* HEARING POSTPONED *

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

~~**MONDAY, MARCH 16, 2020**~~

~~**2:30 P.M. - STATE CAPITOL ROOM 447**~~
~~**(PLEASE NOTE ROOM CHANGE)**~~

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LIST OF PANELISTS IN ORDER OF PRESENTATION

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: OVERVIEW OF DEPARTMENT OF HEALTH CARE SERVICES BUDGET AND MEDI-CAL ESTIMATE

PANEL

- **Dr. Bradley Gilbert**, Director, Department of Health Care Services
- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Erika Sperbeck**, Chief Deputy Director of Policy and Program Support, Department of Health Care Services
- **Jacob Lam**, Principal Policy Budget Analyst, Department of Finance
- **Luis Bourgeois**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 2: MEMBER/STAKEHOLDER PROPOSAL: MEDI-CAL ASSETS TEST - CARRILLO

PANEL

- **Assemblymember Wendy Carrillo**
- **Claire Ramsey**, Senior Staff Attorney, Justice in Aging

ISSUE 3: MEMBER/STAKEHOLDER PROPOSAL: FIELD TESTING TRANSLATED MEDI-CAL DOCUMENTS - CHU

PANELISTS

- **Assemblymember Kansen Chu**
- **Benjamin Tran**, Policy Coordinator, California Pan Ethnic Health Network

ISSUE 4: MEMBER/STAKEHOLDER PROPOSAL: MEDI-CAL DOULA PILOT PROGRAM - REYES

PANEL

- **Assemblymember Eloise Reyes**
- **Zea Malawa**, **MD, MPH**, Physician Director of Expecting Justice, San Francisco Department of Public Health

ISSUE 5: MEMBER/STAKEHOLDER PROPOSAL: WHOLE GENOME SEQUENCING - WALDRON

PANEL

- **Assemblymember Marie Waldron**
- **Charlotte Hobbs, M.D., Ph.D.** Pediatrician and Genetic Epidemiologist, Vice President, Research & Clinical Management Initiatives, Rady Children's Institute for Genomic Medicine

ISSUE 6: MANAGED CARE ORGANIZATION PROVIDER TAX (AB 115) BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Jacob Lam**, Principal Policy Budget Analyst, Department of Finance
- **Luis Bourgeois**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 7: COUNTY ELIGIBILITY OVERSIGHT AND MONITORING BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Cathy Senderling**, Deputy Executive Director, County Welfare Directors Association
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Hinnaneh Qazi**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 8: MANAGED CARE ALTERNATIVE ACCESS STANDARDS (AB 1642) BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Jacob Lam**, Principal Policy Budget Analyst, Department of Finance
- **Luis Bourgeois**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 9: OFFICE OF ORAL HEALTH OVERSIGHT

PANEL

- **Dr. Jayanth Kumar**, State Dental Director, Office of Oral Health, Department of Public Health
- **Jack Zwald**, Principal Policy Budget Analyst, Department of Finance
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 10: MEMBER/STAKEHOLDER PROPOSAL: OFFICE OF ORAL HEALTH PROPOSITION 56 BACKFILL - GARCIA, C.

PANEL

- **Brianna Pittman-Spencer**, Legislative Director, California Dental Association

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 11: MEDI-CAL DENTAL AND CALAIM

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 12: DENTAL SERVICES PROGRAM PROCUREMENTS ADMINISTRATIVE SERVICES ORGANIZATION BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 13: MEDI-CAL DENTAL PROGRAM INTEGRITY BUDGET CHANGE PROPOSAL

PANEL

- **Erika Sperbeck**, Chief Deputy Director of Policy and Program Support, Department of Health Care Services
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 14: MEDI-CAL DENTAL PROGRAM WORKLOAD BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 15: RESTORATION OF DENTAL FEE-FOR-SERVICE IN SACRAMENTO AND LOS ANGELES COUNTIES TRAILER BILL

