dept. of Corrections & Rehabilitation (5225), Dept. of Education (6110), University of California (6440), CA Community Colleges (6870), Dept. of the Military (8940), Dept. of Veterans Affairs (8955)

Last updated 5/11/2018

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Commission present this proposal.

The Subcommittee requests Department of Finance comment on the administration's position on this request, and explain its expected impact on the Proposition 63 State Administration Cap.

Staff Recommendation: No action is recommended at this time.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: MEDI-CAL ESTIMATE MAY REVISE ADJUSTMENTS & TRAILER BILL

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Medi-Cal Caseload

The average monthly caseload for fiscal year 2018-19 is projected to be 13,328,200 beneficiaries, which represents a decrease of 147,500 beneficiaries from the Governor's Budget. The decrease in caseload is primarily attributable to a recovering economy. Total Medi-Cal expenditures for 2018-19 are projected to be $103,881,080,000 ($22,938,499,000 General Fund), which is an increase of $2,376,423,000 total funds and an increase of $1,349,407,000 General Fund from the Governor's Budget

May 2018 Medi-Cal Estimate (Issues 401 and 412)

It is requested that the adjustments below be made to the following items to reflect caseload and other miscellaneous adjustments outlined in the Medi-Cal estimate:

- Item 4260-101-0001 be increased by $1,346,759,000, and reimbursements be decreased by $36,503,000
- Item 4260-101-0232 be decreased by $2,245,000
- Item 4260-101 -0233 be increased by $764,000
- Item 4260-101 -0236 be increased by $1,687,000
- Item 4260-101-0890 be decreased by $880,267,000
- Item 4260-101-3305 be increased by $3,717,000
- Item 4260-102-0001 be decreased by $4,763,000
- Item 4260-102-0890 be increased by $25,377,000
- Item 4260-106-0890 be increased by $ 3,794,000
- Item 4260-117-0001 be increased by $40,000
- Item 4260-117-0890 be increased by $326,000

Medi-Cal
Significant General Fund Adjustments
2018-19
(Dollars in Millions)

Category	*Program*	*Governor's Budget Expenditures*	*May Revision Expenditures*	*Impact on General Fund*
Financing Complexities	Drug Rebates	-$1,483.8	-$1,185.5	$298.3
	Managed Care Financing	10,559.7	10,729.4	169.7
	Hospital Quality Assurance Fee Withhold	0.0	313.9	313.9
Federal Actions	Hospital Quality Assurance Fee	-884.9	-958.8	-73.9
	Children's Health Insurance Program Reauthorization	961.9	307.3	-654.6
	Repayment of Disallowed CHIP Federal Funds	0.0	479.6	479.6
	Deferred Claims	6.3	674.7	668.4
Other Program Adjustments	Base Program[1]	12,429.9	12,577.9	148.0
[1/] Includes net adjustments for various policies in the Medi-Cal May 2018 Local Assistance Estimate.				
Total General Fund		**$21,589.1**	**$22,938.5**	**$1,349.4**

The following are key adjustments made to the 2018-19 Estimate:

- Drug Rebates—Savings are lower due primarily to payments to the federal government tied to the rapid changes allowed under the Affordable Care Act.

- Managed Care Financing—Costs have increased since the Governor's Budget due to updated draft rates for 2018-19 and higher eligibles.

- Hospital Quality Assurance Fee Withhold—Costs have increased since Governors Budget due to the repayment of claims withheld in a previous fiscal year.

- Hospital Quality Assurance Fee—Delays in federal approval of this fee changed the timing of anticipated revenue, offsetting additional current year costs.

- CHIP Reauthorization—In December 2017, Congress reauthorized a short-term extension of enhanced federal funding. Through two actions at the end of January and early February 2018, the federal government passed a ten-year extension, continuing the enhanced 88-percent federal share of costs through September 30, 2019. The enhanced funding then decreases incrementally over time to the historic sharing ratio of 65 percent federal funds and 35 percent state funds. These reductions in federal funding will increase General Fund costs beginning in 2019-20. In the short term, the reauthorization results in a combined

two-year, General Fund decrease of $898.1 million in 2017-18 and 2018-19 compared to the Governor's Budget.

- Repayment of Disallowed CHIP Claims—Costs to repay over-claimed Title XXI federal funds.

- Deferred Claims— Increased costs as a result of new federal requirements, which require repayment for disputed claims while the Department works to substantiate them.

Medi-Cal
Significant General Fund Adjustments
2017-18
(Dollars in Millions)

Category	*Program*	*Governor's Budget Expenditures*	*May Revision Expenditures*	*Impact on General Fund*
Financing Complexities	Drug Rebates	-$1,106.7	-$831.4	$275.3
	Managed Care Organization Taxes	-2,175.2	-1,747.0	428.2
	Managed Care Financing	10,187.4	10,009.8	-177.6
Federal Actions	Hospital Quality Assurance Fee	-851.8	-1,328.9	-477.1
	Children's Health Insurance Program Reauthorization	640.2	396.7	-243.5
	Deferred Claims	71.7	754.0	682.3
Other Program Adjustments	All Other[1]	13,243.9	13,043.2	-200.7
[1/] Includes net adjustments for various policies in the Medi-Cal May 2018 Local Assistance Estimate.				
Total General Fund		**$20,009.5**	**$20,296.4**	**$286.9**

The following are key adjustments made to the 2017-18 Estimate:

- Drug Rebates—Savings are lower due primarily to retroactive payments to the federal government tied to the rapid changes allowed under the Affordable Care Act.

- Managed Care Organization Tax—Offsets to General Fund costs are lower due to updated caseload projections and rate adjustments that reduced the tax on health plans.

- Managed Care Financing—Costs have decreased since the Governor's Budget due to lower than projected caseload, retroactive rate adjustments, and lower Hepatitis C costs.

- Hospital Quality Assurance Fee—Delays in federal approval of this fee changed the timing of anticipated revenue, offsetting additional current year costs.

- CHIP Reauthorization—In December 2017, Congress reauthorized a short-term extension of enhanced federal funding. Through two actions at the end of January and early February 2018, the federal government passed a ten-year extension, continuing the enhanced 88-percent federal share of costs through September 30, 2019. The enhanced funding then decreases incrementally over time to the historic sharing ratio of 65 percent federal funds and 35 percent state funds. These reductions in federal funding will increase General Fund costs beginning in 2019-20. In the short term, the reauthorization results in a combined two-year, General Fund decrease of $898.1 million in 2017-18 and 2018-19 compared to the Governor's Budget.

- Deferred Claims— Increased costs as a result of new federal requirements, which require repayment for disputed claims while the Department works to substantiate them.

Current Year Operating Shortfall (Issue 411)

Medi-Cal program expenditures are expected to exceed the appropriation by approximately $830,532,000 in 2017-18. This is an increase of $286,878,000 since Governor's Budget. Unlike most programs, Medi-Cal operates on a cash, rather than accrual, accounting basis. The rapid expansion of the program and federal constraints have significantly increased the difficulty and uncertainty of budgeting for this program on a cash basis. The Administration will seek a supplemental appropriation bill to fund this increase, which is primarily attributable to the intricacies in forecasting the program expenditures for repayments to the federal government for deferrals and decreased offsets for the Managed Care Organization taxes and drug rebates. These increases are partially offset by increased savings from the Hospital Quality Assurance Fee, reauthorization of the Children's Health Insurance Program at 88-percent federal share, and lower managed care costs. Until supplemental funding is provided, the Department will utilize the loan authorized by Government Code section 16531.1 and will work with the Legislature to increase the existing loan authority to prevent a disruption in payments to various Medi-Cal providers.

Distributed Administration Technical Change (Issue 411)

It is requested that Item 4260-001-0001 be amended by increasing Schedule (2) by $1.5 million and making a conforming action decreasing Schedule (3) to reflect a change in the display of administrative costs.

Reauthorization of Children's Health Insurance Program (CHIP) (Issue 413)

It is requested that Item 4260-113-0001 be decreased by $847,390,000 and Item 4260-113-0890 be increased by $543,001,000 to reflect an 88-percent federal share of costs. In December 2017, Congress reauthorized a short-term extension of enhanced federal funding. Through two actions at the end of January and early February 2018, the federal government passed a -3- ten-year extension, continuing the 88-percent federal share of cost through September 30, 2019. The enhanced funding then decreases incrementally over time to the historic sharing ratio of 65 percent federal funds and 35 percent state funds. In the short-term, the reauthorization results in a combined two-year General Fund decrease of $898.1 million in 2017-18 and 2018-19.

Repayment for Claims Potentially Ineligible for Federal Matching Funds (Issue 414)

It is requested that Item 4260-101-0001 be increased by $674,679,000 and Item 4260-101-0890 be decreased by $299,679,000 to repay the federal government for claims that have been identified as potentially ineligible for federal matching funds. Consistent with the Special Terms and Conditions of the California Medi-Cal 2020 Demonstration, the state must immediately return the federal matching funds to the Centers for Medicare and Medicaid Services while the claims are examined and resolved. When a deferral is resolved in favor of the Department, the funds are returned to the state.

General Fund Reappropriation (Issue 405)

It is requested that Item 4260-491 be added to reappropriate the balances of specified General Fund items and supplemental appropriations for the same purposes detailed in the preceding May Revision Medi-Cal estimate.

> 4260-491—Reappropriation, State Department of Health Care Services. Notwithstanding any other provision of law, upon order of the Department of Finance, the balances of the appropriations provided in the following citations are reappropriated for the same purposes provided for those appropriations as detailed in the preceding May Revision Medi-Cal estimate, and shall be available for expenditure until June 30, 2019.
>
> 0001—General Fund
>
> (1) Item 4260-101-0001, Budget Act of 2017 (Chs. 14, 22, and 54, Stats. 2017)
>
> (2) Item 4260-113-0001, Budget Act of 2017 (Chs. 14, 22, and 54, Stats. 2017)
>
> (3) Any Supplemental Appropriation Bills passed for this purpose prior to June 30, 2018.

Medi-Cal General Fund Loan Trailer Bill (See Issue 3 of this agenda)

Trailer bill language is requested to increase the amount of the General Fund loan to the Medical Providers Interim Payment Fund authorized in Government Code section 16531.1.

Hepatitis C Treatment Clinical Guidelines

The Medi-Cal estimate includes an increase of $70.4 million ($21.8 million General Fund) to authorize treatment for all patients ages 13 and above with Hepatitis C, regardless of liver fibroses stage or co-morbidity, except for patients with a life expectancy of less than 12 months. Currently, Medi-Cal authorizes treatment for individuals with state two or above liver fibrosis, or at any stage if they have a qualifying co-morbid conditions.

Federal Substance Abuse and Mental Health Services Administration Grant Award (Issues 402)

It is requested that Item 4260-115-0890 be increased by $15,675,000 and Item 4260-116-0890 be increased by $2,262,000 to reflect the revised federal grant amounts awarded to provide additional funding for county mental health and substance use disorder services.

Federal Substance Abuse and Mental Health Services Administration Emergency Grant Award (Issue 413)

It is requested that Item 4260-115-0890 be increased by $5.4 million to reflect the revised grant amount awarded for the Regular Service Program Crisis Counseling

Program, which provides counseling services to Californians affected by the recent wildfires.

Legislative Analyst

The LAO provided the following comments and analysis:

2017-18 Deficiency. For 2017-18, the $287 million in increased costs identified in the May Revision is added to the $544 million in increased costs identified in the Governor's January budget proposal relative to the *2017-18 Budget Act*. This creates the need for a supplemental appropriation of $830 million for 2017-18, assuming the Governor's budget is approved without adjustment.

Increased General Fund Costs in 2017-18 and 2018-19 Largely Due to Technical Budget Adjustments. The Governor's May Revision budget proposal features few changes in policy related to Medi-Cal. Rather, increased estimated General Fund spending is largely due to the net effect of several technical budget adjustments.

Technical Adjustments Warrant Scrutiny. Given the magnitude of the increased General Fund costs, we recommend that the Legislature scrutinize these technical adjustments through the May Revision hearing process. Below, we summarize some of the major driving factors behind the net increase in estimated General Fund costs. We also highlight issues related to the most significant of these factors for the Legislature to consider based on our very preliminary review of the May Revision. Additionally, we comment on the administration's Medi-Cal caseload estimates, provide updates on proposals that were included in the Governor's January budget, and assess one new information technology (IT) proposal included the May Revision.

The $1.6 billion upward adjustment across the 2017-18 and 2018-19 fiscal years reflects the net General Fund impact of a wide variety of changes in projected Medi-Cal spending. To a significant degree, these changes reflect a shift of costs to the General Fund from other fund sources, rather than an overall increase in program costs.

Savings of $900 Million from Children's Health Insurance Program (CHIP) Reauthorization. The Governor's January budget assumed federal funding for CHIP would be reauthorized, but not at California's enhanced CHIP federal medical assistance percentage (FMAP) of 88 percent authorized under the Patient Protection and Affordable Care Act (ACA). Instead, the January budget assumes the state would receive its traditional CHIP FMAP of 65 percent starting January 1, 2018. The May Revision reflects the recent reauthorization of federal CHIP funding at the enhanced FMAP of 88 percent, reducing the General Fund costs of the program by a total of $900 million—$300 million in 2017-18 and $600 million in 2018-19. This General Fund savings amount is consistent with what was estimated in our analysis of the Governor's January budget to be the fiscal impact of the recent federal action.

General Fund Costs of $1.5 Billion to Repay Federal Funds Received for Potentially Disallowed Claims. The most significant May Revision Medi-Cal adjustment relates to a $1.5 billion General Fund adjustment over the Governor's January budget—$680 million in 2017-18 and $820 million in 2018-19—to replace a projected loss in federal funds related to an increased amount of claims the federal government now disputes. Based on our initial review, this amount likely represents a high-end estimate of the amount that is at risk. The state may be able to recover a portion of this funding by submitting required supporting documentation for the claims, but the amount and timing for recovering funds is unknown at this time. In the coming

days we will attempt to identify the causes of increased disputed claims and whether any of the potentially disallowed claims could be resolved in 2018-19.

Other Adjustments. Beyond the two large adjustments described above, several other relatively smaller, but still significant, adjustments contribute to the net increase in General Fund spending in Medi-Cal in the May Revision. In the coming days, we will continue to review these items.

