AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

TUESDAY, MAY 17, 2016

1:30 P.M. - STATE CAPITOL ROOM 444

ITEMS TO BE HEARD

ITEMS TO BE HEARD

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 1: MOBILE FIELD HOSPITAL PROGRAM REDESIGN

PANELISTS

- **Howard Backer**, MD, Director, Emergency Medical Services Authority
- **Dan Smiley**, Chief Deputy Director, Emergency Medical Services Authority
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Emergency Medical Services Authority (EMSA) proposes to redesign the Mobile Field Hospital program to modify and expand the potential uses of the equipment into general staging, stabilization and shelter capability. No new resources are being requested for this purpose.

BACKGROUND

Since 2006, the EMSA has maintained three MFHs, each of which consists of approximately 30,000 square feet of tents, hundreds of beds, and sufficient medical supplies to respond to a major disaster in the state, such as a major earthquake in a densely populated area. The 2006 Budget Act allocated $18 million in one-time funds for the purchase of the MFHs and $1.7 million in on-going General Fund funding for the staffing, maintenance, storage, and purchase of pharmaceutical drugs, annual training exercises, and required medical equipment for the MFHs.

The original amount budgeted for the pharmaceutical drug cache was $23,000, which was later determined to be woefully insufficient. Recognizing that the value of the MFHs is quite limited in the absence of sufficient pharmaceutical supplies, the Governor put forth requests in 2009 and 2010 to augment the MFH budget by $448,000 General Fund, however the Legislature denied both requests. In 2011, the Governor instead proposed, and the Legislature approved, to eliminate the $1.7 million in on-going support for the MFHs. There remain on-going storage and maintenance costs for the MFHs.

The EMSA explored various potential shared responsibility arrangements with various non-state entities, such as the Red Cross, in order to find an affordable way for the state to continue to have access to the MFHs in a major disaster. Initially, the EMSA did the following: 1) consolidated the MFHs into two storage facilities in order to reduce warehouse space costs; and 2) entered into a 1-year, no-cost contract with Blu Med (a

subsidiary of Alaska Structures) to continue providing minimal maintenance for the MFHs, at no cost to the state, with the stipulation that Blu-Med could rent out one or two MFHs to any state or country dealing with a major disaster. The contract with Blu-Med has since ended and EMSA has cobbled together sufficient resources to cover maintenance costs over the past few years, including through a separate DPH re-appropriation of Hospital Preparedness Program (federal funds) funds which are currently covering the maintenance costs. Last year EMSA stated that, as of July 1, 2015, all MFHs would be considered non-deployable without extensive rehabilitation to equipment and supplies.

EMSA is now proposing to redesign the Mobile Field Hospital program to modify and expand the potential uses of the equipment into general staging, stabilization and shelter capability. This could include alternate healthcare sites to provide low acuity care for triage and stabilization, command and staff shelters for incident command, and general or medical shelter facilities.

According to the administration, this approach will allow for flexible deployment to support a broad range of emergencies, including earthquakes, fires, floods, severe influenza, a novel virus epidemic, or bioterrorism. Additionally, the equipment may benefit other state agencies, including the Office of Emergency Services, the Military Department and the Department of Public Health.

STAFF COMMENTS/QUESTIONS

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

1. How is this new purpose different from the original purpose of the MFHs?

2. Is EMSA's plan to complete this redesign within existing resources or is there any cost associated with this?

3. Will there still be storage costs or other challenges associated with the redesigned program?

Staff Recommendation: Staff recommends holding this item open at this time.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 2: CHANGES TO THE MEDI-CAL ESTIMATE

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Scott Ogus**, Budget Analyst, Department of Finance
- **Jamey Matalka**, Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

The following table shows the overall change to the Medi-Cal local assistance estimate between the Governor's January budget and the May Revise, for the budget year 2016-17, which includes a $5.1 billion (6%) increase in total funds and a $1.4 billion (7.5%) decrease in General Fund, reflecting the passage of the new managed care organization tax:

Medi-Cal Funding Summary *(Dollars In Millions)*	2016-17 January	2016-17 May	Jan to May $ Change	Jan to May % Change
General Fund	**$19,084.1**	**$17,661.3**	**($1,422.8)**	**-7.5%**
Federal Funds	$54,046.5	$57,668.2	$3,621.6	6.7%
Other Funds	$11,907.7	$14,823.1	$2,915.4	24.5%
Total Local Assistance	**$85,038.5**	**$90,152.5**	**$5,114.0**	**6.0%**
Medical Care Services	$80,481.3	$85,627.2	$5,145.9	6.4%
County Administration	$4,100.4	$4,158.1	$57.7	1.4%
Fiscal Intermediary	$456.7	367.1	($89.6)	-19.6%

Medi-Cal Caseload

DHCS estimates baseline caseload to be approximately 14.1 million average monthly enrollees in 2016-17 as compared to 13.5 million in 2015-16, a 4.8 percent increase. This consistently increasing caseload reflects the Medi-Cal expansion made possible by the ACA.

	2014-15	2015-16	2016-17	14-15 to 15-16 % Change	15-16 to 16-17 % Change
Medi-Cal Caseload	12,242,700	13,469,500	14,117,700	10.02%	4.81%

Significant Medi-Cal Estimate Adjustments

Descriptions of the most significant adjustments to the Medi-Cal estimate include the following:

- **Managed Care Enrollee Tax (MR Issue 557).** The estimate reflects General Fund savings of $1.1 billion as a result of passage of a new managed care tax.

- **Undocumented Children's Coverage**. The budget extends full-scope Medi-Cal coverage to undocumented children, as approved through the 2015 Budget Act, and the May Revise includes $243.8 million ($188.2 million General Fund) to provide full-scope benefits to 250,000 children beginning May 16, 2016.

- **New Federal 1115 Waiver**. The May Revise assumes $2.2 billion in federal funds as a result of the new "Medi-Cal 20-20 Waiver."

- **Substance Use Residential Treatment Costs (MR Issue 556)**. The January Medi-Cal estimate assumes an expansion of residential treatment services for substance use disorders at a cost of $90.9 million ($32.5 million General Fund). The May Revise assumes a delayed implementation timeline and therefore a reduction in these costs of $20,144,000 General Fund and $31,689,000 federal funds.

- **Performance Outcome System (MR Issue 551)**. The budget implements the Performance Outcomes System to track outcomes of Medi-Cal Specialty Mental Health Services for children and youth. The January estimate included a cost of $11.9 million General Fund, for implementing the system, including county collection of assessment data and related training. The May Revise assumes a delayed implementation timeline and therefore a reduction in costs of $5,055,000 each for General Fund and federal funds.

- **Behavioral Health Treatment Costs (MR Issue 563)**. Given federal guidance clarifying that Medicaid programs must cover behavioral health treatment, these costs are being transitioned to Medi-Cal for children who have been receiving them through Regional Centers. The administration began this transition for approximately 13,000 kids in February 2016 and intends to transition all of them within six months. The January estimate increased General Fund by $43.4 million to reflect solidified rates based on actuarial soundness as well as higher utilization than expected. The May Revise increases these costs by $87,894,000 General Fund and $115,789,000 federal funds. The budget also proposes the following Budget Bill Language amendments to allow for the transfer of funds between the Department of Developmental Services and DHCS:

  4260-101-0001
  13. The Department of Finance may authorize the transfer of expenditure authority ~~from~~ between Schedule (2) of item 4300-101-0001 ~~to~~ and Schedule (3) of this item to support the transition of current Medi-Cal eligible regional center clients receiving behavioral health treatment

services pursuant to Section 14132.56 of the Welfare and Institutions Code upon completion of the statewide transition plan.