ADMINISTRATION/LAO PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

STAKEHOLDER PANEL

- **Amir Neshat, DDS**, Chief Executive Officer and Founder, Liberty Dental Plan
- **Dave Meadows**, Senior Vice President, Liberty Dental Plan
- **Dr. Stephanie Sandretti**, Chair, California Dental Association Government Affairs Council
- **Brianna Pittman-Spencer**, Legislative Director, California Dental Association
- **Linda Nguy**, Policy Advocate, Western Center on Law and Poverty

ISSUE 16: STAKEHOLDER PROPOSAL: REDISTRIBUTION OF DISPROPORTIONATE SHARE HOSPITAL FUNDS

PANEL

- **Sherreta Lane**, Senior Vice President Finance Policy, District Hospital Leadership Forum

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: OVERVIEW OF DEPARTMENT OF HEALTH CARE SERVICES BUDGET AND MEDI-CAL ESTIMATE

PANEL

- **Dr. Bradley Gilbert**, Director, Department of Health Care Services
- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Erika Sperbeck**, Chief Deputy Director of Policy and Program Support, Department of Health Care Services
- **Jacob Lam**, Principal Policy Budget Analyst, Department of Finance
- **Luis Bourgeois**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED DHCS BUDGET

Department of Health Care Services (DHCS) Budget

For 2020-21, the Governor's budget proposes $107.4 billion for the support of DHCS programs (primarily Medi-Cal). Of this amount, approximately $955.4 million is budgeted for State Operations, while the remaining is for Local Assistance. The proposed budget reflects nearly a 2.1 percent ($2.2 billion) increase from the revised current year budget. The vast majority of DHCS's budget is for the Medi-Cal Program, for which the January budget proposes $103.5 billion ($25.9 billion General Fund). Given the size of the Medi-Cal program, the significant changes in the budget occur within the Medi-Cal estimate which is described in more detail below.

DEPARTMENT OF HEALTH CARE SERVICES
(Dollars in Billions)

Fund Source	2018-19 Actual	2019-20 Revised	2020-21 Proposed	CYR to BY Change	% Change
General Fund	**$20.0**	**$23.6**	**$26.4**	**$2.8**	**11.9%**
Federal Fund	59.4	66.3	67.5	$1.2	1.8%
Special Funds/ Reimbursements	15.4	15.3	13.5	($1.8)	$11.8%
Total Expenditures	**94.8**	**105.2**	**107.4**	**$2.2**	**2.1%**
Positions	3,434.6	3,600.0	3,606.0	6	0.2%

BACKGROUND

DHCS's mission is to protect and improve the health of all Californians by operating and financing programs delivering personal health care services to eligible individuals. DHCS's programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost effective manner. DHCS programs include:

- ***Medi-Cal.*** The Medi-Cal program is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 12.8 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, low-income people with specific diseases, and childless adults up to 138 percent of the federal poverty level.

- ***Children's Medical Services (CMS).*** CMS coordinates and directs the delivery of health services to low-income and seriously ill children and adults with specific genetic diseases. CMS programs include the Genetically Handicapped Persons Program, California Children's Services Program, and the Newborn Hearing Screening Program.

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations through the following programs: Indian Health Program; Rural Health Services Development Program; Seasonal Agricultural and Migratory Workers Program; State Office of Rural Health; Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program; Small Rural Hospital Improvement Program; and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services***. DHCS oversees the delivery of community mental health and substance use disorder services. This includes both behavioral health services for Medi-Cal recipients, as well as oversight responsibilities with regard to the counties' implementation of the Mental Health Services Act.

- ***Other Programs*****.** DHCS oversees family planning services through the Family Planning Access Care and Treatment Program ("Family PACT"), cancer screening services to low-income under- or uninsured women, through the Every Woman Counts Program, and prostate cancer treatment services to low-income, uninsured men, through the Prostate Cancer Treatment Program ("IMPACT").

MEDI-CAL ESTIMATE

Proposed local assistance funding for the Medi-Cal program is summarized in the table below and includes total funds of $103.5 billion ($25.9 billion General Fund). The proposed 2020-21 Medi-Cal local assistance budget is approximately 2.3 percent more than the estimated 2019-20 budget.