$620 Million in General Fund Costs Related to Drug Rebates. Medi-Cal collects rebates on prescription drugs that are paid for by the program. These rebates come in the form of savings and are used to offset General Fund spending on Medi-Cal. The Governor's May Revision estimates $620 million in lower General Fund savings across 2017-18 and 2018-19 resulting from Medi-Cal prescription drug rebates relative to the January budget. This appears to be due to (1) lower projections of the total savings associated with future drug rebates and (2) a higher share of rebate savings being remitted to the federal government, and therefore not resulting in General Fund savings.

$428 Million in General Fund Costs Related to Managed Care Organization (MCO) Taxes. The MCO tax is assessed on a large number of managed care plans statewide and its revenues leverage additional federal funding for Medi-Cal that provides a substantial General Fund offset. General Fund savings from the MCO tax are offset by increases in plans' capitation payments owing to the tax. The May Revision estimates that net General Fund savings associated with the MCO tax are lower by $428 million over 2017-18 and 2018-19 as compared to the Governor's January budget. This results in higher General Fund costs in Medi-Cal of an equivalent amount.

$445 Million in General Fund Costs Related to Hospital Quality Assurance Fee (QAF) Withholding. Most private hospitals in the state are required to pay a QAF to the state, which uses these revenues to draw down additional federal funding for payments to hospitals, as well as to offset some General Fund costs in Medi-Cal. When hospitals fall behind on QAF payments, the state withholds a portion of the Medi-Cal payments that otherwise would be paid to those hospitals. The May Revision newly identifies $450 million in General Fund costs—$131 million in 2017-18 and $313 million in 2018-19—related to the timing of these withheld payments.

Various Other Offsetting Adjustments. In addition to the adjustment listed above, the May Revision reflects numerous other adjustments to estimated General Fund spending resulting in both costs and savings.

Key Questions. In the coming days, we will work with the administration to better understand these adjustments and will provide any additional comments we have to the Legislature on a flow basis. In the meantime, we provide some key questions below to guide the Legislature's review of these adjustments.

Is the Adjustment Based on a Change in Federal Policy? In some cases, adjustments may be partly the result of changes in federal policy. If the adjustment is largely driven by a federal policy change, it is more likely to be beyond the state's control.

Is the Adjustment Based on a Change in Estimating Methodology? In some cases, these adjustments may be partly the result of a change in the administration's approach to estimating uncertain future spending. The Legislature may wish to ask the

administration to provide additional information about the level of uncertainty in the estimate, the reliability of the previous approach to estimation, and how the new approach represents an improvement.

Will the Adjustment Be One-Time or Ongoing? Some of these adjustments may be expected to result in ongoing costs or savings, while others may be more short-term. The Legislature may wish to ask the administration for more information about how the costs and savings associated with these adjustments are expected to change in future years.

CASELOAD ESTIMATES

May Revision Caseload Estimates Slightly Lower Than January Estimates. The May Revision projects a declining Medi-Cal caseload in both 2017-18 and 2018-19. Specifically, the May Revision projects total average monthly enrollment of 13,343,800 individuals in 2017-18, down 1.3 percent from the prior year. The May Revision projects total average monthly enrollment of 13,328,200 in 2018-19, down only 0.1 percent from updated estimates of 2017-18. Estimates for both 2017-18 and 2018-19 are slightly lower than administration's January estimates.

Children and Families Caseload Projection Is Cautious. Within the Medi-Cal caseload, the families and children caseload (as distinct from seniors, persons with disabilities, or childless adults) has been declining at a rate equivalent to roughly 3 percent annually beginning in 2016-17. This downward trend is likely due to the combination of (1) steps taken to address automation challenges that delayed disenrollment of beneficiaries that were no longer eligible and (2) fewer eligible families due to increased earnings in an improving labor market and as a result of a higher minimum wage. The May Revision projects a much slower decline for the families and children caseload of less than 1 percent in 2018-19. Given the number and magnitude of changes in the Medi-Cal program in recent years, there is uncertainty about how the families and children caseload trend may change in the future. However, we believe there is a good chance the decline will be somewhat more rapid than assumed in the May Revision, provided that current economic conditions continue. For example, if trends observed since 2016-17 were to continue, we estimate the families and children caseload would decline by about 3 percent in 2018-19 and the total Medi-Cal caseload would be closer to 13.2 million, a little more than 1 percent lower than assumed in the May Revision.

Adopting Lower Caseload Estimate Could Free Up Funding for Other Priorities… Assuming a more rapid decline in the families and children caseload as described above would free up General Fund in Medi-Cal for other priorities in the state budget. The amount of potential General Fund savings is uncertain, but would likely be in the low hundreds of millions.

…But Increases Risk of Insufficient Funding if Trends Change. At the same time, assuming savings from a more rapid caseload decline based on recent trends increases the risk that program funding will be insufficient if those trends change. The Legislature may wish to ask the administration to provide more information on the likelihood that the families and children caseload will decline at a faster rate than assumed in the May Revision and the potential savings that could result from assuming a more rapid decline.

Proposition 55

May Revision Includes No Additional Medi-Cal Funding Under Proposition 55. In 2016, voters passed Proposition 55, which extended tax rate increases on high-income Californians. Proposition 55 includes a budget formula that provides additional funding to Medi-Cal if, in the estimation of the Department of Finance (DOF), General Fund revenues will exceed constitutionally required spending on schools and the "workload budget" costs of other government programs that were in place as of January 2016. Under calculations made for the Governor's January budget proposal, the Director of Finance found that General Fund revenues would not be sufficient to trigger additional funding for Medi−Cal pursuant to the Proposition 55 formula. The DOF released updated Proposition 55 estimates with the May Revision. These updated estimates similarly find that General Fund revenues will not be sufficient to trigger additional funding for Medi-Cal. Therefore, the May Revision includes no additional funding for Medi-Cal under the Proposition 55 formula.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present the May Revise changes and adjustments to the Medi-Cal estimate, and respond to the following:

1. Please explain the significant General Fund cost increases in the current year and budget year.

2. What actions did the administration take in response to the shortfalls in the Medi-Cal estimate last year, and have those actions helped produce a more accurate estimate process?

3. Please explain any changes to the federal deferral process that have contributed to increased costs in the Medi-Cal estimate.

4. Please explain the proposed General Fund provisional and trailer bill language and how those are intended to assist with future Med-Cal budgeting.

Staff Recommendation: No action is recommended at this time.

ISSUE 3: INCREASE MEDI-CAL GENERAL FUND LOAN TRAILER BILL

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

In the event of a General Fund deficiency in the Medi-Cal program budget, current state law authorizes a General Fund loan of up to $1 billion, as well as corresponding federal funds, for Medi-Cal payments in that fiscal year. The Department of Health Care Services (DHCS) is proposing to increase the authority for the maximum General Fund loan amount, and corresponding federal funds, from $1 billion to $2 billion. The proposal would also clarify that a General Fund loan may be repaid in a different state fiscal year (SFY) from the SFY in which the loan was provided.

BACKGROUND

The Budget Act of 2003 shifted the Medi-Cal program from a modified-accrual to a cash basis for General Fund, beginning with the SFY 2004-05. When this action was taken, the health budget trailer bill, Assembly Bill 1762 (Committee on Budget, Chapter 230, Statutes of 2003) expanded the permitted use of General Fund loan authority for Medi-Cal to include a deficiency in the Medi-Cal budget. Prior to the enactment of AB 1762 in 2003, the General Fund loan authority was only authorized in the event the state budget was not enacted by June 30. These provisions were adopted concurrent with the transition to a cash budgeting system, as the Legislature and Governor recognized the reduced flexibility and capacity to make budget adjustments under a cash budgeting system.

Under current law, if DHCS has a General Fund deficiency in the Medi-Cal budget, DHCS may exercise the General Fund loan authority by making a request to the State Controller's Office (SCO). The SCO is authorized to transfer up to $1 billion General Fund to the Medical Providers Interim Payment Fund, a continuously appropriated fund established for the purposes of making payments to Medi-Cal providers in the event of a late state budget or a deficiency in the Medi-Cal budget. To repay the loan, the Administration must seek an appropriation through the annual Budget Act, or a supplemental appropriation.

The 2018 May Revision proposes $103.9 billion ($22.9 billion General Fund) for the Medi-Cal budget. This represents a significant increase from the $29.2 billion ($9.8 billion General Fund) for the Medi-Cal budget authorized in the 2003 Budget Act. In addition, significant challenges have emerged in managing the Medi-Cal budget on a cash basis:

- The increased size of the Medi-Cal budget, due to the Affordable Care Act (ACA) and Medicaid expansion, and increased use of Intergovernmental Transfers (IGTs), has increased the magnitude of current year adjustments.
- The increase in IGTs and supplemental payments, as well as enhanced federal funds under the ACA, has resulted in increased complexity for accounting transactions and cash management, as well as more complex policy changes in the Medi-Cal budget.
- DHCS is dependent on external entities for a large volume of incoming funds such as IGT receipts, drug rebates, and managed care recoupments; additionally, DHCS does not control the timing of those receipts. Further, external entities also drive changes in timing for the implementation of policies and expenditures, such as federal approvals of payment rates, contracts, enhanced federal funding, State Plan Amendments, and waivers.
- The shift to managed care as the primary Medi-Cal delivery system, with payments to managed care plans instead of Fee-for-Service providers, results in significantly more funding concentrated in relatively fewer payments. Unanticipated changes in those payments can result in large changes in current year expenditures.
- As Medicaid programs across the U.S. have increased participation in managed care models, the federal Centers for Medicare and Medicaid Services (CMS) has implemented a more time-intensive review and oversight process of all managed care rates. This process requires extensive development and review time at both the state and federal level. As a result, managed care rate packages are often implemented retroactively by several months or longer. These retroactive rate adjustments increase the complexity and uncertainty of budgeting and cash management for DHCS.
- Changing federal fund claiming requirements, which require the state to repay deferred claims while DHCS works to substantiate them.

Legislation is needed to authorize an increase in the Medi-Cal General Fund loan authority. The significant growth in the Medi-Cal budget since 2003 has led to a need for an increased General Fund loan in the event of a deficiency. In 2017, the Legislature authorized a supplemental appropriation bill of $1.16 billion General Fund to the Medi-Cal program, an amount that exceeds the current General Fund loan limit. Without sufficient loan authority, a deficiency in the Medi-Cal cash budgeting structure may lead to delayed or uncertain timing of payments to managed care plans, vendors, and providers. This may cause financial burdens or constraints on providers and reduce provider participation and beneficiary access to care in Medi-Cal. DHCS is proposing trailer bill language and budget bill language to provide greater flexibility in the Medi-Cal budget process.

While the number of beneficiaries has doubled (from 6.5 million to 13.3 million) and the DHCS Medi-Cal General Fund budget has doubled (from $9.8 billion to $22.9 billion) since 2003, the $1 billion loan has remained unchanged. Therefore, DHCS is proposing to increase the authority for the maximum General Fund loan amount, and corresponding federal funds, from $1 billion to $2 billion. In addition, DHCS is proposing

to clarify that a General Fund loan for the Medi-Cal program must be repaid in the same fiscal year it was made or in the subsequent fiscal year and with the appropriate Budget Act items or with the proceeds of a supplemental appropriation, as determined by the Administration. For example, a loan executed in SFY 2017-18 (for the 2017-18 fiscal year) could be repaid with either 2018-19 Budget Act funding, or a supplemental appropriation bill enacted in either SFY 2017-18 or 2018-19.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposed trailer bill.

Staff Recommendation: No action is recommended at this time.

ISSUE 4: FAMILY HEALTH ESTIMATE MAY REVISE ADJUSTMENTS

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Family Health May Revision Estimates (Issue 402)
It is requested that Item 4260-111-0001 be increased by $22,218,000 and reimbursements be increased by $43,000. It is also requested that Item 4260-114-0001 be decreased by $3,354,000 and Item 4260-114-0890 be increased by $619,000. These changes reflect revised expenditures in the four Family Health programs based on: (1) one-time increased costs in the Genetically Handicapped Persons Program attributable to a backlog in processing applications, (2) lower estimated utilization and increased federal grant funding for direct service contracts and claims in the Every Woman Counts program, and (3) other miscellaneous adjustments.

Reduction of Excess Reimbursement Authority {Issue 403)
It is requested that Item 4260-111-0001 be amended by decreasing reimbursements by $36,010,000 in the children's medical services program to reflect an accurate representation of actual expenditures.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present changes or adjustments included in the May Revise to the Family Health Estimate (CCS, CHDP, EWC, and GHPP), including Issue 403 described above.

Staff Recommendation: No action is recommended at this time.

ISSUE 5: PROPOSITION 56 ADJUSTMENTS

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

The Governor's May Revision Proposition 56 proposal does the following:

- Maintains January budget proposal to spend the maximum amount ($1.346 billion) authorized in the two-year budget agreement on provider payment increases funded from Proposition 56 revenues that was part of the 2017-18 budget package.
- Maintains the January budget's proposed extension of the Proposition 56-funded supplemental payments authorized in 2017-18 into 2018-19, consistent with the 2017-18 budget agreement.
- Reduces the estimated General Fund cost of continuing the currently authorized supplemental payments into 2018-19 by an additional $151 million relative to the January budget.
- Proposes using $225 million in Proposition 56 funding to offset General Fund spending on cost growth in Medi-Cal in 2018-19. This represents a $56 million increase over the amount proposed in January.
- Projects $53 million in higher Proposition 56 revenues dedicated to Medi-Cal over 2017-18 and 2018-19 relative to January budget estimates.
- Does not include a detailed plan for how to fully expend between $600 million and $700 million in Proposition 56 funding dedicated to Medi-Cal provider payment increases.

Intermediate Care Facility/Developmentally Disabled and Home Health Provider Payments (Issue 415)

It is requested that Provision 3 of Item 4260-101-3305 be amended to extend supplemental payments to facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Welfare and Institutions Code section 14132.20, and a rate increase for home health providers of medically necessary in-home services. This proposal includes the following provisional language:

> Amend Provision 3 of Item 4260-101-3305 as follows:
>
> "3. The State Department of Health Care Services shall develop the structure and parameters for supplemental provider payments and rate increases to be made pursuant to this item in a manner similar to the structure included in Provision 3 of Item 4260-101- 3305, as added by

Chapter 22, Statutes of 2017. Increases in 2018-19 include an additional augmentation for physician and dental payments: extending payments for Intermediate Care Facilities for the Developmentally Disabled to facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20 of the Welfare and Institutions Code: and, notwithstanding any other provision of law, a rate increase for home health providers of medically necessary in-home services for children and adults in the Medi-Cal fee-for-service system or through home and community-based services waivers. The Department shall post the proposed payment structure of these provider payments on its Internet Web site by September 30, 2018^ upon the approval of the Director of Finance."