Fiscal Intermediary Adjustments (MR Issue 559). The estimate includes savings of $2,240,000 General fund and $23,735,000 federal funds to reflect the stoppage of DHCS's efforts to replace the California Medicaid Management Information System, partially offset by increases associated with close-out activities, transitioning project management to the state, and the reprocurement of new vendors for the operation of the legacy system and system replacement.

Minimum Wage Impacts (MR Issue 562). The May Revise estimate includes $7,067,000 General Fund and $5,086,000 federal funds to implement SB 3 (Leno, Chapter 4, Statutes of 2016), reflecting increased costs in Home and Community Based Services waiver programs and long-term care facilities rate add-ons, in addition to savings in the Medi-Cal program due to decreases in eligibility.

Workload Adjustments (MR Issues 552, 553, 554, and 555). The estimate includes an increase of $73,724,000 General Fund and $2,001,673,000 federal funds to reflect workload changes related to End of Life Services, Palliative Care, Scaling and Root Planning Prior Authorization and Preventive Dental Services, and the Affordable Care Act Optional Expansion.

Miscellaneous (MR Issues 501, 531). The following additional adjustments are being made to the estimate to reflect caseload and other miscellaneous adjustments not highlighted in other Medi-Cal issues:

- Item 4260-101-0001 be decreased by $647,158,000 and reimbursements be increased by $749,916,000.
- Item 4260-101-0890 be increased by $1,491,171,000.
- Item 4260-101-0080 be increased by $11,000
- Item 4260-101-0232 be increased by $4,929,000
- Item 4260-101-0233 be increased by $1,408,000
- Item 4260-101-0236 be increased by $6,673,000
- Item 4260-101-3168 be increased by $482,000
- Item 4260-101-3213 be increased by $41,402,000
- Item 4260-101-0890 be increased by $1,298,000
- Item 4260-101-0001 be increased by $184,022,000
- Item 4260-101-0890 be increased by $558,591,000
- Item 4260-101-0001 be increased by $145,000
- Item 4260-101-0890 be increased by $685,000

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the Medi-Cal estimate and describe the significant changes made as a part of the May Revision, as outlined in this section of the agenda.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 3: MANAGED CARE ENROLLEE TAX ADMINISTRATION – ISSUE 401-MR

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Scott Ogus**, Budget Analyst, Department of Finance
- **Jamey Matalka**, Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests three-year limited-term expenditure authority of $240,000 ($120,000 GF/$120,000 FF) to support the implementation and oversight of the managed care enrollment tax established by SBX2 2 (Hernandez, Chapter 2, Statutes of 2016).

BACKGROUND

Medi-Cal provides health care services to more than 13 million beneficiaries through two distinct health care delivery systems: the traditional fee-for-service system and the managed care system. Over 80 percent of Medi-Cal beneficiaries receive health services by enrolling in contracted Medi-Cal managed care plans (MCPs) in 58 counties. These MCPs offer established networks of organized systems of care, which emphasize primary and preventive care. Most health care plans contracting with the Medi-Cal program are licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code, Section 1340 et seq.).

In 2005, California enacted a Quality Improvement Fee (OIF) on Medi-Cal Managed Care Organizations (MCOs). Based on federal rules, the fee was assessed on all premiums paid to legal entities providing health coverage to Medi-Cal enrollees. When the fee was established, 75 percent of the revenue generated was matched with federal funds and used for payments to MCOs and the remaining 25 percent was retained by the state General Fund. Effective October 1, 2007, as part of the implementation of the State's new managed care rate methodology, this arrangement changed and 50 percent of the revenue generated by the QIF was matched with federal funds and used for payments to MCOs and the remaining 50 percent was retained by the state General Fund (GF). Changes in federal law resulted in this fee to sunset on October 1, 2009, as it no longer complied with federal requirements. New federal law required that provider fees be broad based and uniformly imposed throughout a jurisdiction, meaning that they cannot be levied on a subgroup of providers, such as only those enrolled in Medicaid programs.

Subsequently, AB 1422 (Bass, Chapter 157, Statutes of 2009) imposed a gross premiums tax on the total operating revenue of Medi-Cal MCPs until July 1, 2011 . The proceeds from the tax were continuously appropriated (1) to DHCS for purposes of the Medi-Cal program in an amount equal to 38.41 percent of the proceeds from the tax and (2) to the Managed Risk Medical Insurance Board (MRMIB) for purposes of the Healthy Families Program in an amount equal to 61.59 percent of the proceeds from the tax. The tax was extended by ABX1 21 (Blumenfield, Chapter 11, Statutes of 2011) until July 1, 2012 and updated the sharing percentages for DHCS and MRMIB. Finally, SB 78 (Chapter 33, Statutes of 2013) extended the sunset date to June 30, 2013. After the Healthy Families transition to Medi-Cal in 2013, MRMIB's portion of the tax was then used to offset GF cost for Medi-Cal program.

This was followed by SB 78 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2013), which imposed a sales tax of 3.975 percent on Medi-Cal MCPs' gross receipts effective July 1, 2013 through June 30, 2016. The revenue derived from this sales tax was continuously appropriated to DHCS to be used solely for the purpose of funding the nonfederal share of managed care rates for health care services for children, seniors, persons with disabilities and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served.

In July 2014, CMS issued guidance indicating that MCO taxes similar to California's were no longer permissible for the purposes of funding the Medi-Cal program, and in turn, required states with such taxes to make appropriate modifications prior to the end of their next legislative session.

Senate Bill 2 of the Second Extraordinary Session implements a tax reform proposal to restructure the taxes paid by MCPs in response to the Governor's call for a special session of the Legislature to consider and act upon legislation necessary to enact permanent and sustainable funding from a new MCO tax and/or alternative funding sources. SBX2 2 includes a replacement managed care enrollment tax for the tax expiring at the end of June 2016 and other taxes currently paid by the health plan industry.

SBX2 2 stabilizes funding for the Medi-Cal program and provides rate increases for providers of Medi-Cal and developmental services. SBX2 2 is intended to:

- Generate the amount of non-federal funds for the Medi-Cal program that is equivalent to the amount of funds generated by the current tax on Medi-Cal MCPs.

- Complies with federal Medicaid requirements applicable to permissible healthcare related taxes.

This funding would provide the resources necessary to facilitate the tax and complete the necessary administrative duties to ensure payment, collection, and use of the tax. As the tax will be assessed on managed care plans through capitation rates, DHCS states that the Capitated Rates Development Division and Third Party Liability & Recovery Division will require resources to perform administrative duties related to collecting the tax.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 4: FEDERAL MANAGED CARE REGULATIONS WORKLOAD – ISSUE 402-MR

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Scott Ogus**, Budget Analyst, Department of Finance
- **Jamey Matalka**, Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests the establishment of 38.0 permanent positions and expenditure authority, and 2-year limited-term funding for staff resources and contractual services. The request supports the implementation of Medicaid and CHIP Managed Care Final Rule CMS-2390-P and Fee-for-Service Final Rule CMS- 2328-NC.