Medi-Cal Funding Summary *(Dollars In Billions)*	2019 Budget Act	2019-20 Revised Estimate	2020-21 Estimate	Current Year to Budget Year $ Change	Current Year to Budget Year % Change
General Fund	**$23.1**	**$23.0**	**$25.9**	**$2.9**	**12.4%**
Federal Funds	$66.1	$65.3	$66.7	$1.5	2.2%
Other Funds	$13.2	$12.8	$10.9	($2.0)	-15.4%
Total Local Assistance	**$102.4**	**$101.1**	**$103.5**	**$2.3**	**2.3%**
Medical Care Services	$97.4	$96.0	$98.5	$2.5	2.6%
County/Other Administration	$4.6	$4.7	$4.6	($0.2)	-3.3%
Fiscal Intermediary	$0.36	$0.38	$0.36	($0.02)	-5.1%

BACKGROUND

The Medi-Cal Program

Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 55-year-old joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, people with disabilities, and childless adults. Each state has discretion to structure benefits, eligibility, service delivery, and payment rates within requirements of federal law. State Medicaid spending is "matched" by the federal government, historically at a rate averaging about 57 percent for California, based largely on average per capita income in the State. California uses a combination of state and county funds augmented by a small amount of private provider tax funds as the state match for the federal funds.

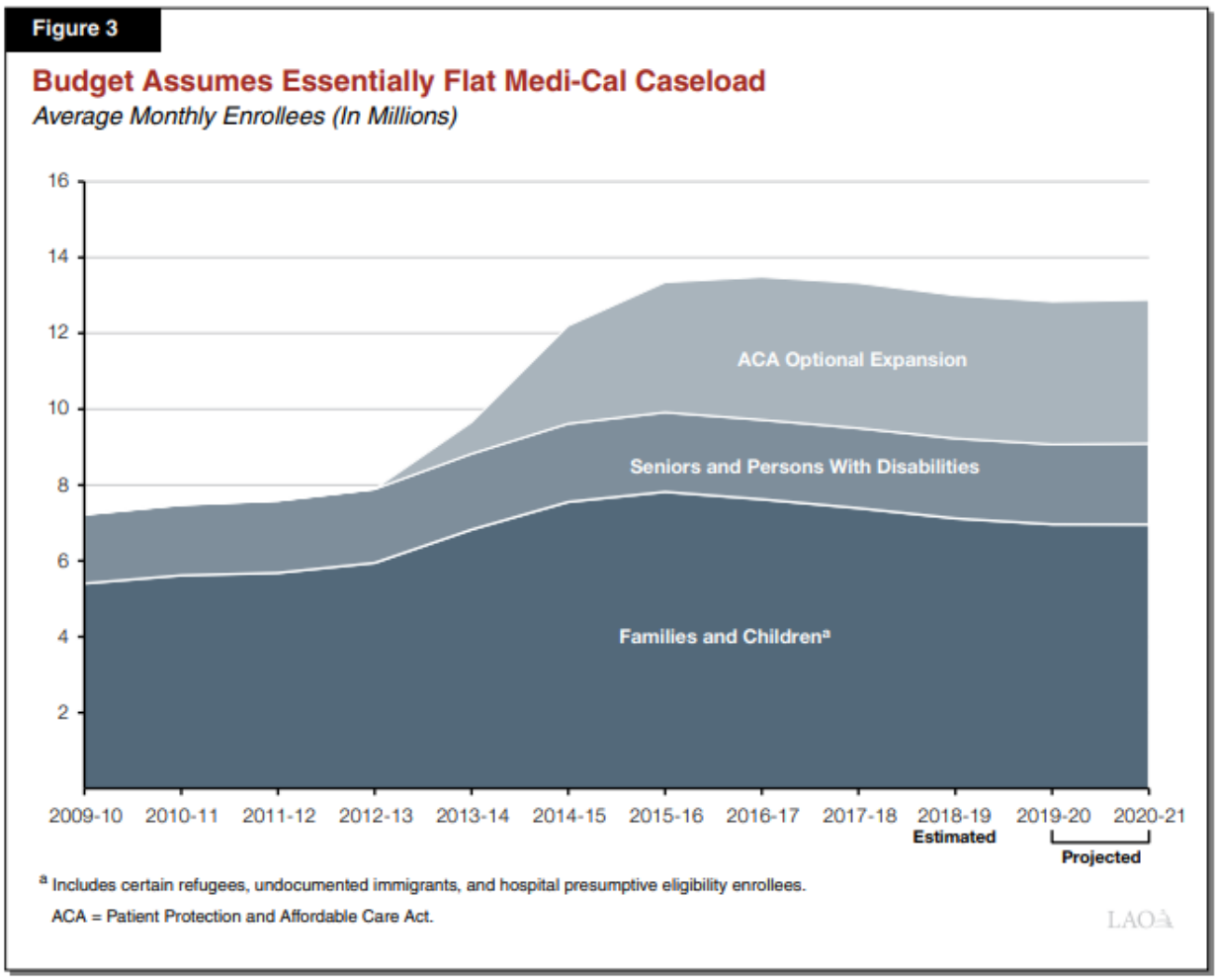
Medicaid is the single largest health care program in the United States. Approximately 32 percent of Californians are enrolled in Medi-Cal. The federal Affordable Care Act (ACA) brought the expansion of Medicaid coverage to non-elderly Americans and legal immigrants who have been in the United States at least five years and who have incomes below 138 percent of the Federal Poverty Level. Medi-Cal eligibility also has been expanded to cover undocumented children and young adults.