Legislative Analyst

The LAO provided the following comments and analysis:

Proposition 56 raised state taxes on tobacco products and dedicates the majority of associated revenues to Medi-Cal on an ongoing basis. Proposition 56 revenues that are dedicated to Medi-Cal can be used for two main purposes: (1) augmenting the program, such as, for example, by increasing Medi-Cal provider payments and (2) offsetting General Fund spending on cost *growth* in Medi-Cal. For background on the use of Proposition 56 funding in Medi-Cal, please refer to our February 2018 report: *The 2018-19 Budget: Analysis of the Health and Human Services Budget*.

Governor's January 2018-19 Budget Proposed Spending Maximum Amount Authorized in 2017-18 Budget Agreement on Provider Payment Increases. The Governor's January 2018-19 budget proposed spending the maximum amount authorized in a 2017-18 Proposition 56 budget agreement ($1.346 billion) on provider payment increases within the provider and service categories designated in the 2017-18 agreement. Specifically, the Governor's January budget proposal extended the provider payment increases structured in the 2017-18 agreement into 2018-19. In addition, the January budget allocated a remaining portion of Proposition 56 funding to pay for *new* provider payment increases above 2017-18 levels ($523 million) and dedicated $169 million in Proposition 56 funding to offset General Fund spending on cost growth in Medi-Cal.

Governor's May Revision Maintains January's Proposal to Spend Maximum Amount on Provider Payment Increases. The Governor's May Revision similarly proposes to spend the full $1.346 billion of Proposition 56 funding authorized in the 2017-18 agreement for provider payment increases. The May Revision dedicates this funding to the provider and service categories included in the 2017-18 agreement, with most of the funding going to physician and dental services supplemental payments.

Higher Proposed General Fund Offset. In addition, the Governor proposes using $225 million of Proposition 56 revenues to offset General Fund spending on cost growth in Medi-Cal, a $56 million increase over the amount proposed in January. To a significant degree, this $56 million proposed increase is paid for by higher projected Proposition 56 revenues that are dedicated to Medi-Cal, which—across 2017-18 and 2018-19—are $53 million higher as of the May Revision compared to the Governor's January budget.

May Revision Does Not Include a Detailed Plan for How to Fully Expend Funding for Provider Payment Increases. As was the case under the Governor's January proposal, the Governor's May Revision budget does not include a detailed plan for how to fully spend this $1.346 billion in Proposition 56 funding dedicated to Medi-Cal provider payment increases.

According to our initial review of updated budget estimates, it appears that approximately 50 percent of this $1.346 billion is needed to fund the provider payment increases currently authorized through 2018-19. This potentially leaves between $600 million and $700 million to be committed by the Legislature in 2018-19 to *new* provider payment increases beyond those currently authorized. While the May Revision appears to broadly dedicate this available funding to physician and dental services supplemental payments, the Governor's May Revision does not include a detailed plan for how to target and structure these additional payments.

LAO Comments

Governor's January Proposal—Continued in the May Revision—to Extend the Currently Authorized Provider Payment Increases Into 2018-19 Has Merit. Implementation of the currently authorized provider payment increases is just getting underway following initial delays and challenges. At this time, it is difficult to tell whether they are having an impact on increasing access to Medi-Cal services. Extending the currently authorized provider payment increases into 2018-19—consistent with the 2017-18 budget agreement—would (1) likely meet fewer implementation challenges than occurred in 2017-18 and (2) give the Legislature more time to evaluate whether the provider payment increases are having their intended impact. Accordingly, we believe that extending the currently authorized provider payment increases through 2018-19 has merit.

Consider Longer-Term Supplemental Payments for Providers. Longer-term increases to provider payments are likely more effective in improving access to care than temporary, year-at-a-time increases. The challenges associated with implementing the 2017-18 supplemental payments have left the Legislature without a solid understanding of the impact that the payment increases have had on access to care. A longer-term piloting of supplemental provider payments may give the Legislature a better opportunity to evaluate the impact of the improved payments on access to care in order to determine whether provider payment increases should be made permanent.

The Legislature Has Additional Options in Deciding How Available Funding Is Spent. The absence of a detailed plan for how to fully spend between $600 million and $700 million in Proposition 56 funding leaves the Legislature with a notable opportunity to provide input into how this available funding is spent. The administration has signaled an openness to working with the Legislature to decide its allocation. Below, we provide a preliminary analysis of a few of the options before the Legislature for spending this available funding.

Further Increase One-Time Supplemental Payments for Providers. As proposed by the Governor, the Legislature could elect to use some or all of the available funding to increase physician and dental services supplemental payments beyond those currently authorized. Should it wish to pursue this general option, the Legislature can provide input into how this funding is targeted. For example, the Legislature could designate additional physician and dental services beyond those currently receiving supplemental payments to be eligible for supplemental payments. Alternatively, or in addition, the Legislature could potentially increase the supplemental payment levels for services currently receiving Proposition 56-funded supplemental payments. Given the challenges experienced during the first round of Proposition 56 supplemental payments implementation, simple supplemental payment proposals should be preferred over complex ones to minimize implementation challenges and payment delays.

Augment the Medi-Cal Program in Ways Other Than Supplemental Payments. The Legislature could consider augmenting Medi-Cal in ways other than providing additional supplemental payments. The Legislature could consider alternative one-time uses of Proposition 56 funding in Medi-Cal that allow for a focus on improving the program's infrastructure. Alternatively, the Legislature could consider augmenting the program in other ways on an ongoing basis—such as, for example, by expanding coverage or covered benefits.

Increase the General Fund Offset for Medi-Cal Cost Growth. The Legislature could consider increasing the amount of Proposition 56 funding that offsets General Fund spending on cost growth in Medi-Cal beyond the $225 million proposed in the May Revision for 2018-19. This would free up additional General Fund resources that could be used to fund other new programs or, alternatively, saved for economic uncertainties.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present the ICF-DD proposal (Issue 415), the overall structure for Proposition 56 Medi-Cal revenue in the May Revise, and how they propose to invest the $600 - $700 million identified by the LAO as funds available and not yet designated for specific payments or other purposes.

Staff Recommendation: No action is recommended at this time.

ISSUE 6: MENTAL HEALTH SERVICES FISCAL OVERSIGHT AND BEHAVIORAL HEALTH DATA MODERNIZATION

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Mental Health Services Fiscal Oversight and Behavioral Health Data Modernization (Issue 402)

The Department of Health Care Services (DHCS) requests the phase in of 28.0 permanent, fulltime positions and two-year limited-term resources equivalent to 20.0 positions, as well as expenditure authority of $6,725,000 ($2,781,000 General Fund (GF), $3,219,000 Federal Fund (FF), and $725,000 Mental Health Services Fund (MHSF)). These resources are requested to strengthen fiscal oversight of the Mental Health Services Act (MHSA), the Medi-Cal Mental Health Managed Care program, and for the planning effort for the comprehensive Behavioral Health Data Modernization Project (Data Modernization). This includes costs of contractor services of $1,710,000 and monthly reporting fees of $54,000 to California Department of Technology (CDT).

Total Funding Request:

Fiscal Year	Total Funds	Mental Health Services Fund	General Fund	Federal Funds
2018-19	$6,725,000	$725,000	$2,781,000	$3,219,000
2019-20	$6,460,000	$1,062,000	$2,700,000	$2,698,000
2020-21	$5,477,000	$1,042,000	$2,218,000	$2,217,000
2021-22 and ongoing	$4,045,000	$1,042,000	$1,502,000	$1,501,000

BACKGROUND

DHCS is responsible for administering California's community mental health system through three primary programs: 1) the Bronzan-McCorquodale Act, 2) the MHSA, and 3) the Medi-Cal Mental Health Managed Care program. DHCS contracts with 57 county mental health departments to provide community mental health services through the Bronzan-McCorquodale Act and the MHSA and contracts with 56 county mental health departments to provide specialty mental health services through the Medi-Cal Mental Health Managed Care program.

MHSA DHCS is responsible for various fiscal oversight activities of MHSA-funded programs. Specifically, these responsibilities are related to:

1. Annual Revenue and Expenditure Report: DHCS is responsible for developing and administering the MHSA Annual Revenue and Expenditure Report which identifies county MHSA expenditures, determines any additional funds generated as a result of the MHSA, and identifies unexpended funds and interest earned (W&I Code § 5899).

2. Reversion: DHCS is responsible for calculating reversion and verifying that funds subject to reversion are returned to the Mental Health Services Fund and reallocated among the counties for the purpose the funds were originally distributed for.

3. Compliance with fiscal reporting: DHCS may withhold funds from a county when it does not submit its RER by the due date and when a county is found to be substantially out of compliance with the contract or the Act.

4. Semi-Annual MHSA Expenditure Report: DHCS is responsible for producing a Semi-Annual MHSA expenditure report for the Legislature.

5. Fiscal Audits: DHCS is authorized to audit county RERs to monitor county compliance with the MHSA.

6. Corrective Action Plans (CAPs): When a county mental health program is not in compliance with its performance contract (including through audits and RER reporting), the department may request a plan of correction and shall post on its Internet Website any plans of correction requested and the related findings (W&I Code § 5897(e).

7. Paper Appeal Process: If the Department finds substantial noncompliance by a county, the county may submit a written appeal and the Department issues a decision after review.

Medi-Cal Mental Health Managed Care Program

DHCS is also responsible for a range of fiscal oversight activities of the Medi-Cal Mental Health Managed Care program. Centers for Medicare and Medicaid Services (CMS) approved California's Certified Public Expenditure (CPE) protocol for the Medi-Cal Mental Health Managed Care program on October 5, 2016. Under the CPE protocol, the Department required counties to follow a payment process to prevent the erroneous claiming of federal funds. The payment process described in the CMS-approved CPE protocol is divided into three phases that include interim payments, interim cost settlements, and final audit settlements

Interim Payments

DHCS uses an electronic claims processing system called the SD/MC claiming system to adjudicate claims that MHPs submit for federal reimbursement. MHPs submit claims for federal reimbursement using an 837 file format. The SD/MC claiming system

adjudicates the claim. After adjudicating the claim, DHCS sends each MHP an 835, which contains information about how DHCS adjudicated the claim. MHPs receive federal, and State General Fund, reimbursement for approved claims. DHCS is responsible for maintaining and updating the SD/MC claiming system to ensure interim payments are made timely and accurately and for monitoring the accuracy and appropriateness of these payments. DHCS does not currently have sufficient authorized positions to timely perform the tasks necessary to maintain and update the SD/MC claiming system and to effectively monitor the accuracy and appropriateness of interim payments.

1. Claiming System Maintenance: DHCS is responsible for making routine updates to the SD/MC claiming system. For example, the CPE protocol requires DHCS to limit interim payments to interim rates for each MHP. DHCS must load those rates into the claiming system at the beginning of each fiscal year and make updates to those rates for counties that request updates throughout the fiscal year. DHCS is also responsible for updating the Federal Medical Assistance Percentage (FMAP) for Affordable Care Act, Title XIX, and Title XXI beneficiaries. DHCS also identifies issues with the claiming system that delay payments to MHPs and need to be resolved timely.

2. Claiming System Updates: DHCS is responsible for updating the claiming system to implement changes in policy. For example, adding new service types, such as Therapeutic Foster Care, requires changes to the claiming system. Proposition 30 has increased the frequency with which these updates need to be made in order to separately identify increased costs and reimburse MHPs the non-federal share of those increased costs.

3. Review and Validate County Claim Certifications: DHCS requires mental health plans to certify all claims submitted for interim payments. The mental health director or designee must certify the accuracy of the claim and the county auditor controller or designee must certify that the county incurred the costs being submitted for reimbursement. MHPs submit a PDF copy of the signed certification on the MH 1982 A claim form that comes with the electronic claim for reimbursement (42CFR433.51). To ensure compliance with federal CPE requirements, DHCS must review the PDF copy of the MH 1982 A to verify that the certification was signed, signed by the appropriate person, and the amount claimed on the MH 1982 A matches the amount claimed on the 837.

4. Monitor Status of Claims Submitted: DHCS is responsible for monitoring the status of claims that MHPs submit. DHCS prepares routine reports to reconcile 837s submitted with 835s and warrants. This allows DHCS to verify that MHPs received an 835 for each 837 or a warrant for an approved 837 within a reasonable amount of time. DHCS is able to investigate and resolve the problem without causing too much delay in payments. These reports also allow DHCS to monitor the timeliness of payments to MHPs (42 CFR 447.45).

5. Late Eligibility Claims: A county may enroll a Medi-Cal beneficiary with an effective date that is more than one year after the month of service if one of five criteria are met (22 CCR 50746). Normally, MHPs must submit a claim for reimbursement within 12 months of the date of service. When a beneficiary is enrolled in Medi-Cal more than 12 months after the month of service, a MHP may submit a claim for reimbursement within 60 days of the date the beneficiary was enrolled. MHPs must submit a Letter of Authorization (LOA) to the Department when such a claim is submitted. DHCS must verify these claims against the LOA before DHCS can adjudicate the claims and pay the MHPs.

6. Claim Appeal Process: 9 CCR 1850.325 allows a MHP to appeal DHCS' processing or payment of its claim for services paid through the SD/MC claiming system within 90 calendar days of the date the payment was due. DHCS is required to make a decision on the appeal within 60 days from the date the appeal was received.

7. Technical Assistance: MHPs often have questions about the status of a payment, denied claims, or how to enroll a provider. MHSD assists with these inquiries.

8. Audit Coordinator: The Federal and State Government conduct a variety of audits that include interim payments. For example, the Federal Government conducts the Payment Error Rate Measurement (PERM) audit every three years and the State conducts a single audit on an annual basis. MHSD is responsible for coordinating these audits for the MediCal Mental Health Managed Care program.