Total funding request: $10,411,000 ($4,984,000 GF/$5,427,000 FF)

BACKGROUND

Managed Care Regulations
Since 1965, Medicaid has financed health care coverage for certain categories of low income individuals. States administer the program within broad federal guidelines and have considerable flexibility in designing certain aspects of the program, including eligibility, covered services, and provider payment rates. States generally cover Medicaid services for beneficiaries through two major financing approaches: traditional fee-for-service (FFS), in which the Medicaid program directly reimburses providers for care provided to beneficiaries, and capitated managed care, in which the state pays Managed Care Organizations (MCOs) a fixed monthly per member per month (capitation) payment for covered health care services. Managed care is a health care delivery system organized to manage cost, utilization, and quality.

States design, administer, and oversee their own Medicaid managed care programs within the requirements set forth in federal Medicaid law and further elaborated in regulation. These federal regulations, last updated in 2002, set forth state responsibilities and requirements in areas including enrollee rights and protections, quality assessment and performance improvement (including provider access standards), external quality review, grievances and appeals, program integrity, and sanctions. The 2002 regulations (67 Fed. Reg. 40989, June 14), were a response to the Balanced Budget Act of 1997 (Pub. L. 105- 33).

The Centers for Medicare and Medicaid Services (CMS) released its Medicaid managed care proposed revision to the 2002 rule on May 26, 2015; it was published in the Federal Register on June 1, 2015. CMS issued Final Rule CMS-2390-P on May 6, 2016. The final rule primarily amends and expands the requirements of Title 42, Code of Federal Regulations, Part 438, pertaining to managed care.

Noting that the health care delivery landscape has changed substantially both within the Medicaid program and outside of it, CMS proposes changes to the Medicaid managed care regulatory structure to facilitate and support delivery system reform initiatives resulting in improved health outcomes and the beneficiary experience, while effectively managing costs. The agency additionally seeks to align managed care with other sources of coverage such as Medicare Advantage and Exchange plans.

The rules have multiple, direct purposes: to improve accountability in the Medicaid managed care program; to ensure beneficiary protections in the areas of provider networks, coverage standards, and treatment of appeals; and to strengthen program integrity safeguards. In so doing, the rule effectively seeks to balance greater regulatory oversight and accountability of both state and industry practices with wider deference to states in how they choose to design managed care and utilize contractors.

Most fundamentally, the new rule extends a more rigorous regulatory structure to all forms of capitated managed care, whether full-risk managed care organizations or partially capitated plans. The reforms themselves sweep across a broad landscape.

Fee-For-Service Regulations

In November 2015, CMS amended the requirements for states' documentation of access to care for fee-for-service beneficiaries found in 42 CFR Part 447\e new requirements necessitate the design and development of a new access monitoring plan, and list specific measures for separate analyses. CMS requires that both the monitoring plan and analyses be revised and updated periodically as new information is evaluated. These new requirements represent a dramatic increase in a highly technical politically sensitive workload beyond DHCS' current monitoring efforts. For example, whereas DHCS now monitors eight physician specialty types, related only to primary care, new requirements call for the inclusion of all physician specialty types. Since the Medi-Cal program has over 50 physician specialty types, this change exponentially increases the scope and complexity of current reporting. DHCS explains that such changes increase the number of datasets relied upon, data linkages that must occur, development of analytic files, calculation of statistics, overall analyses, and research writing. These efforts can only be completed through the addition of skilled research staff.

Finally, pursuant to 42 CFR Part 447, CMS requires states to incorporate provider rate reviews into their access monitoring plans and analyses. These reviews examine Medi-Cal services and providers, and must include a comparison of Medi-Cal payment rates to those of other public and private payers. The new requirement to include such analyses will increase the complexity of DHCS' reports.

Final Rule 2390-P changes the Medicaid managed care regulations to reflect the increased utilization of managed care as a delivery system. It aligns the rules governing Medicaid managed care with those of other major sources of coverage, including Qualified Health Plans and Medicare Advantage Plans; implements statutory provisions; changes actuarial payment provisions; and promotes the quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also strengthens beneficiary protections and policies related to program integrity. This rule also requires states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries.

Final Rule 2328-NC requires states to develop and implement a transparent, data-driven process to evaluate provider payments, in regards to covered care and services consistent with section 1902(a)(30)(A) of the Social Security Act.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 5: INSTITUTIONALLY DEEMED BEHAVIORAL HEALTH TREATMENT POPULATION CASE MANAGEMENT EXPEDITED CONTRACT TRAILER BILL – ISSUE 560-MR

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Guadalupe Manriquez**, Staff Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS proposes trailer bill to expedite the contract process specific to the procurement of case management for institutionally deemed Medi-Cal beneficiaries. The contract will encourage the transition to comprehensive health coverage effective March 2017.

BACKGROUND

Federal guidance clarified that Medicaid programs must cover behavioral health treatment and therefore these costs (benefits) are being transitioned to Medi-Cal for children who have been receiving them through Regional Centers. The administration began this transition for approximately 13,000 kids in February 2016 and intends to transition all of them within six months. Approximately 400 of these children were "institutionally deemed" eligible for Medi-Cal for purposes of receiving these services. Their eligibility was based on the income of just the child, whereas comprehensive (no-share-of-cost) Medi-Cal eligibility is based on the income of the family. Therefore, these children will become ineligible for Medi-Cal, and therefore will need other comprehensive health coverage.

In order to ensure these children remain insured, DHCS is proposing to contract with an organization that will offer assistance to these children and families in securing comprehensive health coverage outside of Medi-Cal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 6: COVERED OUTPATIENT DRUGS FINAL RULE TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests trailer bill to provide DHCS authority to comply with the final federal rule related to Medicaid reimbursements for covered outpatient drugs. The final rule, issued on February 1, 2016, requires states to align pharmacy reimbursements with the actual acquisition costs of drugs and to pay an appropriate professional dispensing fee.

BACKGROUND

The Deficit Reduction Act (DRA) of 2005 required the Centers for Medicare & Medicaid Services (CMS) to use 250 percent of the Average Manufacturer Price (AMP) to establish the federal upper limit (FUL) on generic drugs. CMS had estimated that the new FULs would be implemented on January 30, 2008. However, an injunction preventing CMS from implementing these changes and sharing pricing information with the states put the AMP and FUL changes on hold. The Affordable Care Act (ACA) modified federal statute to establish the FUL to be no less than 175 percent of the weighted average (based on utilization) of the AMP and redefined how AMP is calculated.

On February 1, 2016, in accordance with the final regulation with comment CMS-2345-FC, CMS published a final rule establishing an exception to the ACA FUL calculation which allows for a higher multiplier. This multiplier is used when the FUL falls below the average retail acquisition cost. In these instances, CMS will establish the respective FUL at an equal value to the most current average retail community pharmacy acquisition cost. The final rule further stipulates that the updated FUL reimbursement rates shall be effective beginning April 1, 2016, and, that future updates will be published on a monthly basis.

The proposed trailer bill includes the following language:

1. Effective April 1, 2017, the department shall implement a new professional dispensing fee or fees.

2. When establishing the new professional dispensing fee or fees, the department shall do so consistent with the provisions of Section 447.518 (d) of Title 42 of the United States Code of Federal Regulations.

3. The department shall consult with interested parties and appropriate stakeholders in implementing this paragraph.

4. If the department determines that a change in the amount of a professional dispensing fee is necessary pursuant to this section in order to meet federal Medicaid requirements, the department shall establish the new dispensing fee through the budget process.