Medi-Cal Caseload

The Medi-Cal estimate assumes caseload to be approximately 12.9 million average monthly enrollees in 2020-21, as in the current year, reflecting the stabilization of the caseload following a slight decline since 2016.

	2018-19	2019-20	2020-21	CY to BY Change	CY to BY % Change
Medi-Cal Caseload	13,001,5000	12,834,700	12,880,400	45,700	0.4%

The Legislative Analyst provided the following caseload chart in their *2020-21 Analysis of the Medi-Cal Budget*:



Significant Medi-Cal Estimate Adjustments

The most significant adjustments to the November 2019 Medi-Cal estimate include the following:

Current-Year (2019-20) Adjustments:

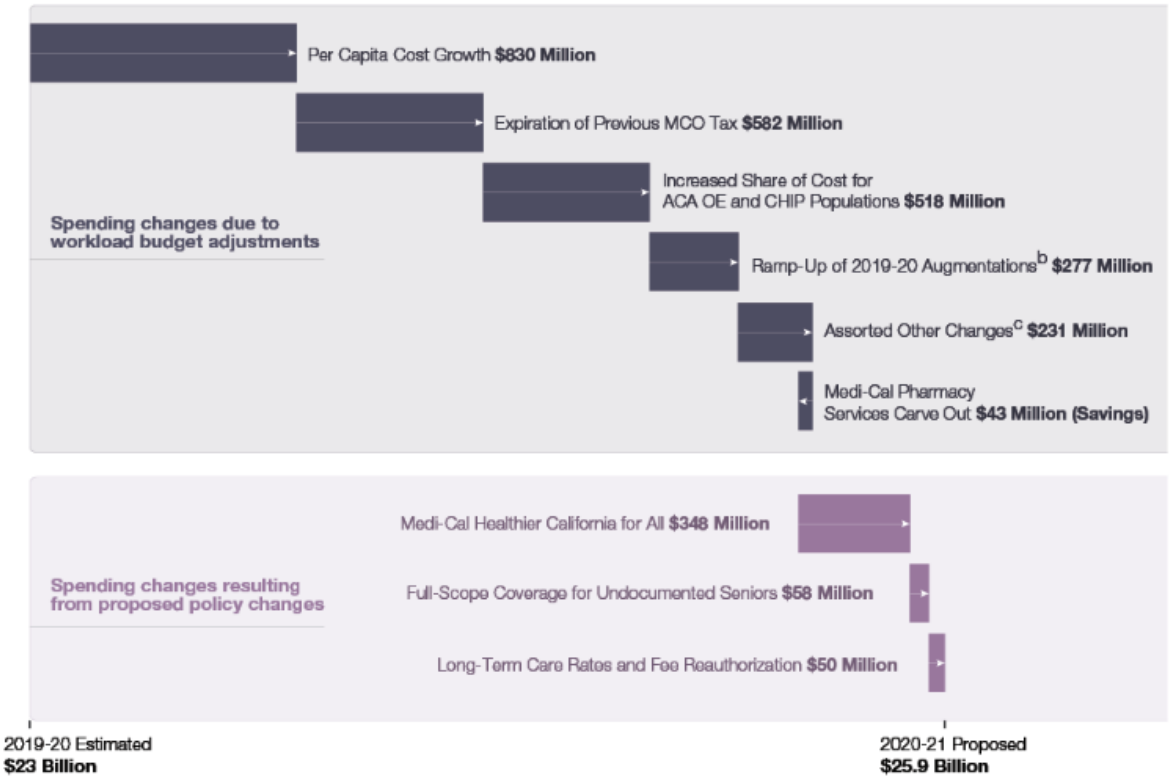
The Governor's budget projects that Medi-Cal spending will be $92 million lower (0.4 percent) in 2019-20 relative to what was assumed in the 2019-20 Budget Act. This is a small current-year adjustment relative to previous years. The downward adjustment primarily reflects: 1) savings from reduced expected enrollment in the program; and 2) a number of other, primarily technical adjustments that largely offset one another.