Interim Cost Settlements

Welfare and Institutions (W&I) Code, § 14705 requires mental health plans and all of their providers to submit a cost report by December 31 following the close of the fiscal year. The cost report determines actual costs that each provider incurred to render the specialty mental health services, for which the mental health plan submitted claims for interim reimbursement. DHCS reconciles all interim payments to the actual cost of rendering those services. If interim payments exceed actual cost, DHCS recoups and returns the difference to CMS. If actual costs exceeds interim payments, DHCS makes an additional payment to the mental health plan. DHCS performs the following functions to administer the interim cost settlement process.

1. Cost Report Template: DHCS provides the mental health plans and their providers with a cost report template and instructions that mental health plans must use to prepare the cost report. DHCS maintains the cost report template in a Microsoft (MS) Excel workbook. DHCS must update the MS Excel workbook each year to capture any changes in state or federal policy or regulations. One example is related to the passage of Assembly Bill (AB) 403 in Fiscal Year 2016-17, DHCS modified the cost report template to capture the increased costs to counties to participate in a child and family team.

2. Automated Edit Process: MHPs submit cost reports through the DHCS Information Technology and Web Services (ITWS) secure portal. ITWS runs an automated edit process on each cost report submitted. The automated edit

process generates an error report that is automatically e-mailed to the MHP staff who submitted the cost report and to DHCS staff. DHCS staff update the automated edit process each year based upon changes made to the template.

3. Cost Report Training: DHCS provides annual training to MHP staff on the cost report template.

4. Cost Report Submission: MHPs must submit their cost report by December 31®' following the close of the fiscal year.

5. Cost Report Technical Assistance: DHCS staff review each MHP's automated edit report and provide technical assistance to MHP staff with correcting identified errors.

6. Manual Review: DHCS staff complete a manual review of each report submitted to ensure accuracy. Each MHP submits over 500 individual cost reports, including initial and amended cost reports for their primary contracts and subcontractors for each fiscal year.

7. Cost Report Reconciliation: DHCS prepares and sends a letter to each MHP after the MHP has cleared all errors in the cost report. MHPs are required to reconcile the units of service in the cost report to the final approved units of service. MHPs may submit claims up to 12 months after the date of service. MHPs may not know the status of all Medi-Cal services six months after the close of the fiscal year, which is the date when the initial cost report is due.

8. Paid Claims: DHCS staff prepare a summary of paid claims for each MHP and posts that report to ITWS for mental health plans.

9. Cost Settlement: DHCS staff compare the amount of Federal Financial Participation (FFP) due to the MHP as determined in the cost report to the summary of paid claims. If the summary of paid claims is more than the cost report, DHCS recoups the difference and returns those funds to CMS. If the summary of paid claims is less than the cost report, DHCS makes an additional payment to the county in the amount of the difference.

DHCS currently has a four-year backlog in processing interim cost settlements timely. DHCS recently completed interim cost settlements for most Fiscal Year 2010-11 county cost reports. DHCS should be able to complete interim cost settlements within twenty-one months after the close of a fiscal year. Therefore, DHCS should be finished completing interim cost settlements for Fiscal Year 2014-15. DHCS is working to complete interim cost settlements for Fiscal Year 2011-12, 2012-13, 2013-14, and 2014-15.

Final Audit Settlements

W&I Code, § 14170 requires DHCS to audit Medi-Cal cost reports within three years of the date the original or amended cost report is filed. The CMS-approved CPE protocol for the Medi-Cal Mental Health Managed Care program requires DHCS to audit each MHPs cost report on an annual basis. DHCS currently audits 47 cost reports annually.

Data Modernization Project

California's community behavioral health system is administered by DHCS, through a variety of programs that include the Medi-Cal Mental Health Managed Care Program, the Drug Medi-Cal (DMC) Program, the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Community Mental Health Block Grant (MHBG), the MHSA, and the Bronzan-McCorquodale Act. Counties administer community behavioral health services, providing or arranging for the provision of services to individuals who have a serious mental illness or serious emotional disturbance, those at risk of or with early onset of mental illness or emotional disturbance, and individuals who have a substance use disorder (SUD).

Federal requirements related to Medicaid, the Community MHBG and the SAPT Block Grant mandate DHCS to monitor behavioral health services provided with these funds, which includes data collection and reporting. In addition, there are state data collection, reporting, evaluation, and/or monitoring requirements related to MHSA and the Bronzan-McCorquodale Act. To comply with these requirements, it is essential that the number and diverse characteristics of individuals served, the outcomes, and use/impact of the funds, are accurately tracked, analyzed, and made available to the state and federal government, counties, the Legislature, the public, and other stakeholders in ways that are accessible and useful.

DHCS collects data relevant to these mandates using multiple data systems; however, DHCS' current behavioral health data collection and reporting systems and the IT infrastructure for these data systems makes data collection, analysis, and reporting extremely labor-intensive. There are 12 legacy behavioral health data systems that were transferred into DHCS with the former Departments of Mental Health and Alcohol and Drug Programs. Each of these legacy data systems are at least 12 years old, were built in dated technologies, and do not meet DHCS' Information Technology standards (e.g., server standards, server software standards, platform types, database standards, database management standards, etc.), requiring DHCS to house these data systems in an external environment (called the Data Migration Zone). This makes adding or changing data elements within these data systems very difficult and costly. Each county has local behavioral health data systems in which state and federally required data are captured, and then the data are extracted and submitted to the different 12 DHCS data systems in batches on a monthly basis. Also, there may be gaps in data collection, duplicative or redundant data collection, collection of data that may no longer be relevant or useful. Finally, there are significant data quality issues caused by the antiquated platform, lack of validations, among other issues.

The specific problems that the Comprehensive Behavioral Health Data Systems Modernization Project will seek to address include:

1. Tracking information: DHCS is often unable to track key information about clients receiving services such as number of clients served, specific programs in which clients are enrolled, appropriateness and characteristics of clients' services, clinical status of clients within individual programs and services, client-level outcomes, costs linked to services, specific funding sources used for a client's services, and client satisfaction levels.

2. Updating information: Unable to add or change data elements easily, limiting the ability to respond to changes in federal reporting standards or requirements, and negatively affecting counties' and providers' data collection and reporting efforts. This in turn can affect funding for programs. For example, requirements in the Medicaid Managed Care (MMC) Final Rule (42 Code of Federal Regulations Part 438) necessitate additional and new data collection, which cannot be implemented easily and require additional, manual data collection mechanisms. Data needs related to the Drug Medi-Cal Organized Delivery System (DMCODS) Waiver also cannot be easily met within the current behavioral health data systems infrastructure. These issues are a direct result of the current processes and systems that support the collection and storage of behavioral health data. Currently, data is spread across multiple systems which have not been designed to support consolidation. Each system has a separate user interface for data entry and submission. Each system is on a different technical platform and systems differ in how they store program data. Some key data elements (such as Provider ID) are not captured in each system. As a result, processes required for program data aggregation, evaluation, and reporting is manual and time consuming.

3. Evaluating effectiveness: DHCS is unable to evaluate the effectiveness of behavioral health services and its ability to meet program goals. DHCS is often unable to efficiently identify and evaluate trends in program effectiveness; facilitate timely and accurate communications with stakeholders about program effectiveness; support problem identification and resolution; associate client satisfaction levels with specific programs; and work with programs to implement program improvements and efficiencies. Additionally, processes required for program data aggregation, preparation, evaluation, analysis, and reporting are manual and time consuming. These issues are a direct result of the lack of data integration between the processes and systems discussed above; they are also exacerbated by existing gaps in data collection.

4. Monitoring compliance: DHCS cannot monitor and determine program compliance effectively. The ability to perform its program compliance responsibilities is constrained by the methods through which it acquires basic information from counties about behavioral health program offerings and program expenditures.

5. Enforcing data quality: DHCS is often unable to enforce consistent data quality standards across systems. Data quality across the behavioral health data systems is inconsistent, which reduces the usefulness of data analysis as a tool for effective decision-making. The current process of redundant data entry across multiple systems also creates an undue burden on trading partners when they try to submit their data. In addition, because automated systems cannot support all of the State's reporting needs, counties submit manually generated reports, which further contributes to data inconsistencies.

These issues are a direct result of the current processes and systems that support the collection and storage of behavioral health data. The data is fragmented across multiple systems that lack a consistent set of data validations. Each of these systems differs in how they receive and store program data. Some key data elements (such as Program ID) are not captured in every system. Additionally, processes required for program data aggregation, evaluation, and reporting is manual and extremely labor intensive. For example, monthly batch submissions from counties and/or providers must be manually extracted and formatted for data analysis. Similarly, all data analyses are manual as the data files extracted from each system must be manually imported into separate analytical software, which are then cleansed and prepared for analysis and reporting. The limited flexibility to modify these data systems and the labor intensive, manual data analysis processes, hinder efficient fulfillment of state and federal oversight and accountability requirements related to behavioral health services, and likely impact data reporting accuracy since there is a high number of manual steps that must be taken before the data may be analyzed.

The Stage 1 Business Analysis (81 BA) for this planning work was approved by CDT in October, 2016.

In order to address the behavioral health data system issues described above, in December 2017, DHCS submitted a Planning Advanced Planning Document (PAPD) to CMS to request enhanced FFP for 21 months of planning activities for the Data Modernization Project. On February 2, 2018, CMS approved the total computable costs requested in the PAPD, for Federal Fiscal Years (FFYs) 2018 and 2019. The total amount approved by CMS for FFY 2018 & 2019 is $1,148,937. DHCS will initiate a Request for Offer (RFO) to obtain contractor services through an IT vendor to conduct the business and alternatives analyses necessary to inform the next phase of the project. These planning work and analyses will include:

- Identification and involvement of key stakeholders (e.g.. County Behavioral Health Directors Association of California, IT Committee; MHSOAC, CMHPC, etc.);
- Development of high-level 'as-is' and 'to-be' business processes;
- Identification of existing cost to support the community behavioral health systems and collect, analyze and report on behavioral health program data;
- Development of high-level business requirements;
- Identification and analysis of solution alternatives in the marketplace;
- Recommendation of preferred solution(s);
- Estimation of the cost to acquire, build, and maintain the proposed solution(s);

- Development of a methodology to allocate the project cost over the appropriate state and federal programs;
- Identification of a proposed project timeline;
- Development of an Implementation Advanced Planning Document (lAPD) and Stage 2 Alternatives Analysis; and
- Analysis of the certification checklists and MECL requirements associated with this project. The information gathered through the activities described above will be used by the contractor to develop an lAPD to request FFP for the cost of the Design, Development, and Implementation (DD&I) activities and a Stage 2 Alternatives Analysis (S2AA) for submission to the California Department of Technology (CDT). If approved by the State, the lAPD would need to be submitted to CMS, to request approval and additional FFP for the DD&I phase of the project. The S2AA will be submitted to CDT for required reporting through CDT's Project Approval Lifecycle (PAL) process.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this BCP.

Staff Recommendation: No action is recommended at this time.

ISSUE 7: HOMELESS MENTALLY ILL OUTREACH AND TREATMENT

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Homeless Mentally Ill Outreach and Treatment (Issue 415)

It is requested that Item 4260-118-0001 be added in the amount of $50 million in one-time funding for the Department to provide counties with targeted funding for multi-disciplinary teams to provide intensive outreach, treatment, and related services for homeless persons with mental illness. To implement this proposal, DHCS requests the following provisional language:

4260-118-0001—For local assistance, the State Department of Health Care Services 50,000,000

Schedule:
(1) 3960050-Other Health Care Services 50,000,000

Provisions:

1. The distribution of funds appropriated in this item shall be allocated by the State Department of Health Care Services, in consultation with the Department of Finance and California State Association of Counties, and shall consider a county incidence of homeless individuals with serious mental illnesses and county population. The initial allocation will be completed and shared no later than July 31, 2018. Allocations to local entities may include counties with Whole Person Care pilots, but are not limited to counties with such pilot programs. Other counties with demonstrated need, including populations with recent involvement in the criminal justice system or release from incarceration are eligible to receive funding under this item.
    a) Interested counties may submit requests for an allocation pursuant to this item within 90 days of enactment of this act. This request shall be accompanied by a resolution, adopted by the county's board of supervisors, supporting the use of funds for the intended purpose of this item.
    b) Counties may use all available and appropriate funding to leverage other fund sources, such as federal grants in serving individuals with severe mental illness who are also homeless or at immediate risk of being homeless.
    c) These funds shall pay for only that portion of the costs of services not otherwise provided by federal funds or other state funds and shall not supplant other funds for these purposes.
    d) Counties that receive an allocation pursuant to this item shall be required to report to the State Department of Health Care Services within 90 days after the full expenditure of funding pursuant to this item. This report shall include the disposition of such funds, the services provided and the number of individuals receiving services.
    e) These allocations shall be implemented only to the extent that federal financial participation is not otherwise jeopardized.

f) Notwithstanding any other law, for any fiscal years in which the State Department of Health Care Services implements the allocations described in this provision, the amount of state funding provided shall not be included as revenues for purposes of determining an applicable county's redirection obligation pursuant to Article 12 or Article 13 of Chapter 6 of Part 5 of Division 9 of the Welfare and Institutions Code.
g) The funds appropriated in this item shall be available for encumbrance or expenditure until June 30, 2020.
h) These funds shall be distributed by the Controller according to a schedule provided by the Department of Finance for counties that comply with provision (a).
i) Notwithstanding subdivision (h) of Section 14184.60 of the Welfare and Institutions Code, local entities may participate and apply for an allocation pursuant to this item.

2. Of the funds appropriated in Schedule (1), $150,000 shall be available to the State Department of Health Care Services for the activities described in Provision 1. The Department of Finance may authorize the transfer of expenditure authority from Schedule (1) of this item to Schedule (1) of Item 4260-001-0001.

BACKGROUND

The May Revision proposes a one-time augmentation of $50 million, and associated budget bill language, for DHCS to provide counties with targeted funding for intensive outreach, treatment and related services for individuals with severe mental illness who are also homeless or at immediate risk of being homeless.

This funding is expected to result in outcomes such as: earlier identification of mental health needs, prevention of criminal justice involvement, improved coordination of care for this population at the local level, and reductions in hospitalization and homelessness.

Based on the principles of Chapter 518, Statutes of 2000 (AB 2034) and Chapter 617 Statutes of 1999 (AB 34), the one-time funding will be allocated to counties, which will be encouraged to leverage other fund sources, such as federal grants in serving individuals with mental illness who are homeless and at immediate risk of homeless.