Pharmacies have raised significant concerns with the Subcommittee regarding this issue. They explain that there has been consensus that both components of pharmacy reimbursement have warranted change for a long time in that the dispensing fees are too low, but are compensated by high ingredient-cost reimbursements. They explain that the new federal rules, that are the subject of this proposed trailer bill, effectively reduce the reimbursements for the ingredient costs, but do not increase dispensing fees. The rules require states to pay an appropriate dispensing fee by April 1, 2017, and the proposed trailer bill authorizes DHCS to change the fees. Nevertheless, between now and at least April 1, 2017 (assuming DHCS increases the fees at that time), the pharmacies will experience a reduction in reimbursements for ingredient costs and no change to dispensing fees. The National Association of Chain Drug Stores (NACDS) estimates that the implementation of the federal changes to pharmacy drug reimbursement that were effective April 2016 will reduce Medi-Cal drug reimbursement to pharmacies by 37%. They state that this cut translates to state General Fund savings of approximately $72.3 million.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 7: AMENDMENTS TO PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) MODERNIZATION TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS is proposing amendments to their January trailer bill proposal to modernize the PACE program. The January proposal included the following key components:

- Rate Setting: DHCS is currently required to use a Fee-for-Service (FFS) equivalent cost/upper payment limit methodology to set capitation rates for PACE Organizations, however the FFS data is no longer available. DHCS proposes setting experience/cost-based actuarially sound rates using a methodology that is to be nearly identical to the methodology used to set rates for other Medi-Cal managed care plans.

- Cap on the Number of PACE Organizations: Removal of existing statutory language that caps the number of PACE Organizations with which DHCS can contract.

- Not-for-Profit Requirement: Removal of existing statutory language to align with updated PACE federal rules and regulations.

- PACE Flexibilities: Addition of new statutory language enabling DHCS to seek flexibility from the Centers for Medicare and Medicaid Services (CMS) on several issues including the composition of the PACE interdisciplinary team (IDT), the frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and development of a streamlined PACE waiver process.

Based on stakeholder feedback, the proposed amendments, included in the May Revise, add the following language:

1. The specific rate methodology applied to PACE organizations shall address features of PACE that differentiate it from other managed care plan models.

2. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its Medi-Cal cost and utilization data, or other data sources as deemed necessary by the department.

3. The rate methodology developed pursuant to this subdivision shall contain a mechanism to account for the costs of high-cost drugs and treatments.

4. Rates developed pursuant to this subdivision shall be actuarially certified prior to implementation.

5. Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating an upper payment limit, the department may correct the applicable data as necessary. In calculating an upper payment limit, the department shall consider the risk of nursing home placement for the comparable population when estimating the level of care and risk of PACE participants.

6. During the first year in which a new PACE organization or existing PACE organization enters a previously unserved area the department may, in its sole discretion, pay at any rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11).

BACKGROUND

The PACE model of care provides a comprehensive medical/social service delivery system using an IDT approach that provides and coordinates all needed preventive, primary, acute and LTSS. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model affords eligible individuals to remain independent and in their homes for as long as possible. The PACE plan receives a monthly Medicaid and/or Medicare capitation payment for each enrolled participant and retains full risk for the cost of all Medicare and Medi-Cal services as well as any additional services determined necessary by the PACE IDT.

PACE enrollment in the State is voluntary for Medi-Cal beneficiaries. Federal regulations (Title 42, Code of Federal Regulations, Section 460.162) specify that a PACE participant may voluntarily disenroll from the program without cause at any time. Participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. The PACE program becomes the sole source of Medicare and Medi-Cal services for PACE participants.

The PACE population is comprised predominantly of beneficiaries dually eligible for Medicare and Medi-Cal, and the Seniors and Persons with Disabilities (SPD) Medi-Cal only population. These populations have been transitioned to the Medi-Cal managed care delivery system over the past five years under California's Bridge to Reform Section 1115 Medicaid Waiver. As a result, the enrollment base for PACE

Organizations has changed from a majority FFS population to a managed care population over the last four years.

Legislative change is necessary to enable modernization of the Program for All-Inclusive Care for the Elderly (PACE) as current statute includes limitations which create barriers for DHCS to efficiently administer and oversee the program. DHCS states that the proposed legislative changes would ameliorate these limitations.

Rate Setting: The PACE FFS rate methodology does not take into account plan-specific experience and utilization when setting PACE rates. Pursuant to subdivision (e)(1) of Welfare and Institution (W&I) Code Section 14593, DHCS is required to "establish capitation rates paid to each PACE organization at no less than 95 percent of the FFS equivalent cost, including DHCS's cost of administration, that DHCS estimates would be payable for all services covered under the PACE Organization contract if all those services were to be furnished to Medi-Cal beneficiaries." However, there is an erosion of FFS data as Medi-Cal transitions to a managed care delivery system creating a fundamental issue with the current FFS equivalent PACE rate methodology DHCS is required to use to set rates. In December 2015, CMS issued guidance updating rate setting criteria for PACE Medicaid capitation rates. As part of this guidance, CMS has stated that new managed care rates must be based on data no older than three years. The current rate methodology needs to change to address any future data credibility issue(s) regardless of what type of new methodology is established.

DHCS states that legislation is required to move away from the traditional FFS equivalent rate methodology to set capitation rates for the PACE Organizations and instead implement actuarially sound rates based on plan-specific cost, service utilization, quality and performance based measures utilized for other managed care health plan models contracting with DHCS. The FFS equivalent rate methodology specified in state statute is not in alignment with the plan-specific cost and experience-based rate methodology that is utilized for other managed care health plans contracting with DHCS. The scope of the rate methodology utilized for managed care health plans is defined in W&I Code Section 14301.1. DHCS believes that standardizing rate-setting will allow the department to determine comparability of cost and experience between PACE and like population subsets served through managed care health plans that provide care to similar populations.

Cap on the Number of PACE Organizations: Removing the PACE Organization cap will allow continuing expansion of PACE in California, which aligns with ongoing DHCS efforts to transition to a statewide managed care delivery system. Currently, there are eleven PACE Organizations that are in operation with three additional interested applicants.

Not-for-Profit Requirement: Removal of the existing specification that DHCS enter into contracts only with nonprofit organizations for the purpose of implementing PACE aligns with recently released federal guidance permitting for-profit entities to apply as PACE Organizations. Removal of the nonprofit specification will also align with ongoing DHCS efforts to transition to a statewide managed care delivery system by further enabling continuing expansion of PACE in California.

PACE Flexibilities: PACE continues to grow at a rate much faster than anticipated, expanding and evolving with the advent of newer health care delivery practices and methods, much unlike the rules governing PACE. Federal PACE regulations do not provide any flexibility in requirements of the composition of the PACE IDT and frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and the PACE waiver process. The lack of flexibility in the PACE regulations hinders PACE Organizations from keeping up with current best practices and as a result disservices California participants that may benefit from newer methods.