Budget-Year (2020-21) Changes:

Under the Governor's proposed budget, General Fund spending in Medi-Cal would grow from $23 billion in 2019-20 to $25.9 billion in 2020-21—a $2.9 billion, or 12.4 percent, increase in year-over-year spending. From the Legislative Analyst's Office (LAO) report, "*The 2020-21 Budget: Analysis of the Medi-Cal Budget*," figure 2 (below) summarizes the major factors responsible for the proposed growth in General Fund spending in Medi-Cal, which includes both workload budget adjustments and new policy proposals.

Figure 2

Major Drivers of Increased Costs in Medi-Cal[a] From 2019-20 to 2020-21



[a] Spending changes reflect costs, unless otherwise noted as savings.

[b] Includes the full-scope expansion for young undocumented adults, increased eligibility threshold for seniors and persons with disabilities, expanded eligibility for postpartum mental health services, expansion of screening and brief intervention services, and restoration of certain optional benefits.

[c] Summarizes the net impact of a large number of budget adjustments, among the major ones being the reductions in Disproportionate Share Hospital funding, changes related to the Health Insurer fee, and a modest projected increase in caseload.

MCO = managed care organization; ACA OE = Patient Protection and Affordable Care Act optional expansion; and CHIP = Children's Health Insurance Program.

LAO

The LAO identifies the following as the most significant adjustments to the 2020-21 Medi-Cal estimate:

- Per capita cost growth -- $830 million increase over the 2019-20 estimate.
- MCO Tax -- $582 million increase over 2019-20 due to the expiration of the previous MCO Tax.
- Scheduled reductions in federal share of costs -- $518 million increase over 2019-20 due to scheduled changes in the federal share of costs for the ACA optional expansion and CHIP populations.
- Ramp-up of 2019-20 augmentations -- $277 million increase over 2019-20 due to continued implementation of 2019 augmentations including:
  - expansion of full-scope Medi-Cal for undocumented young adults;
  - increased income eligibility threshold for seniors and persons with disabilities;

- expanded eligibility for postpartum mental health services;
- expansion of screening and intervention for substance use disorder services; and
- restoration of some optional Medi-Cal benefits.

- Disproportionate share (DSH) hospital reduction -- $83 million reduction in spending on payments to private DSH hospitals triggered by a scheduled reduction in federal funding, contingent on Congressional approval of another delay to this funding reduction.

- New policy proposals:

  - CalAIM - $490 million increase in General Fund for new CalAIM reforms.
  - Full-scope eligibility expansion to undocumented seniors -- $58 million (for half-year costs in 2020-21, annualized at about $110 million General Fund).
  - Skilled Nursing Facility Rate Reform -- $50 million (for half-year costs in 2020-21, annualized at about $100 million).
  - Supplemental Payment Pool for non-hospital-based clinics -- $26 million (half-year costs in 2020-21, annualized at $53 million).