In making the allocations, DHCS, in consultation with the Department of Finance and California State Association of Counties, will consider a county's incidence of homeless individuals with severe mental illness and county population. Allocations will be completed and shared by July 31, 2018.

Within 90 days of being identified, counties will be responsible for submitting a request for allocation accompanied by a resolution adopted by the county's board of supervisor supporting the use of funds. Within 90 days of full expenditures of the allocated funds, the county must report to DHCS on the use of the funds, services provided, and the number of individuals who received services.

Of the $50 million proposed, $150,000 will be available for DHCS to implement these provisions. The funds will be available for encumbrance or expenditure until June 30, 2020, and cannot be used to supplant other funds.

Legislative Analyst

The LAO provided the following comments and analysis:

One-Time Nature of Funding Proposal Raises Questions. We agree with the administration that homelessness and mental health are significant and related issues in the state. We do have questions, however, as to how limited-term funding for services is intended to fund ongoing needs. In order for grant-receiving programs to have lasting effectiveness, it might be necessary to allocate additional sustaining funds. The administration has not currently indicated that it considers the programs that would receive grants as pilot programs that may receive ongoing or expanded funding in the future. It is also unclear how the administration determined the particular size of the proposed allocation.

Unclear How Proposal Interacts With the Governor's Larger Mental Health and Homelessness Initiatives. Additionally, this program is proposed by the administration in conjunction with the No Place Like Home program, which also directs funding to counties for homeless persons with mental illness, but with an emphasis on financing the provision of housing for the target population as opposed to funding teams that provide mental health services. It is uncertain the extent to which the administration intends that these two programs will be coordinated or interact with each other.

Proposed Authorizing Language Grants Administration Significant Discretion and Lacks Detailed Reporting Requirements. Furthermore, while the administration has stated its intent to incorporate program design and lessons learned from the pilot grant programs established by AB 2034 (2000) and AB 34 (1999), the proposed budget bill language does not codify this intent and therefore lacks the same level of detailed prescriptions related to the award of grants, service standards, reporting, and program evaluation contained in those prior statutes.

Questions for the Legislature to Ask the Administration. During May Revision budget hearings, we recommend the Legislature obtain additional information from the administration regarding this proposed grant program, including:

- ***Specific Objectives of the One-time Funding.*** Such information could include both short-term goals and how this program fits into a broader, long-term strategy for addressing homelessness and mental health. The Legislature might also want to consider to what extent the proposed program should be coordinated with the larger mental health and homelessness initiatives—including the No Place Like Home program—and what the administration's rationale is for doing so or not. The administration should also disclose specific objectives of what this proposed funding is intended to achieve, such as, for example, the number of homeless persons with mental illness that will be served.
- ***Administration's Perspectives on Appropriateness and Tradeoffs of a One-Time Funding Allocation.*** The administration should address (1) the appropriateness and tradeoffs of providing limited-term funding for services where there are ongoing needs and (2) its plans, if any, of structuring the proposed grant program as a pilot program.
- ***Greater Detail on How the Program Will Be Structured.*** The administration should provide the Legislature with a more explicit description of which components of AB 2034 and AB 34, as well as the subsequent recommendations from studies of those programs, would be incorporated into this proposed program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 8: PAYMENTS TO COUNTIES FOR SERVICES FOR SERIOUSLY EMOTIONALLY DISTURBED CHILDREN & SPECIALTY MENTAL HEALTH SERVICES FEDERAL AUDIT SETTLEMENT

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

AB 3632 Mandate Payments

The May Revision includes repayment of approximately $254 million plus interest for repealed state mandates related to services provided by counties to seriously emotionally disturbed children (AB 3632). The Administration expects counties to use this funding for early intervention and prevention of mental health services for youth, with an emphasis on teens.

Specialty Mental Health Services Federal Audit Settlement (Issue 403)

It is requested that Item 4260-101-0001 be increased by $180.7 million and Item 4260-101-0890 be decreased by $180.7 million to repay the federal government for specialty mental health disallowances. The responsibility for specialty mental health services was realigned to counties as part of 2011 Realignment. These funds will be paid by the state in 2018-19 with repayments from counties occurring over the next four years to prevent significant funds from being removed from the mental health delivery system in a single year.

STAFF COMMENTS/QUESTIONS

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

1. Can the state direct the use of the AB 3632 mandate payments?

2. Could counties choose to use these funds to cover the upfront implementation costs of AB 1299 (Ridley-Thomas, Chapter 603, Statutes of 2016)?

Staff Recommendation: No action is recommended at this time.

ISSUE 9: ELECTRONIC VISIT VERIFICATION MULTI-DEPARTMENTAL PLANNING TEAM

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Electronic Visit Verification Multi-Departmental Planning Team (Issue 401)
It is requested that Items 4260-001-0001 and 4260-001-0890 both be increased by $143,000 to support planning workload to comply with federal Electronic Visit Verification requirements related to Waiver Personal Care Services and Home and Community-Based Services programs.

This request is a component of an Agency-wide proposal which requests $949,000 ($558,000 General Fund) in total for limited-term resources to support planning of a federally mandated electronic visit verification (EW) system across multiple programs. The other components of this proposal were included on the Subcommittee's morning hearing agenda today (May 16, 2018).

BACKGROUND

EVV is a telephone and computer-based method that electronically verifies service visits. Pursuant to Subsection I of Section 1903 of the Social Security Act (42 U.S.C. 1396b), all states must implement EVV for Medicaid-funded personal care services by January 2019 and home health care services by January 2023. There is no prescribed solution from the federal government, so states can select and implement their own EVV design. However, EVV systems must verify:

- Type of service performed; Individual receiving the service;
- Date of the service;
- Location of service delivery;
- Individual providing the services; and
- Time the service begins and ends.

EVV will impact all personal care services and home health care services provided under the Medi-Cal state plan and various Medicaid Home and Community-Based Service (HCBS) programs. In California, personal care services are delivered to eligible aged, blind and disabled individuals as an alternative to out-of-home care, such as nursing or assisted living facilities. These services are provided through programs managed by the CDSS, the Department of Developmental Services (DDS), the Department of Health Care Services (DHCS), the Department of Public Health (CDPH),

and the Department of Aging (CDA) that support over 600,000 recipients. Most publicly-funded personal care services are managed by CDSS through the following four programs collectively known as the In-Home Supportive Services (IHSS) Program:

- Personal Care Services Program
- IHSS Plus Option
- Community First Choice Option
- IHSS Residual

DHCS and its designees (CDA, DDS and DPH) are responsible for providing oversight of personal care services provided under HCBS programs. Impacted HCBS programs include:

1. Home and Community-Based Alternatives Waiver
2. In-Home Operation
3. Assisted Living Waiver
4. Pediatric Palliative Care Waiver
5. HIV/AIDS Waiver
6. HCBS Waiver for Californians with Developmental Disabilities
7. 1915(i) State Plan Amendment for Californians with Developmental Disabilities
8. Multipurpose Senior Services Program
9. Coordinated Care Initiative
10. Senior Care Action Network Health Plan

Through regional centers, DDS provides EW-impacted services (e.g. supported living, respite, and personal assistant services) to individuals with developmental disabilities, but does not have an E W system.

Currently, the Case Management Information and Payrolling System (CMIPS) provides payroll, case management, and reporting services for the CDSS managed IHSS programs administered by California's 58 counties; however, it does not meet all the EVV requirements.

In November 2017, a Request for Information (RFI #32236) for EVV was released for consideration of all impacted departments. Responses were received from vendors in December 2017. Currently the vendor responses are being reviewed by the Office of System Integration (OSI), CDSS, DHCS, and DDS.

There are two models for the provision of personal care services. Individual Provider and Agency Provider. Individual Providers are employed directly by the recipients and/or waiver recipient, who hire and direct them, while the State processes the payroll on behalf of recipients and waiver recipients. It is most common to have a one-to-one (one recipient with one provider) relationship. However, some recipients have multiple providers, and some providers work for multiple recipients. In these situations the IHSS and/or Waiver Personal Care Services (WPCS) recipient is the employer and IHSS and/or WPCS provider is the employee. The Agency Providers are employed by commercial agencies who manage their work, process payroll and issue their paychecks. These agencies can either have contracts with counties or enroll through

DHCS as a Medi-Cal provider. Due to the various programs impacted by this federal mandate, CHHS will have to deploy both an Individual and Agency model.

Throughout 2018, California has planned an extensive stakeholder communication and collaboration process to inform the planned design and implementation of the EVV solution, however the State does not anticipate meeting the January 2019 deadline. The State plans to work with the Centers for Medicare and Medicaid Services (CMS) to request a good faith effort extension of time, and will work with CMS and stakeholders to identify a realistic implementation timeline that will allow for full stakeholder engagement. This cross-department request provides for the consideration, design, development, and procurement work needed for system development and the initial implementation of EVV.

The Legislative Analyst

The LAO provided the following comments and analysis:

Federal law requires states to use an Electronic Visit Verification (EVV) system for Medicaid personal care services by January 1, 2019, and for home health care services by January 1, 2023. Required functions of the EVV system include electronically collecting and verifying date of service, start and end time, and type of services provided—functions that the current systems in California are not fully equipped to do. Failure to comply with EVV will result in the escalating reduction of Medicaid federal funds for only those services affected by EVV. It is our understanding that the administration is working with the federal government to request a "good faith effort" time extension to implement EVV in order to avoid the out-year penalties for failure to comply with the set deadlines. Below, we discuss the May Revision proposal regarding the planning and subsequent implementation of EVV across various departments.

Governor's May Revision Proposal

Proposal. The Governor's May Revision requests $949,000 ($559,000 General Fund) for two-year limited-term resources to support planning for the federally mandated EVV system across multiple departments. Specifically, these resources are shared across DSS, DHCS, and DSS as they administer personal care service programs subject to the federal EVV mandate. OSI will also receive a portion of the requested resources as it will be a technical liaison to stakeholders, participate in risk management activities, and provide technical assistance during the planning effort.

Provisional Budget Bill and Trailer Bill Language. Reflecting that DSS is potentially further ahead in its planning to support the implementation of EVV relative to other departments, the Governor proposes provisional budget bill language that authorizes Finance to increase DSS's state operations and local assistance resources by an unlimited amount in 2018-19 to develop and implement an EVV solution. The Governor also proposes trailer bill language that exempts the administration from creating regulations for the implementation of EVV—allowing it to instead implement solely through all county letters.

LAO Assessment and Recommendations

Resource Request Appears Reasonable. We have no specific concerns with the resources requested in the proposal. We agree that some resources are necessary to implement these changes.

Administration May Need Some Flexibility… Given the complexity and limited information surrounding the details of what the federal government will ultimately require from an EVV system, and the potential penalties for not complying, we understand that the administration may need *some* level of increased flexibility to implement EVV.

…But Proposed Language Limits Legislative Oversight. Although some flexibility may be needed, we find the proposed language to be too broad and limiting of legislative oversight. As such, we encourage the Legislature to ask the following questions in order to gain the necessary information to place additional parameters within the language. The goal would be to allow some flexibility without jeopardizing legislative oversight.

1. When does the administration expect to develop and implement EVV?
2. How much will development and implementation of EVV cost?
3. The budget bill limits the number of days the Joint Legislative Budget Committee (JLBC) has to review any proposed augmentation from the typical 30 calendar days down to 10. This shorter timeframe would necessarily limit legislative oversight of the project. Why is this shortened timeline necessary?

The proposed trailer bill language seems to exempt DSS from the typical rulemaking process for EVV. It is unclear to us why the trailer bill language is necessary. Why is the typical rulemaking process not viable for EVV?

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal, and explain how this fits into the Agency-wide proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 10: CALIFORNIA MEDICAID MANAGEMENT INFORMATION LEGACY AND MODERNIZATION RESOURCES (CA-MMIS) AND MODERNIZATION MODULES PROVISIONAL LANGUAGE

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

California Medicaid Management Information Legacy and Modernization Resources (CA-MMIS) (Issue 406)

The Department of Health Care Services (DHCS), CA-MMIS Division requests expenditure authority of $41,715,000 ($9,675,000 General Fund (GF), $32,040,000 Federal Fund (FF)) in Fiscal Year (FY) 2018- 19. The following resources requested are necessary to further implement and expand our Modernization Approach:

- 17.0 permanent positions and associated expenditure authority in FY 2018-19, increasing to 25.0 positions in FY 2019-20 and ongoing, consistent with the phased-in approach in transitioning fiscal intermediary (FI) contract responsibilities to state staff.
- Expenditure authority equivalent to 2.0 two-year, limited-term (LT) positions;
- Three-year funding for personal services contractors (consultants);
- Two-year funding for hardware and software; and
- Provisional budget bill language to address funding needs related to additional digital services team activities, subject to approval of requisite state and federal project documents.

New and Additional CA-MMIS Modernization Modules

It is requested that the following provisional language be added to Items 4260-001-0001 and 4260-001-0890 to allow for an augmentation of $5,298,000 General Fund and $47,684,000 federal funds for project activities related to additional modules for the CA-MMIS modular modernization efforts, subject to verified satisfactory progress that incorporates lessons learned, or completion of milestones related to CA-MMIS modernization modules that are in progress:

Add the following provision to Item 4260-001-0001:

6. The Department of Finance may augment the amount appropriated in Item 4260-001-0001 up to a maximum of $5,298,000 for project activities related to additional modules for the CA-MMIS modernization effort upon approval of the Department of Finance, in consultation with the Department of Technology. The approval shall consider verified satisfactory progress that incorporates lessons learned, or completion of milestones related to CA-MMIS modernization modules that are in progress. Any such increase shall be authorized no less than 10 calendar days following written notification to the Chairperson of the Joint Legislative Budget Committee, or a

lesser period if requested by the Department and approved by the Chairperson of the Joint Legislative Budget Committee, or his or her designee.

Add the following provision to Item 4260-001-0890:
1. The Department of Finance may augment the amount appropriated in Item 4260-001-0890 up to a maximum of $47,684,000 for project activities related to additional modules for the CA-MMIS modernization effort upon approval of the Department of Finance, in consultation with the Department of Technology. The approval shall consider verified satisfactory progress that incorporates lessons learned, or completion of milestones related to CA-MMIS modernization modules that are in progress. Any such increase shall be authorized no less than 10 calendar days following written notification to the Chairperson of the Joint Legislative Budget Committee, or a lesser period if requested by the Department and approved by the Chairperson of the Joint Legislative Budget Committee, or his or her designee.