Stakeholder Concerns with January Proposal

CalPACE, an association of PACE programs, supports the overall direction of this proposed trailer bill but also had concerns with the original proposal, primarily with regard to the proposed new rate-setting methodology. In reaction to the January proposal, CalPACE stated that the bill language should clarify how the rate methodology will reflect the ways in which PACE is different from other managed care. Specifically, PACE programs cover ALL services necessary to improve and maintain participants' health status, yet it is unclear if various services not officially covered by Medi-Cal would be included in the cost analysis used to set the rates. This covers a wide array of costs, from de-fleeing a patient's dog to capital costs, none of which are covered by managed care plans. Also, CalPACE argued that the methodology should include a way to spread out the costs of unusually high-cost patients given that the PACE risk pool is smaller than for typical managed care plans. CalPACE requested the following changes to the trailer bill:

- Specification that the proposed methodology reflects and accounts for all PACE costs.
- Clarification on covering the costs of high-cost (outlier) patients.
- Clarification on covering the costs of high-cost drugs and treatments for chronic diseases.
- Require that each PACE program's cost data be the primary source of data used for rate setting.
- PACE organizations be held harmless from rate changes under the new methodology.
- Rate setting for new PACE programs should be using the current methodology for the first 2 years of operation, given the absence of experience-based data.
- Align the methodology timeline with the schedule and progress of the PACE actuarial work group.

CalPACE supports the proposed increased regulatory flexibility and states that there are additional areas in need of flexibility beyond those identified in the bill, such as: 1) expansion applications; 2) PACE Innovation Act; and 3) state licensing requirements. In response to the proposals to remove the cap on the number of programs and to allow PACE programs to be for-profit entities, CalPACE recommends that DHCS carefully review new PACE applications to ensure applicants meet all state and federal requirements in order to ensure quality of care and consumer protections.

Some of the individual PACE programs have shared their concerns with the Subcommittee regarding all of the provisions of the trailer bill. They state that the proposed rate setting methodology is lacking in critical detail; and that the combination of lifting of the cap and allowing for for-profit programs opens the market up to competition in a way that might not encourage quality care and may drive good, non-profit PACE programs out of business.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal and explain the amendments being proposed and how these address stakeholder concerns.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 8: NEW QUALIFIED IMMIGRANT AFFORDABILITY AND BENEFIT PROGRAM TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Guadalupe Manriquez**, Staff Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS proposes trailer bill to adjust the income eligibility requirements for the New Qualified Immigrant Affordability and Benefit program to no more than 150 percent of the federal poverty level, based on the applicant's eligibility for Advanced Premium Tax Credit, a health insurance federal subsidy. The trailer bill also extends the date by which DHCS must promulgate program regulations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 9: EMERGENCY MEDICAL AIR TRANSPORTATION ACT CLEANUP TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Scott Ogus**, Budget Analyst, Department of Finance
- **Jamey Matalka**, Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS proposes trailer bill to remove Welfare and Institutions Code section 10752, added by SB 326 (Beall, Chapter 797, Statutes of 2015).

W&I Code Section 10752:
The department shall, by March 1, 2017, in coordination with the Department of Finance, develop a funding plan that ensures adequate reimbursement to emergency medical air transportation providers following the termination of penalty assessments pursuant to subdivision (f) of section 76000.10 of the Government Code on January 1, 2018.

BACKGROUND

The Assembly Floor analysis of SB 326 included the following background:

"SB 326 Extends the sunset date of the $4 penalty assessment for Vehicle Code violations, other than parking offenses, from January 1, 2016, to January 1, 2018, and extends the resulting revenue be deposited in the Emergency Medical Air Transportation Act (EMATA) Fund from June 30, 2017, to June 30, 2019. States it is the intent of the Legislature to cease collection of penalty assessments on January 1, 2018, pursuant to EMATA and that the Legislature identify alternative funding sources for emergency medical air transportation and cease reliance on penalty assessment revenue. Requires the Department of Health Care Services, in coordination with the Department of Finance, to develop a funding plan that ensures adequate reimbursement to emergency medical air transportation providers following the termination of the Vehicle Code penalty assessments.

AB 2173 (Beall, Chapter 547, Statutes of 2010), levied a $4 additional penalty on Vehicle Code violations (excluding parking tickets), with the resulting revenue being used as the state match to draw down additional federal Medicaid matching funds to fund Medi-Cal emergency air medical transportation services. Between $11.2 million

and $13.7 million has been raised annually from the AB 2173 penalty assessment. Of that amount, $2.2 million to $2.7 million is used as the state match to fund current emergency air ambulance Medi-Cal provider rates. The remaining $9 million to $11 million is used to match with federal dollars to augment Medi-Cal rates to emergency air ambulance providers.

According to the Judicial Council, the calculation for a traffic ticket in California, and determining where the money goes once collected, is complex. The cost of a traffic ticket includes a base fine amount plus penalty assessments and fees to fund specific state and local activities. The base fine is collected for, and distributed to, either the local government or local government and county. The increase in the total cost of a traffic ticket (above the base fine) in California over the last 20 years is primarily the result of the addition of mandatory penalty assessments and fees."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 10: CONTINUUM OF CARE REFORM, SPECIALTY MENTAL HEALTH – ISSUE 561-MR

PANELISTS

- **Karen Baylor**, Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Budget Analyst, Department of Finance
- **Carla Castaneda**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests $6,569,000 (General Fund) and $5,054,000 (federal funds) for county mental health costs associated with the implementation of AB 403 (Stone, Chapter 773, Statutes of 2015). These adjustments reflect increased county mental health costs to participate in child and family teams and training for county mental health staff.

BACKGROUND

AB 403 fundamentally changes the structure and manner In which foster care and other social, health, and education entitles coordinate and deliver services to foster children and youth on state and local levels. Affected stakeholders include state departments, counties, providers, families, and children.

AB 403 seeks to accomplish numerous goals which Include: decreasing reliance on congregate care, supporting greater capacity for home-based family care, increasing engagement with foster children/youth and families, revising the rate-setting structure, increasing provider accountability and performance, and increasing transparency of providers, among others.

The Department of Social Services (DSS) is responsible for maintaining and supporting a state-supervised and county-administered child welfare services program that focuses on safety, permanency, and the well-being of foster children and youth. The impetus for Continuum of Care Reform (CCR) began in 2012 with SB 1013 (Committee on Budget and Fiscal Review, Chapter 35, Statutes of 2012) which required DSS to consult with a number of stakeholder organizations to develop recommendations for revisions to the State's current rate-setting system, services, and programs serving children and families across the continuum of Aid to Families with Dependent Children-Foster Care placement settings. The DSS produced the 2015 CCR Report to the Legislature, which was released concurrently with the 2015-16 Governor's Budget. The CCR report contained 19 recommendations developed over the span of three-years of collaboration with county partners and stakeholders.

AB 403 seeks to achieve California's longstanding goal that all children live as members of committed, nurturing, and permanent families. To advance that goal, children In foster care and their families must have local access to a broad continuum of services and support to maintain permanent family settings. This will decrease the incidence of frequent placement changes and decrease the reliance of placements in congregate care facilities.

DHCS states that they are engaged in on-going discussions with counties on the implementation of AB 403, and specifically this proposal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal and provide an update on the department's discussions with counties on this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 11: DRUG MEDI-CAL RATE SETTING PROCESS TRAILER BILL

PANELISTS

- **Karen Baylor**, Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Budget Analyst, Department of Finance
- **Carla Castaneda**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS proposes trailer bill to permit rate adjustments by way of bulletin authority or similar instructions to improve administrative efficiencies.

BACKGROUND

Under existing law, Drug Medi-Cal rates are updated annually through regulations based on the cumulative growth in the implicit price deflator for the costs of goods and services to governmental agencies. The annual rates are based either on the developed rates for use in the next fiscal year or the 2009-10 Budget Act rates adjusted for the deflator, whichever is lower.