Medical Fiscal Accountability Regulation ("MFAR")

In October 2019, the federal government released draft regulations related to financing and oversight in the Medicaid program. These rules, if implemented in their current or a similar form, would require significant changes to major Medi-Cal financing mechanisms, possibly resulting in several billion dollars of higher General Fund costs. These rules also would dramatically increase the amount and types of information the state would be required to report to the federal government. The LAO provides the following description of the proposed regulation:

The draft regulations significantly change what the federal government would allow as a source of nonfederal funding for Medi-Cal. Specifically, it would limit:

- Use of State Special Funds. The draft regulation specifies that state funding for Medi-Cal would need to come from the General Fund, which would appear to preclude the possibility of the state using state special funds, such as those that receive tobacco tax revenues, to finance Medi-Cal.

- Permissible Sources of Inter-Governmental Transfers (IGTs). The draft regulation also specifies that the source of IGTs would be limited to state and local government tax revenues. This limitation would exclude local governments' patient care revenue—a very significant source of funding for IGTs under current financing structures.

The draft regulations would:

- Add additional, nonstatistical tests beyond the existing statistical test to determine whether a health care-related tax falls too disproportionately on Medicaid services.

- Significantly expand the amount and types of information the state would be required to provide to the federal government. These new reporting requirements could result in significant new state costs.

- Require the state to provide information on the amount of supplemental payments provided to each individual provider.

- Require the state to seek federal reauthorization every three years for all payments.

- Require the state to commit to evaluating the impacts of supplemental payments on quality and access to services.

The LAO reports that if the draft regulations were finalized in their current or similar form, many of the state's mechanisms for financing Medi-Cal with non-General Fund sources would be at risk of being disallowed. The ultimate fiscal impact of the regulations on the state will depend on what provisions are in the final rule and how the federal government elects to implement them. Given this uncertainty, the LAO recommends that the Legislature approach new ongoing General Fund obligations with caution.

2019 Supplemental Report Language

The 2019 budget includes the following Supplemental Report Language (SRL) that is directed at creating a more transparent and accountable Medi-Cal estimate process.

> *Item 4260-101-0001—Department of Health Care Services:*
>
> *Fiscal Management. No later than August 31, 2019, the Department of Health Care Services (DHCS) shall initiate a fiscal stakeholder workgroup including the California Health and Human Services Agency, Department of Finance, legislative fiscal and policy staff, and the Legislative Analyst's Office to identify enhancements to DHCS' budgeting, accounting, and information technology systems to promote sound Medi-Cal Estimates and budget transparency. At its first budget subcommittee hearings of the 2020-21 budget process, DHCS shall update the health and human services budget subcommittees of both houses of the Legislature on fiscal management resources included in the 2019-20 budget, enhancements implemented to date, and longer-term enhancements identified to date (including estimated costs and timelines).*

DHCS provided the following update on the department's response to this SRL:

"As part of DHCS' initiative to enhance its fiscal management functions, the Department received 25 positions related to the 2019-20 Strengthening Fiscal Estimates and Cash Flow Monitoring BCP. In August 2019, DHCS appointed a Chief Financial Officer (CFO) and fully consolidated its fiscal functions. DHCS has filled the majority of the positions received, and although the work is challenging and ongoing, the Department has made progress in strengthening fiscal operations throughout the organization.

The Department has convened two fiscal stakeholder workgroup meetings in August and December 2019 to solicit input on enhancements to Medi-Cal Estimates and budget transparency. Future meetings are planned for March and May 2020. The workgroups were well attended by the California Health and Human Services Agency, Department of Finance, Legislative Analyst's Office, and relevant Assembly and Senate policy and fiscal committee staff.

The meetings have been helpful in identifying areas where improvements could be made related to the usability of DHCS financial information. The workgroup areas of improvements to date are focused on enhancing the displays within DHCS' Medi-Cal Local Assistance Estimate documents and regular reporting to stakeholders of budgeted vs actual expenditures.