BACKGROUND

Last spring, the FY 2017-18 "CA-MMIS Modernization" Budget Change Proposal (BCP) (4260-501-BCP-2017-MR CA-MMIS Modernization) was approved. This initial funding and resources provided DHCS with the means to begin implementation of the CA-MMIS Medical Fee-for-Service Claims Processing Modernization Approach (Modernization Approach) strategy, to replace the legacy CA-MMIS.

DHCS is the single state agency responsible for the administration of California's Medicaid program, known as Medi-Cal, which provides health care to approximately 13.5 million members. DHCS contracts with a fiscal intermediary (FI) to maintain and operate CA-MMIS, which is utilized to process approximately 200 million claims annually for payment of medical services provided to Medi-Cal members, resulting in over $19 billion a year in payments to health care providers. Under the CA-MMIS contract, the FI adjudicates both Medi-Cal and non-Medi-Cal claims for the state and delivers other FI services to program providers, beneficiaries, and federal and state users of the system. The CA-MMIS Division is responsible for oversight, management, monitoring, and administration of the single FI vendor responsible for providing information technology system maintenance and operations (IT M&O) and business operations (Bus Ops.) services, as well as the design, development and implementation (DD&I) of a new system to modernize CA-MMIS. DHCS defines CA-MMIS as a nearly 40-year-old legacy system, comprised of 92 separate systems that supports 24 DHCS programs and ten Medicaid Information Technology Architecture (MITA) Business Areas. This definition is consistent with the language in 42 Code of Federal Regulations, Section 43.111, which defines the Medicaid Management Information Systems (MMIS) as a "system of systems" and indicates "the pertinent business areas are those included in the MMIS Certification Toolkit," which align with the business areas in the MITA Framework.

In 2010, through the competitive bid process, DHCS contracted with an FI vendor to maintain and operate CA-MMIS. The contractor was also responsible for the DD&I of a new system to replace CA-MMIS. In 2015, due to continued missed deadlines, DHCS and the FI reached a settlement agreement to terminate the System Replacement Project (SRP) DD&I activities creating both a challenge and new opportunity for

replacement efforts. Subsequently, under the settlement agreement, the terminated SRP activities, including DD&I, project management, integration and testing activities were transitioned to DHCS ownership. The fiscal intermediary contractor continues to provide IT M&O and business services in operating the CA-MMIS legacy system until September 30, 2019, at which point DHCS intends to award new vendors to provide IT M&O and Bus Ops. services. Currently, the CA-MMIS Division is tasked with transforming its role from "oversight to ownership" (020) to absorb the transitioned activities listed above and to replace the legacy system with a modern, robust, and Centers for Medicare and Medicaid Services (CMS) compliant system. This fulfills two of three strategic initiatives that are represented in this BCP:

1. Sustain - Ensure stable and effective operations.
2. Transform - Implement organizational changes for CA-MMIS Division's expanded role from 020 managing a multi-vendor environment.
3. Innovate - Implement a new CA-MMIS solution.

The termination of previous SRP DD&I came at a time where the pace of technological change for health enterprise data systems had significantly accelerated in the years since DHCS began procurement work on the terminated project. This termination created an opportunity to significantly change and improve our replacement approach. At the same time, the termination also meant that DHCS would be required to continue to utilize a Medi-Cal claims processing system that is more than 40-years-old and is comprised of severely outdated technology. These changes created an opportunity for DHCS to examine the best approach forward so California has a modern, robust and sustainable system that meets CMS' expectations, our various health programs needs, and is designed around the business areas of the MITA Business Architecture/Areas.

In 2016 and 2017, after in-depth planning and discussions with state and federal partners, including the California Department of Technology (CDT) and our various program and business partners, the CA-MMIS Division developed a new Modernization Approach to replace the legacy CA-MMIS and planned the approach for meeting our 020 initiative. The adopted approach to replace the legacy system includes using a modular procurement approach coupled with agile design and development techniques to incrementally deliver new functionality to CA-MMIS across multiple fiscal years. This consists of iteratively implementing CA-MMIS business functionality in the form of "digital services" as they are developed. Each new digital service will replace CA-MMIS business functionality that aligns with a MITA Business Area and will be delivered by DSTs. Implementation of our Modernization Approach and 020 initiative kicked off with the approval of our FY 2017-18 Modernization BCP, which authorized the new positions and personal services consultants needed. During FY 2017-18, the CA-MMIS Division has made significant progress in implementing the approved activities outlined in our FY 2017-18 Modernization BCP. The BCP milestones and corresponding status for each include:

BCP Milestones	Current Status
FY 2017-18	
1. Recruit and fill 7.0 positions approved in 4260-501-BCP-2017-MR CA-MMIS Modernization	***In progress*** - Interviews complete for 7.0 positions; 5.0 position filled, 2.0 positions pending selection of candidate and on target to be filled by end of May 2018.
2. Identify service, product, and delivery managers	***Completed August 2017*** – Product Owner (business) and Product Manager in place for MedCompass, Cal-ARM (California Automated Recovery Management) and Federal Draw and Reporting (FDR, formerly CMS64).
3. Procure consultants	***In progress*** – Advisory consultants to support agile coaching and digital services start-up in place. Modern Development Environment (MDE) vendor to be announced following CMS' approval of the selectee by end of June 2018.
4. Establish DSTs	***Completed December 2017*** – MedCompass ***In progress*** – Cal-ARM, team in place. Procurements in process. Solicitation release target is June 2018, with Intent to Award in February 2019. ***In progress*** – FDR, team in place. Procurements in progress for engineering staff. Draft solicitation release target is May 2018.
5. Procure hardware, software, and hosting services necessary to establish a modern development environment (MDE) for the DSTs	***Completed December 2017*** – Initial Modern Development Environment (MDE) configuration defined. Hardware and hosting accounts in place for Amazon Web Services. Required software licensing in place with accounts active. ***In progress*** – MDE Vendor procurement evaluation complete and control agency approvals in process. Target completion date is May 2018.
6. Initiate the first two system modules/initiatives: i. a solution (Advantage Collection Application, or Computer Assisted Collection System for Government) to replace existing systems for collections and recoveries by the Third Party Liability and Recovery Division. ii. a solution, FDR to replace the federal draw and reporting system	***In progress –*** i- Cal-ARM (Third Party Liability): • Statement of work for the Cal-ARM is under development, target completion date is June 2018. ii- FDR: • Development of user stories underway in collaboration with program representatives and product owners. • Acquisition of engineering resources in process. Draft procurement was released

BCP Milestones	Current Status
FY 2017-18	
and processes utilized within the Department.	for vendor comment and questions and is concurrently under review by CMS.
7. Complete the discovery process for both DST projects.	***In progress*** – • Discovery underway and on-track for Cal-ARM. • Discovery complete for FDR.
8. Complete the alpha process (building a working prototype of the service to validate assumptions and test the solution against real user needs) for Advantage Collection Application.	***Completed June 2017*** – After market survey analysis for Cal-ARM project conducted with CDT determined that the best value to the state was to pursue a competitive procurement.
9. Start the beta process (building the service to production level standards) for Advantage Collection Application; complete the alpha process for FDR.	***In progress*** – To begin engineering on FDR pending Project Approval Lifecycle (PAL) Approval. On track to begin procurement for Cal-ARM.
10. Develop a Service Management Framework that supports delivery of IT services and the transfer of functions from the FI to the state, to support Modernization and O2O efforts.	***Completed September 2017*** – CA-MMIS Service Management Framework and Project Management Frameworks. ***In progress*** – Implementation of services and capabilities within the Frameworks, target start date of June 2018.

Given the progress and successes of the milestones achieved, the department proposes to move forward with implementing further phases of the Modernization Approach and 020 initiatives; this BCP seeks specialized resources for this purpose.

The Legislative Analyst

The LAO provided the following comments and analysis:

Proposal. DHCS requests expenditure authority of $42 million ($10 million General Fund, $32 million federal funds) and 17 permanent positions in 2018-19 to continue efforts to modernize CA-MMIS—the state's fee-for-service (FFS) claims processing system for Medi-Cal. (The BCP adds an additional 8 permanent positions in 2019-20, with no additional expenditure authority requested at this time.) The administration estimates that the total cost of the CA-MMIS modernization project will be between $400 million and $600 million, $40 million to $60 million of which will be General Fund as the project likely qualifies for an enhanced federal medical assistance percentage (FMAP) of 90 percent. (Design, development and implementation activities that support state MMIS systems generally qualify for a 90 percent FMAP.) The administration also estimates that it will take about 10 years to complete the modernization project.

LAO Assessment. We have concerns about the lack of detail included in the project timeline and about the provisional language attached to the proposal:

Proposed Timeline Lacks Sufficient Detail. The administration's proposed timeline of about 10 years, with a total cost of between $400 million and $600 million, does not provide the Legislature with enough information about—as examples—the estimated completion dates for currently proposed system modules, the future modules that are being considered as part of the project, and the estimated costs associated with each module. Limited information prevents the Legislature from exercising its oversight responsibility for this project.

Provisional Language Provides Administration Too Much Discretion to Increase Costs. Provisional language included in the BCP allows the administration to augment appropriations for this proposal by $53 million ($5.3 million General Fund, $47.7 million federal funds). This means appropriations for the proposal could more than double, if approved by the Department of Finance. The provisional language also reduces the number of days the Joint Legislative Budget Committee (JLBC) has to review any proposed augmentation from 30 calendar days down to 10. This shorter timeframe would inappropriately limit legislative oversight of the project.

LAO Recommendations. Based on our assessment, we recommend the Legislature:

Request Additional Information About the Project From DHCS. We recommend the Legislature request that DHCS provide more information about the project, including those details we described that are currently lacking in the department's proposed timeline.

Require DHCS to Justify Augmentation Language. We recommend the Legislature require that DHCS justify the maximum amounts included in the proposed augmentation language. Should DHCS be unable to provide sufficient evidence of the need for these maximum amounts, the Legislature could consider reducing those amounts to (at a minimum) less than the cost of the proposal.

Revise Provisional Language to Provide JLBC With 30 Calendar Days to Review Proposed Augmentations. We recommend the Legislature revise the proposed provisional language to give the JLBC its traditional 30-day timeframe to review proposed augmentations of appropriations for this project.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this BCP and proposed provisional language.

Staff Recommendation: No action is recommended at this time.

ISSUE 11: COST-BASED REIMBURSEMENT CLINIC DIRECTED PAYMENT PROGRAM TRAILER BILL

PANEL

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Trailer bill language is requested to establish a directed payment program for certain cost-based reimbursement clinics (CBRCs), effective no sooner than July 1, 2019. This proposal will expand cost-based reimbursement for CBRCs that contract with managed care plans for services provided to Medi-Cal beneficiaries.

BACKGROUND

DHCS reimburses Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) a Prospective Payment System (PPS) rate for services provided to Medi-Cal fee-for-service beneficiaries. For the dual Medicare/Medi-Cal beneficiaries or beneficiaries enrolled in managed care plans, the Department establishes an interim rate paid to the clinics. Annually, the Department calculates the difference between each clinic's final PPS rate and the expenditures already reimbursed and provides a differential payment to these clinics to achieve the equivalent PPS rate.

DHCS reimburses Cost-Based Reimbursement Clinics (CBRC), as defined in Welfare and Institutions Code section 14105.24, at 100 percent of reasonable and allowable costs for services provided to beneficiaries in Medi-Cal fee-for-service and for Seniors and Persons with Disabilities in Medi-Cal managed care. Currently, CBRCs that contract with managed care plans do not receive cost-based reimbursements for other Medi-Cal populations, and do not receive a differential payment similar to FQHCs and RHCs.

This proposal establishes a new Cost-Based Reimbursement Clinic Directed Payment Program no sooner than July 1, 2019 to reimburse CBRCs that contract with managed care plans as described in 14105.24. The nonfederal share of the Program may be funded through voluntary intergovernmental transfers from public entities pursuant to WIC section 14164. Subject to an appropriation in the annual Budget Act, the first thirty million dollars of nonfederal share in each subject fiscal year, or such lesser amount as determined by the department, shall be financed by other state funds appropriated to the department for this purpose.

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that amended and expanded the requirements of Title 42, Code of Federal Regulations (CFR) Part 438 pertaining to Medicaid managed care. The final rule introduced new requirements, practices, and procedures related to Medicaid capitation rate setting, and fundamentally overhauled existing ones. In particular, the final rule prohibits states from directing provider reimbursement through managed care contracts (Title 42, CFR Section 438.6(c-d)), except in the following circumstances:

- Through one of the following allowable directed payment mechanisms:
    - Value-based purchasing models for provider reimbursement, such as pay-for-performance arrangements, bundled payments, or other payment arrangements that recognize value or outcomes over volume of services;
    - Delivery system reform or performance improvement initiatives; and
    - Minimum or maximum fee schedules, or uniform dollar or percentage increases, for network providers that provide designated services under the contract; or

- Through existing pass-through payments, as defined in Title 42, CFR Section 438.6(a), subject to a 10-year phase-down and annual "base amount" calculation beginning July 1, 2017.

This proposal is allowable under the CMS Final Rule requirements for reimbursements to managed care plans.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposed trailer bill.