According to DHCS, this trailer bill does not change the rate setting methodology. Rather it allows the department to share new rate information with providers through bulletins, rather than through emergency regulations, thereby making this information available to providers faster.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 12: ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM TRAILER BILL

PANELISTS

- **Karen Johnson**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Sergio Aguilar**, Budget Analyst, Department of Finance
- **Jamey Matalka**, Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DHCS requests trailer bill to increase the existing General Fund annual limit for state administrative costs associated with the implementation of the Medi-Cal Electronic Health Records Incentive Program (EHRIP).

BACKGROUND

The American Recovery and Reinvestment Act of 2009 established the EHRIP for Medicaid and Medicare providers. Beginning in 2011, eligible Medi-Cal professionals and hospitals have been able to receive incentive payments to assist in purchasing, installing, and using electronic health records in their practices. Billions of dollars in federal funding has been provided to healthcare providers through this program.

The Office of Health Information Technology (OHIT) has been established in DHCS to develop goals and metrics for the program, establish policies and procedures, and to implement systems to disburse, track, and report the incentive payments. OHIT works closely with the Office of the Deputy Secretary for Health Information Technology in the California Health and Human Services Agency to coordinate the Medi-Cal EHR Incentive Program with wider health information exchange efforts throughout California and the nation.

The federal government provides a 90 percent match for activities related to health information technology (HIT), including efforts tied to electronic health record (EHR) adoption and support. Previously, these efforts were funded with federal grant funds. These grant funds have expired. The Medi-Cal EHR incentive payments are 100 percent funded by the federal government. California's providers have received over $1 billion in these incentive payments. The operating costs of the Medi-Cal EHR Incentive Payment Program require a 10 percent match by the state in order to draw down an additional 90 percent funding from the federal CMS.

A federal grant was used to provide the technical assistance support to implement EHR and achieve meaningful use. Subsequently, this grant expired and a capped amount of General Fund has been authorized for state support.

STAFF COMMENTS/QUESTIONS

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

1. How much is the current statutory cap on General Fund for this program? What cap is DHCS proposing?

2. Is there still a justification for maintaining a General Fund cap on this program?

3. How much federal funding has gone to California health care providers through this program?

Staff Recommendation: Staff recommends holding this item open at this time.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 13: MARIJUANA STUDY – ISSUE 427-MR

PANELISTS

- **Karen Smith, MD**, Director and State Public Health Officer, Department of Public Health
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The California Department of Public Health (CDPH) requests $500,000 General Fund for 2016-17 to support a study analyzing the health risks associated with the use of marijuana for medical and/or recreational purposes. CDPH will participate in decision making regarding the direction and scope of the study organized by the Centers for Disease Control and Prevention (CDC) Foundation on the impacts of medical marijuana to provide information that can guide the state's regulatory process to ensure patient safety.

BACKGROUND

Marijuana is classified as a Schedule 1 drug by the U;S Drug Enforcement Administration. Schedule 1 substances are defined as having high potential for abuse and no currently accepted medical use in treatment. Marijuana is the most commonly-used illicit drug, with 22.2 million past-month users according to a 2014 National Survey on Drug Use and Health.

Over the past 19 years, 40 states have legalized marijuana for medical or recreational use (four states have legalized retail marijuana sales, the District of Columbia has legalized possession, 23 states and the District of Columbia have legalized medical marijuana use, and 17 states have legalized cannabidiol use). Recent reports suggest there has been a doubling of marijuana use both in adults and adolescents over the past 15 years, with 30 percent of adult users meeting the criteria for a marijuana disorder.

The CDC and other federal and state public health agencies do not yet have a clear picture of how these changing patterns of marijuana use might impact youth and adult health. To date, there has not been a national-level systematic synthesis of available evidence on marijuana health effects comparable to those conducted for alcohol and tobacco. As a result, less is known about the health consequences of marijuana use than is known about other psycho-active drugs available for legal purchase, such as alcohol, caffeine and nicotine.

To address this need, the CDC Foundation has sought financial contributions from a variety of federal agencies, states, philanthropies, and a national nonprofit. This BCP would provide $500,000 in onetime funding from California towards this effort for the Institute of Medicine (lOM) to perform a comprehensive review of existing scientific evidence about the health consequences of marijuana use. The lOM is a well-respected institution with a long history of generating reports and research agendas that have successfully helped advance both science and policy on a wide variety of issues.

The scientific review project Is expected to focus on the following categories: 1) patterns of marijuana initiation and use among United Slates youth and adults, 2) potential and proven health risks of marijuana use, 3) potential therapeutic uses of marijuana, and 4) public health research gaps and recommendations. The project will include both medical and recreational marijuana usage and effects.

Funding from the CDPH will allow the state to contribute to and participate in this study including supporting the report development and dissemination activities. The project will review existing research on the health effects of marijuana and identify scientific questions that still need to be answered about the consequences of marijuana use on public health outcomes, and how best to gather that information, it may help determine the level of cannabinoid in the blood that is considered safe, which the State could utilize for the establishment of regulations for the sale of medical marijuana edibles pursuant to existing law. The research agenda will similarly provide recommendations for short and long term research priorities for both medical and recreational marijuana. Below are the states that are contributing to the lOM study and the mechanisms in place for marijuana regulation.

Alaska. Recreational marijuana is legal for adults over age 2J1up to one (1) ounce and adults may grow up to six (6) plants in their homes and possess any marijuana grown from their plants.

Arizona. Medical marijuana is legal with the possession and personal use of up to two and one half (2.5) ounces of marijuana in a 14-day period by patients with written certification from a physician to alleviate a variety of symptoms associated with conditions (and the treatment prescribed for these conditions) such as cancer, glaucoma. AIDS, Crohn's disease, and Hepatitis. Home cultivation is limited to a qualifying patient that lives more than twenty-five miles from a designated dispensary to grow up to 12 marijuana plants within an enclosed and locked area.

Colorado. Recreational marijuana is legal for adults 21 years of age or older, up to one (1) ounce of marijuana. Home cultivation is allowed for up to six (6) plants total.

Oregon. Recreational marijuana is legal for adults 21 years old and individual cultivation is allowed up to four (4) plants on their property, possess up to eight (8) ounces usable marijuana in their homes and up to one ounce (1) on their person.

Washington. Recreational marijuana is legal for adults over 21 years of age for up to one (1) ounce of useable marijuana, marijuana-related paraphernalia, 16 ounces of

solid marijuana-infused product and 72 ounces of liquid marijuana-infused product. Home cultivation is prohibited.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 14: CHANGE TO JANUARY PROPOSAL ON PROTECTING CHILDREN FROM LEAD POISONING – ISSUE 421-MR

PANELISTS

- **Mark Starr**, Acting Deputy Director, Center for Chronic Disease Prevention and Health Promotion, Department of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

CDPH, Division of Environmental and Occupational Disease Control, Childhood Lead Poisoning Prevention Branch (CLPPB) requests expenditure authority of $180,000 in Fiscal Year (FY) 2016-17 and $320,000 in FY 2017-18 from the Childhood Lead Poisoning Prevention Special Fund. This funding will allow the Geographic Information System (GIS) mapping of lead-poisoned children, which can assist in describing locations of lead exposure.