Because some identified enhancements require information technology solutions, DHCS is leveraging existing and planned modernization efforts to implement system changes necessary to support fiscal enhancements. These efforts include further integration with FI$Cal, DHCS' Federal Draw and Reporting (FDR), and DHCS' California Automated Recovery Management (CalARM). As DHCS and the workgroup identify additional, specific enhancements, we will provide the Legislature additional updates."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the Medi-Cal estimate, highlighting the major policy and fiscal proposals and changes proposed for 2019-20 and 2020-21, and respond to the following:

1) Please describe and discuss the proposed MFAR, its current status, timing, and potential fiscal impacts on California.
2) Please provide an update on the 2019 Medi-Cal Fiscal Management SRL described above.

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

ISSUE 2: MEMBER/STAKEHOLDER PROPOSAL: MEDI-CAL ASSETS TEST - CARRILLO

PANEL

- **Assemblymember Wendy Carrillo**
- **Claire Ramsey**, Senior Staff Attorney, Justice in Aging

Public Comment

PROPOSAL

Western Center on Law and Poverty (WCLP) and Justice in Aging propose to simplify how assets are counted, increase the assets level for Medi-Cal programs not using the Modified Adjusted Gross Income methodology, and eliminate the assets test for Medicare Savings Programs. The cost estimate for this proposal is in development.

BACKGROUND

Stakeholders provided the following background information:

Currently, seniors and persons with disabilities whose Medi-Cal eligibility is still determined under the old income counting rules, rather than the Affordable Care Act rules known as the Modified Adjusted Gross Income methodology, are subject to a limit on their assets. The limit is $2,000 for an individual and $3,000 for a couple – amounts that have remained unchanged since 1989. Although assets exclusions exist, the exclusions themselves are complex and difficult to navigate. The exclusions privilege assets such as an owned primary residence, which people of color are less likely to have, and exclude other assets that allow for self-sufficiency, such as higher levels of cash savings.

This proposal increases the assets limit to $10,000 for an individual and $15,000 for a couple to be indexed on an annual basis, eliminating the assets test for the Medicare Savings Program as several other states have done, and simplifying the list of excluded assets so that beneficiaries do not need lawyers to help determine if they are eligible. At a time when senior homelessness is on the rise, we must allow seniors and persons with disabilities to have sufficient savings while on Medi-Cal so that they can retain enough resources to weather an eviction or major home or vehicle repair.

Funding will be used both for the direct costs of potential new enrollees, and the additional staff time and system programming changes needed to implement this proposal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Carrillo and Justice in Aging present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 3: MEMBER/STAKEHOLDER PROPOSAL: FIELD TESTING TRANSLATED MEDI-CAL DOCUMENTS - CHU

PANEL

- **Assemblymember Kansen Chu**
- **Benjamin Tran**, Policy Coordinator, California Pan-Ethnic Health Network

Public Comment

PROPOSAL

Western Center on Law and Poverty (WCLP) and the California Pan-Ethnic Health Network (CPEHN) request $1 million one-time to support field testing translated Medi-Cal documents.

BACKGROUND

Stakeholders provided the following background information:

At least one in three Medi-Cal beneficiaries speaks a language other than English as their primary language. In comparison with their English-speaking counterparts, limited English proficient individuals are more likely to have low literacy levels and/or low health literacy. As a result, many Medi-Cal beneficiaries do not understand the translated materials they receive that explain their benefits. This negatively affects their ability to effectively communicate with their health care provider and to meaningfully access their benefits, which can lead to lower quality health care and poor health outcomes.

Medi-Cal beneficiaries will have greater access to needed health care services if the translated materials they receive are written in plain, simple, and culturally appropriate language. This can be achieved through field testing of Medi-Cal documents. Field testing is essentially a review of translations for accuracy, cultural appropriateness, and readability by a focus group or another form of review involving native speakers. It can be conducted internally or through a third-party contractor.

- Funds will be used to conduct field testing at least the 10 most important Medi-Cal documents that are translated into threshold languages and released by the Department of Health Care Services; and

- Certain managed care materials, including plan termination notices and new member welcome packets that are translated into threshold languages and released by the managed care plans contracting with the Department.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Chu and CPEHN present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 4: MEMBER/STAKEHOLDER PROPOSAL: MEDI-CAL DOULA PILOT PROGRAM - REYES

PANEL

- **Assemblymember Eloise Reyes**
- **Zea Malawa**, **MD, MPH**, Physician Director of Expecting Justice, San Francisco Department of Public Health

Public Comment

PROPOSAL

Health advocates* propose funding (amount to be determined) for establishment of a 3-year Medi-Cal pilot program designed to demonstrate how providing doula care for pregnant and postpartum Medi-Cal enrollees in the 14 California counties with the highest birth disparities can improve health outcomes for various populations.