Staff Recommendation: No action is recommended at this time.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 12: METROPOLITAN BED EXPANSION

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Metropolitan State Hospital Bed Expansion (Issue 300)
It is requested that Item 4440-011-0001 be decreased by $28,304,000 and 183.3 positions to reflect the delayed activation of 140 incompetent to stand trial beds at Metropolitan State Hospital. Activation of the first unit is estimated to shift from September 2018 to March 2019.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 13: JAIL-BASED COMPETENCY TREATMENT PROGRAM EXPANSIONS

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Jail-Based Competency Treatment Program Expansions (Issues 310, 320, 330, 340)

It is requested that Item 4440-011-0001 be decreased by $6,514,000 to reflect reduced costs and fewer beds in the Jail-Based Competency Treatment program expansions included in the Governor's Budget. This change reflects recent contract negotiations and activation delays. The loss of beds is partially offset by a new 15-bed activation for a net decrease of 13 beds in budget year.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 14: ENHANCED TREATMENT PROGRAM IMPLEMENTATION

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Enhanced Treatment Program Implementation (Issues 350, 360)
It is requested that Item 4440-011-0001 be decreased by $7,406,000 and 80.1 positions to reflect savings associated with the delayed activation of four Enhanced Treatment Program units at Atascadero and Patton State Hospitals. The timeline has shifted from activating the first unit in September 2018 to March 2019. This decrease is net of a requested one-time increase of $2,140,000 to install communication and safety systems for the second two units to be activated.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 15: LOS ANGELES COUNTY INCOMPETENT TO STAND TRIAL TREATMENT IN COMMUNITY SETTING

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Los Angeles County Incompetent to Stand Trial Treatment in Community Setting (Issues 230, 260)

It is requested that Item 4440-011-0001 be decreased by $1,666,000 to reflect a phased-in approach for community placements. This net decrease assumes a limited-term request for contract resources to treat and divert an additional number of incompetent to stand trial referrals while in jail to avoid being admitted to state hospitals.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 16: NAPA EARTHQUAKE REPAIRS ADJUSTMENT

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Napa Earthquake Repairs Adjustment (Issue 290)
It is requested that Item 4440-011-0001 be amended by increasing reimbursements by $1,217,000, to reflect the expected increase in Federal Emergency Management Agency funding to repair damages sustained at Napa State Hospital during the August 2014 earthquake.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 17: PROTECTED HEALTH INFORMATION IMPLEMENTATION

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Protected Health Information Implementation (Issue 001)

The Department of State Hospitals (DSH) requests $988,000 General Fund for 8.0 three-year limited term positions beginning in Fiscal Year (FY) 2018-19 to implement new procedures for processing invoices and payments from external medical providers containing Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA); and consolidating DSH's financial operations into a single appropriation/budget unit. This request will help DSH to more effectively process payments for outside medical services without jeopardizing access to PHI and quality patient care as well as standardizing the process for capturing medical invoice data and minimizing redundant key data entry.

BACKGROUND

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals and employs nearly 11,000 staff. Additionally, DSH provides contracted services such as jail-based competency treatment programs, the admission, evaluation, and stabilization program, and conditional release programs throughout the 58 counties. In 2016-17, DSH served 13,403 patients with an average daily census of 7,087; and the jail-based competency programs served a total of 729 patients with a capacity of 178. The conditional release program (CONREP) maintains an average daily census of approximately 636. DSH's five state hospitals are Atascadero, Coalinga, Metropolitan - Los Angeles, Napa and Patton. Pursuant to the Budget Act of 2017-18, the psychiatric programs operating at state prisons in Vacaville, Salinas Valley, and Stockton, where DSH treated mentally-ill prisoners, have been transferred to the responsibility of the California Department of Corrections & Rehabilitation (CDCR) as of July 1, 2017. DSH continues to designate 336 beds at three of its state hospitals, Atascadero, Coalinga, and Patton for the treatment of mentally-ill prisoners.

DSH uses the State's California State Accounting and Reporting System (CalSTARS) application for its critical accounting and financial reporting and makes medical supplier payments via the State Controller's Office (SCO) claim schedule output. DSH currently processes over 55,000 invoices and more than 65 percent of these (35,750) contain

protected health information (PHI). DSH patients have unique and acute medical and clinical needs that oftentimes require visits to specific external providers (i.e. specialists, emergency services, etc.). These medical providers' invoices in turn contain a combination of patient information (i.e. patient's name, patient identification number, diagnosis, medical service received, date of service, etc.) to document services rendered to DSH patients.

Invoices that contain PHI are governed by mandated HIPAA requirements. Each state hospital receives direct invoices from outside medical providers for services rendered to its patients. Every invoice is adjudicated by the appropriate DSH accounting and program staff.

As DSH undertakes efforts to increase automation such as moving from paper-based processes into electronic systems, there is additional risk of exposure of PHI. New electronic systems introduce the need to improve DSH protection measures, auditing and incident response, and to develop and implement policies and procedures for internal controls. As noted previously, a significant portion of DSH's invoices contain confidential and sensitive information, including patient data that falls under mandated HIPAA compliance. Security experts estimate data breach costs ranging from $150 to $350 per record. These costs include required fines that the state would pay and services for the individuals impacted that include phone service to answer questions, advertising to publicize the breach, and credit monitoring services if social security numbers (SSN) are involved. A data breach would be detrimental to those whose data is compromised and costly to the State.

One area of vulnerability for a security breach is processing payments for external medical providers. FI$Cal is not configured to accept PHI and given DSH's approximate volume of 36,000 PHI invoices, the risk of information security breaches is high. As such, DSH must develop a HIPAA compliant process for procurement, claim adjudication, and claim payments of approximately 36,000 invoices to external providers. The PHI solution requires the development of a data base known as the Medical Claims Processing (MedCP) system which will standardize the process for capturing medical invoice data. MedCP will de-identify PHI so payments can still occur timely, but will not include any PHI, consequently reducing DSH's risk of an information security breach. Also, FI$Cal is working on developing an upload that DSH will use to build vouchers in PeopleSoft thereby minimizing redundant key data entry. FI$Cal will allow a certain number of alphanumeric characters to be included in the payment voucher to identify the purpose of the payment. DSH must include enough information so that vendors can reconcile their invoice to the voucher and reduce the number of vendor inquiries regarding vouchers.

The most significant potential exposure of PHI is during the vouchering process (formerly the claim scheduling system) if patient name and treatment information is inputted into FI$Cal and then printed on the warrant and remittance advices sent to the provider. This issue needs to be addressed immediately to ensure that DSH does not put PHI at risk, threaten timely payment for services to contracted vendors (in the absence of a mechanism to make payments) or cause medical providers to be unwilling to continue providing necessary medical services to DSH patients.

The PHI solution requires the development of operating policies (such as workflow, records retention, and SCO audit procedures) and protocols to de-identify PHI data from outside medical invoices so payments can still occur timely, consequently reducing DSH's risk of an information security breach. DSH sought an expert opinion to determine if three specific elements from a contract medical providers invoice entered onto a remittance advice would expose DSH to a HIPPA breach. The expert determination concluded that the three de-identified elements does not put DSH at great risk for a breach. Detailed data from the contract medical providers invoice will be used develop a summarized transaction with the three de-identified data elements to be used in the vouchering process to produce a payment to the contract medical providers. All medical provider, original invoice data will be maintained at the respective hospitals; images will also be captured and maintained on confidential, HIPAA compliant, network folders. SCO will also periodically audit samples of the original invoices maintained at the respective hospitals.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this BCP.

Staff Recommendation: No action is recommended at this time.

ISSUE 18: METROPOLITAN CENTRAL UTILITY PLANT

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Metropolitan State Hospital Central Utility Plant (Issue 270)
lt is requested that Item 4440-011-0001 be increased by $2,580,000 to provide the Department the resources necessary to continue operating the existing central utility plant providing heating and cooling throughout Metropolitan State Hospital.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 19: REVISED INCOMPETENT TO STAND TRIAL DIVERSION TRAILER BILL

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

The proposal establishes the Diversion for Individuals with Mental Disorders Program, allowing pretrial diversion to be granted for individuals with mental disorders who meet specified criteria. In addition, it seeks to mitigate the entry and re-entry into the criminal justice system for individuals who are likely to be found incompetent to stand trial on felony charges. The proposal also allows courts, under specified conditions, to rescind a finding of incompetence and grant pretrial diversion to a defendant who had been deemed incompetent to stand trial (IST) pursuant to Penal Code sections 1367 or 1368, if the individual may benefit from a diversion program. The diversion program will provide linkages to mental health treatment in lieu of continuing with the court proceedings for the criminal charges.

BACKGROUND

Under existing law, when a defendant has been determined IST on felony charges, the defendant may be committed to the Department of State Hospitals (DSH) or other secure treatment facilities for competency restoration treatment. Some of these defendants are ultimately committed to DSH, even though community mental health services and supports may provide an appropriate alternative for their needs.

Since Fiscal Year 2013-14, the department has experienced a 33% increase in the number of ISTs referred annually to DSH programs. Despite the addition of over 400 state hospital beds and 200 jail-based competency treatment beds since 2013-14, the number of IST defendants pending placement into DSH facilities continues to grow. As of May 7, 2018, a total of 967 IST defendants were awaiting admission. Because of these IST patient population growth trends, DSH has been exploring alternative solutions to reduce the need for limited beds in State Hospital facilities, and at the same time, improve the services for individuals who may be designated as IST defendants. DSH estimates approximately 20% of its IST referrals annually may meet the following criteria:

- Primarily diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder;
- Charged with a felony offense(s) where there is a significant correlation between the individuals' mental illness and/or conditions of homelessness and the instant offense; and

- Will not pose a significant safety risk if treated in the community.

As such, IST referrals to DSH may have been appropriate candidates for a diversion program, if the alternative was available for consideration by the court prior to being found IST. Currently, there is not a statutory diversion program that allows the courts to divert defendants with mental disorders, as specified, to obtain mental health services and supports and receive continuous care in the community, however in some counties, through collaboration with the mental health court, the district attorney and other county partners, defendants with mental disorders may have their charges dropped or reduced if a defendant agrees to receive mental health treatment.

The proposed trailer bill in Penal Code creates the Diversion for Individuals with Mental Disorders program. A diversion program that allows courts to divert defendants with mental disorders from the criminal justice system into the community for treatment.

While the proposed Penal Code language provides the statutory authority for courts to divert individuals with mental illness who committed either felony or misdemeanor crimes, the changes to Welfare and Institutions Code also allow DSH to contract with counties to support individuals diverted into the community mental health systems who have the potential to be deemed IST on felony charges. This funding ($100 million General Fund over three years) is proposed in the 2018-19 Governor's Budget. Participating counties will be required to provide 10 to 20 percent funding match, dependent on the size of the county, to receive funding for community mental health services and supports for these individuals and will be required to report specified data and outcomes.

The proposed trailer bill gives DSH the authority to contract with counties to establish new or expand existing post-booking diversion programs for individuals with a serious mental illness who have the potential to be found IST, to place the individuals into needed community-based mental health services and supports, with the goal of reducing the number of ISTs referred to DSH facilities by approximately 20-30%

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposed trailer bill.

Staff Recommendation: No action is recommended at this time.

ISSUE 20: COMPETENCY RESTORATION ASSESSMENTS TRAILER BILL

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

This proposed trailer bill language would allow courts to make a determination that a patient has regained competency prior to admission into the proposed Los Angeles County Restoration in Community Treatment Program facility or a Department of State Hospital (DSH) facility.

BACKGROUND

Under existing law, when a defendant has been determined incompetent to stand trial (IST) on felony charges, the defendant may be committed to the Department of State Hospitals or other secure treatment facilities for competency restoration treatment. Some of these defendants could be restored to competency in this proposed community treatment setting. Existing law provides for the medical director of a state hospital, or community program director to provide a certificate of restoration for a patient committed to DSH as incompetent to stand trial. However, there is no statutory authorization for a community program administered through a state and county partnership to file a certificate of restoration once a patient has regained competency either after the patient has been successfully treated at a community treatment program or prior to transferring to the community treatment program.

In addition, counties have reported that many patients, upon further assessment after court commitment but prior to admission to DSH, have regained competency and no longer require competency restoration services. There is currently no mechanism in statute to allow the finding that a patient, who has regained competency prior to admission to a DSH facility or program, has been restored to competency.

The proposed trailer bill would allow a patient committed to the proposed Los Angeles County Restoration Community Treatment Program, upon restoration of competency, to be returned to the court as competent and also allow the LA County service provider who is assessing and stabilizing a patient in jail prior to placement in a community program to file a certification of restoration with the court, if they have determined the individual has been restored to competency.

In addition, this bill would allow the court to appoint a licensed psychiatrist, psychologist or other expert to make a determination of whether a patient committed to DSH, but not yet admitted to a DSH facility, has regained competency.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposed trailer bill.

Staff Recommendation: No action is recommended at this time.

ISSUE 21: CONDITIONAL RELEASE PROGRAM UPDATE

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

As of spring 2018, DSH has located one prospective provider in Northern California and is in the process of finalizing costs for both housing and clinical services to establish a 26-bed STRP. DSH anticipates activation of this new program in December 2018 at an estimated annual cost of $61,000 per patient. Additionally, the proposed facility will require minor modifications, start-up supplies and furniture for patient rooms and common spaces at a cost of approximately $50,000. Based on the projected activation date, DSH is not requesting a change to its budget year augmentation request of $976,000 proposed in the 2018-19 Governor's Budget. The full year ongoing cost of the 26-bed STRP is $1.6 million.

In the current year, DSH will yield one-time savings of $566,000 resulting from the termination of its STRP contract provider in Fresno.

BACKGROUND

The Forensic Conditional Release Program (CONREP) is the Department of State Hospital's (DSH) statewide system of community-based services for specified court-ordered forensic individuals. Mandated as a State responsibility by the Governor's Mental Health Initiative of 1984, the program began operations on January 1, 1986 and operates pursuant to statutes in Welfare and Institutions Code (WIC) 4360 (a) and (b). The goal of CONREP is to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system. DSH contracts with county-operated and private organizations who administer direct treatment and supervision services to DSH patients.

The CONREP population includes: Not Guilty by Reason of Insanity (PC 1026), Mentally Disordered Offenders (both PC 2964 parolees who have served a prison sentence and PC 2972s who are civilly committed for at least one year after their parole period ends), felony Incompetent to Stand Trial (PC 1370s who have been court-approved for outpatient placement in lieu of state hospital placement), and Mentally Disordered Sex Offenders (WIC 6316). CONREP services are also offered to Sexually Violent Predators (WIC 6604) as discussed in greater detail in the CONREP-SVP Program Update (see Section D (b)).

Individuals suitable for CONREP may be recommended by the state hospital medical director to the courts for outpatient treatment. Currently, DSH contracts with seven

county-operated and three private organizations to provide outpatient treatment services to clients in all 58 counties in the state with non-SVP commitments.