BACKGROUND

Lead is a toxin that damages most body organs with lifelong effects. While higher blood lead levels have historically been thought to be of concern, it is now recognized that there is no known safe level of lead in the blood.

The Childhood Lead Poisoning Prevention (CLPP) Program in CLPPB works to prevent lead exposure and Identifies lead-poisoned children. The CLPP Program provides interventions, including educational services, to children at increased risk of lead exposure, and full public health nursing and environmental services to children who are identified as cases of lead poisoning, including follow-up to assure that sources of lead exposure are removed. These activities are carried out by the CDPH CLPPB, in conjunction with state-supported CLPP Programs in local jurisdictions throughout California. This information is processed into the CLPPB database, the Response and Surveillance System for Childhood Lead Exposures (R2). R2 is the system which supports lead poisoning prevention and lead poisoning case management activities statewide. The information in R2 is used to identify Individuals who have high blood lead levels and are considered cases of lead poisoning, as well as to identify individuals with lead exposure not meeting the definition of a case, for the purposes of delivering appropriate services.

For children with lead exposure, but not meeting the case definition, approximately 5,500 children a year are identified with blood lead levels at and above the Centers for Disease Control and Prevention (CDC) reference level indicating increased lead

exposure, and nearly half of these children are currently receiving some services and additional tracking. The number of these children receiving services and tracked in the R2 system is expected to increase to over 12,500 a year in the next few years, as more attention is placed on identifying and following individuals with blood lead values lower than were previously considered concerning. The CDC reference level is currently 5 micrograms per deciliter of blood. Similarly, the number of children considered to be cases of lead poisoning is expected to increase from about 200 a year to 600 a year due to changing the definition of a case to lower blood lead values. These children will receive case management services and will also be tracked in the R2 system. For FY 2016-17, the Governor's Budget includes a Budget Change Proposal to provide CLPP services to children with lower blood lead levels than have previously been served.

CDPH explains that, given that CLPPB would expand services to more children, adding a mapping system to R2 will help better identify areas with high prevalence of childhood lead exposure and lead poisoning. Currently, the R2 system does not have a GIS capability for CLPP to effectively analyze lead exposure based upon geography. The system operates on older technology which limits: availability of information; ability to identify areas and populations of increased risk for lead exposure; and overall CLPP functions.

In the last 15 years, substantial advances have occurred in the ability to integrate geographic information with other data. In order to better target sources of lead exposure to children, the current R2 system requires enhanced capabilities. Because R2 was developed before more modern systems were in place, It is not currently connected to more advanced mapping systems that are now available, such as the CDPH Enterprise GIS. This proposal would enable CLPPB to document geographic areas where children are at increased risk for lead exposure (i.e., provide data for comparison of areas where children have high blood lead levels to known and suspected lead sources such as industries, freeways, old housing, and waste sites).

Legislative Analyst

The LAO provided the following comment: "While we do not have concerns with these requested changes, we continue to note—as we commented on in budget hearings—that DPH is not maximizing funds for this program as proposed. The Governor's January budget proposed to extend services to children defined by a new lower blood lead level but did not propose alignment with the Medi-Cal State Plan and therefore did not request related federal reimbursement under Medi-Cal. We note that about 90 percent of children in the CLPP program are Medi-Cal beneficiaries. The administration has indicated they are in discussions regarding possible alignment with the state plan. Accordingly, we recommend the Legislature continue to follow-up on this issue."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 15: LICENSING AND CERTIFICATION: LOS ANGELES COUNTY CONTRACT – ISSUE 425-MR

PANELISTS

- **Jean Iacino**, Deputy Director, Center for Healthcare Quality, Department of Public Health
- **Kimberly Harbison**, Staff Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The CDPH, Center for Health Care Quality (Center), requests an increase in expenditure authority of $2.1 million from the Stale Department of Public Health Licensing and Certification Program Fund. The increase will augment the Los Angeles (LA) County contract to account for two, 3 percent salary increases effective October 2015 and October 2016, an increase to the employee benefit rate from 55.1 to 57.3 percent, and a decrease in the indirect cost rate from 33.2 to 31.4 percent.

BACKGROUND

The Center licenses and certifies over 7,500 health care facilities and agencies in California in 30 different licensure and certification categories. For over 30 years, CDPH has contracted with LA County to perform federal certification and state licensing surveys and investigate complaints and entity-reported Incidents for approximately 2,500 health care facilities in the LA County area. The 2015 Budget Act authorized an additional $14.8 million dollars in expenditure authority to fully fund LA County to conduct tier 1 and tier 2 federal workload, long term care complaints and entity-reported incidents, and pending complaints and entity-reported incidents. In July 2015, CDPH and LA County renewed the contract for a three-year term (ending June 30, 2018), for an annual budget of $41.6 million to fund 225 positions.

Roughly one third of licensed and certified health care facilities in California are located in LA County, and 18.7 percent of the long term care complaints and entity-reported incidents received statewide each year are generated In LA County.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 16: CHANGES TO GENETIC DISEASE SCREENING PROGRAM ESTIMATE – ISSUE 433-MR

PANELISTS

- **Richard Olney, MD**, Division Chief, Department of Public Health
- **Connie Mitchell, MD**, Deputy Director, Center for Family Health, Department of Public Health
- **Leslie Gaffney,** Assistant Deputy Director, Center for Family Health, Department of Public Health
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The following table shows the proposed changes to the Genetic Disease Screening Program 2016-17 estimate from the January budget to May Revise, which are significant with a $13.6 million (15%) increase in operational support. Though not shown in this chart, the estimate also includes an increase of $3,970,000 for the current year over the Governor's January budget.

Genetic Disease Screening Program Budget			
	2016-17 January Estimate	2016-17 May Estimate	January to May Change
PNS Local Assistance	$36,002,304	$36,002,304	$0
NBS Local Assistance	$42,769,479	$42,769,479	$0
Operational Support	$13,379,000	$26,999,037	$13,620,037
TOTAL	**$92,150,783**	**$105,770,820**	**$13,620,037**

In order to cover the increased costs of the program that are reflected in the May Revise, this budget proposes increases to both the Pre-Natal Screening (PNS) and NBS Newborn Screening (NBS) fees as follows:

- PNS: The May Revise proposes to increase the PNS fee from $207 to $221.60.

- NBS: The January budget proposes to increase the NBS from $112.70 to $122.70, and the May Revise proposes to raise it to $130.25

BACKGROUND

Prenatal Screening Program (PNS). This program screens pregnant women who consent to screening for serious birth defects. The fee paid for this screening is about $207. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. There are three types of screening tests for pregnant women in

order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester. Women who are at high risk based on the screening test results are referred for follow-up services at state-approved "Prenatal Diagnosis Centers." Services offered at these Centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

Newborn Screening Program (NBS). This program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is $111.70. Where applicable, this fee is paid by prepaid health plans and insurance companies. Medi-Cal also covers the fee for its enrollees. The NBS screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment that mitigates more severe health problems. Informational materials are provided to parents, hospitals and other health care entities regarding the program and the relevant conditions, and referral information is provided where applicable.