As specified in PC 1600-1615 and 2960-2972, the CONREP Community Program Director, with the Court's approval (or in the case of MDOs, the Board of Parole Hearings' approval), assesses and makes the recommendation for individuals' placement in CONREP. CONREP delivers an array of mental health services to individuals during their period of outpatient treatment. In conjunction with the court-approved treatment plan, contractors coordinate and provide a wide array of services needed to support community reintegration, including forensic mental health treatment through individual and group therapy settings, life skills training, residential placement, collateral contacts (e.g., other individuals/agencies), home visits, substance abuse screenings, psychiatric services, case management, court reports, and psychological assessments. DSH has developed standards for these services which set minimum treatment and supervision levels for individuals court-ordered to CONREP. Regular evaluations and assessments on treatment progress are completed by contractors during the period of state hospitalization and while receiving treatment in CONREP.

When a DSH patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. However, if a CONREP-eligible patient has not demonstrated the ability to live in the community without direct staff supervision, the patient is referred to a Statewide Transitional Residential Program (STRP).

The STRPs are a cost-effective resource used by CONREP to provide patients with the opportunity to learn and demonstrate appropriate community living skills in a controlled setting with 24 hours per day, seven days per week (24/7) supervision while they transition from a state hospital to a community site. Alternatively, patients placed in an independent living situation and are having difficulties adjusting can be placed in a STRP, in lieu of re-hospitalization, to help re-stabilize them when their psychiatric symptoms increase or if they are non-compliant with their treatment plan. The STRP is limited to a 90 to 120-day stay as residential treatment. Once the patient has made the necessary adjustments and is ready to live in the community without structured 24/7 services provided by the STRP, the patient is able to live in a Board & Care, Room & Board, or other independent living arrangements and without direct staff supervision. DSH contracts for one 17-bed STRP in Los Angeles County and had operated an additional 16-bed STRP in Fresno County that closed in November 2017.

Transitional Housing (STRP)

The Budget Act of 2017 included a one-time appropriation of $976,000 to expand the Statewide Residential Treatment Program (STRP) to serve up to an additional 16 clients at an annual rate of $61,000 per bed. The annual rate is offset by benefits received by CONREP clients, primarily Supplemental Security Income and Social Security Disability Income (SSI/SSDI), valued at approximately $12,000 per bed, per year. The funding authorized in FY 2017-18 was used to operate a 16-bed STRP in Fresno County. However, as of November 2017, DSH ended its contract with the provider and has been actively working to establish a new contract for this important resource to CONREP providers and clients.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this program update/proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 22: HEPATITIS C TREATMENT EXPANSION AND MISCELLANEOUS TECHNICAL ADJUSTMENTS IN MAY REVISE

PANEL

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Hepatitis C Treatment Expansion (Issue 370)
lt is requested that Item 4440-011-0001 be increased by $3.3 million to expand the treatment schedule for patients diagnosed with the chronic Hepatitis C virus. The May Revision also includes a similar expansion of Hepatitis C clinical guidelines for the California Department of Corrections and Rehabilitation and the Department of Health Care Services.

Miscellaneous Technical Adjustments (Issues 250)
lt is requested that Item 4440-017-0001 be amended by decreasing reimbursements by $1,154,000 to remove excess authority that remained after the transition of the Department of Mental Health to the Department of State Hospitals.

Hospital Police Officer Academy Reimbursement Adjustment
DSH requests a one-time augmentation (4440-011-0001) of $150,000 in reimbursement authority as part of its expanded Hospital Police Officer (HPO) Academy program. Participants in the academy receive college credits through Allan Hancock Community College and DSH receives partial reimbursement from that institution for the cost of the academy program. DSH can collect up to$72,000 per academy session with a maximum enrollment of 50 cadets. In FY 2018-19, the Department will hold three academy sessions and will be able to collect reimbursements up to $216,000. DSH has already allocated $66,000 in existing miscellaneous reimbursement authority to the academy and is requesting the balance of $150,000 in BY 2018-19..

HIPAA Reimbursement Adjustment
The Department of State Hospitals (DSH) requests the removal of $1.154 million in reimbursement authority (4440-017-0001) in its appropriation for the implementation of the Health Insurance Portability and Accountability Act (HIPAA). The reimbursement authority budgeted as part of this appropriation was used to collect funds from the Department of Health Care Services (DHCS) for HIPAA related Medi-Cal costs tied to the Department of Mental Health's (DMH) Mental Health Services Act (MHSA) responsibilities. The Department ceased collecting these reimbursements when DMH became DSH and the department's MHSA functions were transitioned to DHCS.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present these adjustments.

Staff Recommendation: No action is recommended at this time.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 23: PROPOSITIONS 99 AND 56 ADJUSTMENTS

PANEL

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

Prop 99 Adjustment: Health Education Account (Issue 405)-lt is requested that Item 4265-001-0231 be increased by $122,000 and Item 4265-111-0231 be increased by $1 million to reflect changes in Proposition 99 revenues. These increases support competitive grants and state administration activities.

Prop 99 Adjustment: Unallocated Account (Issue 405)-lt is requested that Item 4265-001-0236 be increased by $66,000 to reflect the changes in Proposition 99 revenues. This increase will support state administration activities.

Proposition 56 Authority and Technical Adjustments (Issues 420-422 and 430)
lt is requested that the following items be eliminated: 4265-001-3307, 4265-001-3318, 4265-001-3322, 4265-111-3307, 4265-111-3318, and 4265-111-3322. Expenditures and positions previously budgeted in these items will be transferred to continuously appropriated, non-budget act items, consistent with Proposition 56 and the provisions of the Revenue and Taxation Code.

Additionally, the Proposition 56 Department of Public Health, Tobacco Prevention and Control Programs Account, CA Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund will be increased by $3,522,000, to reflect increased revenue estimates.

Legislative Analyst
The LAO provided the following comments and analysis:

> Last week DOF sent letters requesting that the budget items for most of the Prop 56 tobacco revenue allocations (Fund #3304) be removed from the Budget Act and transferred to continuous appropriations. They did not make such a request for the largest piece of Prop 56, which goes to Medi-Cal.
>
> We recommend rejecting all of these requests. Although Rev & Tax Code 30130.53 states that the money is continuously appropriated, some of the allocations involve choices that are fundamentally incompatible with continuous appropriations. For example, according to Rev & Tax Code 30130.57(a), CDTFA shall receive "not more than 5 percent" of net revenue (Item 7600-001-3304). In last year's budget process, the

administration proposed and the Legislature approved an amount that was far less than 5 percent. With a continuous appropriation, it is unclear how this amount would be determined.

Given adequate time, the Legislature might determine that continuous appropriation is suitable for some of the requested items but not for others. There is no need, however, to take any of the proposed actions at this time. The administration can make these requests next January.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present all May Revise changes and adjustments to the Proposition 99 and 56 estimates within DPH, and respond to the following:

Please also explain the proposal to make the Proposition 56 funds continuously appropriated, and how this would affect the counties' ability to "roll-over" these funds across multiple years.

Staff Recommendation: No action is recommended at this time.

ISSUE 24: GENETIC DISEASE SCREENING PROGRAM ESTIMATE MAY REVISE ADJUSTMENTS

PANEL

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

2018 May Estimate: Genetic Disease Screening Program (Issues 401 and 435)
It is requested that Item 4265-001-3114 be decreased by $1.8 million to reflect a shift of the birth defects surveillance activities from the Birth Defects Monitoring Program Fund to the Genetic Disease Testing Fund. This shift will better align the birth defects surveillance activities with the broader Genetic Disease Screening Program and resolve the structural imbalance within the Birth Defects Monitoring Program Fund. It is also requested that Item 4265-111-0203 be increased by $28,000 to reflect updated caseload and expenditure projections for the Newborn Screening and Prenatal Screening programs.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present any May Revise changes and adjustments to the GDSP Estimate.

Staff Recommendation: No action is recommended at this time.

ISSUE 25: WOMEN, INFANTS, AND CHILDREN PROGRAM ESTIMATE MAY REVISE ADJUSTMENTS

PANEL

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

2018 May Estimate: Women, Infants, and Children Program (Issue 402)
It is requested that Item 4265-111-0890 be decreased by $45,981,000 and Item 4265-111-3023 be decreased by $1,080,000 to reflect updated caseload and food expenditure projections based on a decline in participation.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present any May Revise changes and adjustments to the WIC Estimate.

Staff Recommendation: No action is recommended at this time.

ISSUE 26: AIDS DRUG ASSISTANCE PROGRAM ESTIMATE MAY REVISE ADJUSTMENTS

PANEL

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

2018 May Estimate: AIDS Drug Assistance Program (ADAP}

lt is requested that the ADAP Rebate Fund expenditures be increased by $2,037,000. This increase will support program enhancements to the interim ADAP Enrollment System, contract amendments, and planning resources to assist with the Project Approval Lifecycle process for a long-term enrollment system.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present any May Revise changes and adjustments to the ADAP Estimate.

Staff Recommendation: No action is recommended at this time.

ISSUE 27: LICENSING & CERTIFICATION ESTIMATE & CERTIFIED NURSING ASSISTANT TRAINING KICKSTARTER PROGRAM

PANEL

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office
- Public Comment

PROPOSAL

2018 May Estimate: Center for Health Care Quality (Issue 403)

It is requested that provisional language be added to Item 4265-115-0942 to allow the Department the flexibility to increase expenditure authority up to $1,730,000 if the federal Centers for Medicare and Medicaid Services approves the Certified Nursing Assistant (CNA) Training Kickstarter program. Any approved funding will be provided to the Quality Care Health Foundation, which will contract with health employers for CNA training classes, and provide technical assistance to skilled nursing facilities to develop and obtain approval of their own CNA training program.

Add the following provision to Item 4265-115-0942:

1. The Director of Finance may augment this item by an amount not to exceed $1,730,000 from the Special Deposit Fund, Federal Health Facilities Citation Penalties Account, after review of a request submitted by the Department of Public Health reflecting federal approval to use this penalty account to implement the Certified Nursing Assistant Training Kickstarter Program. Any augmentation shall be authorized not sooner than 30 days after notification in writing to the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may determine.

Legislative Analyst

The LAO provided the following comments and analysis:

Governor's May Revision Proposes Expenditure Authority for a New CNA Kickstarter Project. DPH proposes $1.7 million in local assistance expenditure authority—for a grant to the Quality Care Health Foundation (QCHF)—from the Federal Health Facilities Citation Penalties Account. QCHF would use the grant funding to increase the number of in-house CNA training programs at skilled nursing facilities (SNFs) from 48 to more than 100. Specifically, this proposal attempts to respond to the anticipated increase in demand for CNAs at SNFs as new statutory CNA-related SNF staffing requirements take effect. Using the federal citation penalty account for this purpose requires approval from the Centers for Medicare and Medicaid Services. The administration consequently proposes provisional budget bill language that conditions the appropriation on CMS approval and legislative review through the typical 30-day notification of the Joint Legislative Budget Committee.

January Budget and Spring Finance Letter Proposals Included Several Augmentations Related to CNA Workforce Demand. Responding to the new CNA-related staffing requirements at SNFs, the Governor's January budget and a Spring Finance Letter included a package of proposals in Medi-Cal, DPH (for its certification activities), Proposition 98 higher education, and the Employment Training Panel (ETP)—a division of the Employment Development Department. The higher education and ETP proposals included one-time funding for CNA training programs. Specifically, $2 million in Proposition 98 General Fund would provide funding to California Community Colleges through the Strong Workforce program to increase CNA enrollment slots and $2.5 million in ETP funds would reimburse SNFs and other training providers for the cost of new or expanded CNA training programs. ETP funds could be used for training programs that increase the number of new CNAs or provide on-the-job post-certification training.

Previous Proposals, if Restructured Somewhat, Would Likely Meet CNA Workforce Demand. In earlier LAO analysis, we estimated that the state needs between 1,700 and 2,400 CNAs to meet the new CNA-related SNF staffing requirements. If the Legislature restructured the Governor's proposals based on LAO recommendations from our earlier analysis (for example, providing flexibility on minimum qualifications for CNA instructors and requiring all ETP funds be used to increase the number of new CNAs rather than also providing post-certification training), we estimate these proposals would result in an additional 3,000 CNA training program slots (1,700 funded through ETP and 1,300 funded through Proposition 98). The actual number of CNAs produced and working at SNFs would be somewhat lower than that amount, due to attrition and job placement in other non-SNF health care settings.

It Is Unclear if DPH Proposal Complements or Duplicates Governor's Other CNA Training Proposals. The DPH proposal from the May Revision and the Proposition 98 and ETP proposals from January appear to serve similar purposes—to increase the supply of CNAs through new and expanded training programs. The DPH and ETP proposals in particular both attempt to increase in-house CNA training programs at SNFs. However, documents presented to the Legislature in connection with DPH's May Revision proposal make no reference to the multiple related proposals in the Governor's previously proposed package, making it appear that it was developed separately. Thus, there is the potential for the DPH proposal to actually duplicate these previous proposals.

DPH Appears to Have Already Awarded the Grant to QCHF. Based on a QCHF press release from May 8, 2018, it appears DPH recently awarded QCHF a $2.4 million grant over two years to increase the number of expanded and new in-house CNA training programs. The press release states that these efforts will result in 1,000 new CNAs.

LAO Preliminary Recommendation and Questions for the Legislature to Ask the Administration. For now, we recommend the Legislature reject DPH's May Revision request, unless the administration can provide supporting documentation to justify why it needs additional expenditure authority to support SNF-based CNA training programs beyond its previous proposals. We have identified several questions the Legislature may wish to ask the administration in May Revision budget hearings:

- Why did DPH presumably award the grant to QCHF prior to (1) the Legislature taking the requisite action to approve the budget request and (2) CMS approving the use of the federal citation penalty account for this purpose? Have any funds been paid to QCHF?

Was DPH's request for $1.7 million in expenditure authority coordinated with the administration's previous proposals related to meeting workforce demand for CNAs in SNFs?

Was it determined that the administration's previous proposals would not meet the need for CNA training programs? If so, can the administration provide information as to what changed, why the previous proposals would not meet the need, or why the need has grown?

Why is it necessary to provide funding to both ETP and DPH to increase the number of new or expanded in-house CNA training programs at SNFs?

If, based on information provided to the Legislature, it is determined that additional funding is needed for in-house CNA training programs at SNFs…

How will DPH and ETP coordinate their efforts? How will they ensure they target different SNFs and avoid duplicating their efforts?

Might there be benefits if efforts to increase in-house CNA training programs at SNFs were administered through one department rather than two? If so, which one?

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present any changes to the Licensing and Certification Program Estimate included in the May Revise, and present the Kickstarter proposal.

Staff Recommendation: No action is recommended at this time.