The program estimate is based on three new assumptions that have a significant impact on the costs of the program, as follows:

Operational Support for Enhancements and Maintenance and Operations (M&O) for Screening Information System (SIS) and Accounts Receivable (AR) System; Data Center Transition; Accounts Receivable Vendor Transition
GDSP requests $3.6 million in 2015-16 and $10.7 million in 2016-17 for the Deloitte Consulting Contract amendments, lockbox payment services, and specimen shipping costs from collection sites to labs. GDSP is in the process of amending Deloitte's contract to add services needed for the migration and support of the AR system. Deloitte will work with the DPH Information Technology Services Division (ITSD) to move SIS from DHCS to DPH. The contract also will include 2 years of M&O support for the AR system and training support.

Transition In-House Patient Billing to an Outsourcing Vendor
GDSP requests $340,000 in 2015-16 and $2.9 million in 2016-17 for the transition to an outsourcing vendor. GDSP hopes to accelerate revenue collection, reducing uncollectable accounts, and reducing the overall risk and cost to collect.

GS $Mart Loan Repayment
GDSP requests a GS $Mart Loan from the Department of General Services of $7.3 million to cover the software and hardware needs for transitioning SIS from DHCS to DPH ($26 million) and equipment to perform statewide screening of newborns for adrenoleukodystrophy (ALD) ($4.7 million).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this estimate, explain the cost increases, and respond to the following:

1. When did the administration become aware of the need for these operational changes?

2. Have appropriate budget adjustments been applied to DHCS' budget?

3. Is there a possibility to partially support maintenance and operation functions of the SIS and AR system needs with federal Medicaid reimbursement funds and therefore offset proposed fee increases?

4. Has the transition of SIS already occurred and have loan repayments started? The Governor's May Revise proposal indicates that DPH anticipates repayments of the GS $Mart loan starting April 2016.

Staff Recommendation: Staff recommends holding this item open at this time.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 17: COLEMAN MONITORING TEAM – ISSUE 010-MR

PANELISTS

- **Pam Ahlin**, Director, Department of State Hospitals
- **George Maynard,** Deputy Director, Strategic Planning, Department of State Hospitals
- **Carla Castaneda**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Department of State Hospitals (DSH) requests $867,000 (General Fund) and 4 positions to establish a Coleman monitoring team within the DSH to coordinate and monitor implementation of the Special Master's recommendations to improve inpatient care for Coleman patients at each facility.

BACKGROUND

DSH states that given the number of Special Master's recommendations DSH will be implementing, these resources will be used to address the increased workload to evaluate and coordinate those efforts.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 18: NAPA STATE HOSPITAL 60-BED EXPANSION – ISSUE 040-MR

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Carla Castaneda**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DSH requests $12,857,000 (General Fund) and 113.8 positions for the activation of 60 beds at Napa State Hospital.

BACKGROUND

There are currently over 450 Incompetent to Stand Trial (IST) commitments and over 30 Not Guilty by Reason of Insanity (NGI) commitments awaiting admission to a state hospital (as of May 2016). This proposal would result in a net increase of 50 beds to serve IST commitments and 10 beds to serve NGI commitments, effective September 1, 2016.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 19: NAPA STATE HOSPITAL FORENSIC PATIENT INCREASE TRAILER BILL

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Carla Castaneda**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DSH proposes trailer bill to increase the number of forensic patients that may be treated at Napa State Hospital.

BACKGROUND

There are currently over 450 Incompetent to Stand Trial (IST) commitments and over 30 Not Guilty by Reason of Insanity (NGI) commitments awaiting admission to a state hospital (as of May 2016).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 20: METROPOLITAN STATE HOSPITAL 36-BED EXPANSION – ISSUES 80 AND 85-MR

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Carla Castaneda**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DSH requests $5,277,000 (General Fund) and $2,262,000 (reimbursements) and 61.7 positions to activate 36 beds at Metropolitan State Hospital.

BACKGROUND

As of this month (May, 2016), the state hospitals waiting list includes 50 pending civil commitment admissions and over 450 pending IST commitment admissions. This proposal would result in a net increase of 25 IST beds and 11 Lanterman-Petris-Short (civil commitments) beds.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 21: JAIL-BASED RESTORATION OF COMPETENCY PROGRAM EXPANSION – ISSUE 060-MR

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Matt Garber**, Department of State Hospitals
- **Carla Castaneda**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DSH requests $2,736,000 (General Fund) to expand the Jail-Based Restoration of Competency Program by 25 beds. DSH also requests 1 position to provide oversight of this program.

This proposal includes Budget Bill Language to authorize expenditures proposed at Governor's Budget, as well as these proposed resources, once a contract has been executed. DSH proposes the following language:

> 4440-011-000
> "12. Of the funds appropriated in Schedule (2), up to $4,025,000 is available for additional restoration of competency contracts. The Department of Finance may authorize these expenditures upon completed contract negotiations and county approval of program expansion. The Department of Finance shall notify the Legislature within 10 days of authorizing expenditures for this purpose."

BACKGROUND

DSH continues to work with counties to identify additional expansion opportunities throughout the state and anticipates an activation date of January 2017 for these 25 new beds.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 22: CONDITIONAL RELEASE PROGRAM TRANSITIONAL HOUSING – ISSUE 100-MR

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Matt Garber**, Department of State Hospitals
- **Carla Castaneda**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DSH requests $1,586,000 (General Fund) to activate up to 26 transitional beds for the Conditional Release Program (CONREP).

BACKGROUND

These proposed Statewide Transitional Residential Program beds provide temporary housing for CONREP patients that require direct supervision to live in the community. Currently, there is one CONREP transitional care facility with 17 beds in Los Angeles County. These proposed additional beds cost $61,000 per bed annually, consistent with the cost for the existing beds.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 23: NAPA STATE HOSPITAL EARTHQUAKE REPAIRS – ISSUE 110-MR

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Administrative Services, Department of State Hospitals
- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Carla Castaneda**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DSH seeks approval for a reduction of $989,000 General Fund to reflect updated costs associated with the repair of damages sustained at Napa State Hospital during the August 2014 earthquake.

BACKGROUND

DSH anticipates that $989,000 will be spent in 2015-16, resulting in current year savings of $4,736,000 General Fund. This will reduce costs in 2016-17 by $989,000. Federal reimbursement was authorized for 75 percent of approved repair costs by the Federal Disaster for the South Napa Earthquake event. These reimbursements require initial General Fund expenditures; however, reimbursements are not expected until 2017-18.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.

ISSUE 24: METROPOLITAN BED EXPANSION WORKING DRAWINGS REAPPROPRIATION

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Koreen Hansen**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DSH requests a technical adjustment to reappropriate the working drawings ($1,706,000 General Fund) be taken for inclusion in the 2016-17 Budget Act. Without this, the project will be delayed by more than a year.

BACKGROUND

The 2015-16 Budget Act appropriated preliminary plans and working drawings for the increased bed capacity at the Metropolitan State Hospital (by fencing in buildings), which would help alleviate the IST waiting list. CEQA got started late, and while it is underway now, the Notice of Determination will not be filed with the State Clearinghouse until June 21st, and the 30-day statute of limitation will expire after the end of this fiscal year. The PWB will not be able to approve preliminary plans until after the end of this fiscal year, which would be too late to encumber the working drawings appropriation for the next phase.

DSH considers this project very sensitive and points out that there is now federal litigation in regards to IST patients. DSH states that this project will help address the concerns outlined in the federal litigation.

With funding for the working drawings reappropriated into 2016-17, DSH states that they will be able to approve preliminary plans and begin working drawings in July.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal.

Staff Recommendation: Staff recommends holding this item open at this time.