*Proposal sponsors:

- Western Center on Law and Poverty
- National Health Law Program
- Black Women for Wellness Action Project
- Birthing Project USA
- North State Doula Program
- South Los Angeles/South Bay African American Infant & Maternal Mortality Community Action Team

BACKGROUND

Stakeholders provided the following background information:

Pregnant and postpartum Black people are 3-4 times more likely than other ethnic groups in California to die during pregnancy or in the year after their pregnancies end. Black babies are 2.5 times more likely than babies of other ethnic groups to be born prematurely or die within the first year of life. Doulas can reduce the impacts of racism and racial bias in health care on pregnant people of color by providing individually tailored, culturally appropriate, and client-centered care and advocacy. Doulas provide pregnant and postpartum people with social and emotional support, individualized and culturally specific education, and strategies to reduce stress and other barriers to healthy pregnancies. Studies show that doulas improve birth outcomes through: reduced birth complications;

decreased rates of preterm births and low birth weight babies; reduced likelihood (25%) of cesarean births; and increased breastfeeding rates.

This proposal creates a 3-year Medi-Cal pilot program designed to demonstrate how providing doula care for pregnant and postpartum Medi-Cal enrollees in the 14 California counties with the highest birth disparities can improve health outcomes for various populations. Services will include at least four prenatal doula appointments during pregnancy, attendance at birth, and at least eight appointments in the year following birth. Doula support will also be available during miscarriage, stillbirth, and abortion.

The request creates a doula advisory board to standardize core competency requirements and certification; practicing doulas and community-based doula groups must be involved in the design, development, and implementation of the pilot program.

The request seeks to create lower maternal and infant mortality rates, fewer birth complications, fewer pre-term births, and a drop in C-section rates. The pilot is intended to demonstrate the efficacy of providing doula services, thus if the pilot program achieves improved birth outcomes, a statewide doula benefit for Medi-Cal enrollees will be considered.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Reyes and the San Francisco Department of Public Health present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 5: MEMBER/STAKEHOLDER PROPOSAL: WHOLE GENOME SEQUENCING - WALDRON

PANEL

- **Assemblymember Marie Waldron**
- **Charlotte Hobbs, M.D., Ph.D.** Pediatrician and Genetic Epidemiologist, Vice President, Research & Clinical Management Initiatives, Rady Children's Institute for Genomic Medicine

Public Comment

PROPOSAL

Rady Children's Hospital San Diego (RCHSD) and the Rady Children's Institute for Genomic Medicine (RCIGM) requests $10 million one-time to expand the established California clinical pilot project to test a minimum of an additional 750 Medi-Cal neonatal and other pediatric patients with undiagnosed diseases that have remained undiagnosed, or had multiple incorrect diagnoses, over an extended period of time using cWGS as a first line diagnostic test to produce precise condition diagnoses and treatment pathways.

BACKGROUND

Stakeholders provided the following background information:

The successful conclusion of the previous pilot project (a/k/a Project Baby Bear) has previewed the value of an initial, modest investment of $2 million. The charge was to sequence a minimum of 100 neonatal cases. Through extraordinary stewardship of the funds, over 154 cases were sequenced.

Preliminary data (provided in detail in three (3) reports generated by the initial cWGS pilot program which produced over 50% more case sequencings than envisioned by the first grant of $2 million, strongly underscore the value of cWGS to the Medi-Cal program. A second, final, phase of the pilot, will build on that investment and provide definitive data.

The objective of this funding would be to expand the established California clinical pilot project to test a minimum of an additional 750 Medi-Cal neonatal and other pediatric patients with undiagnosed diseases that have remained undiagnosed, or had multiple incorrect diagnoses, over an extended period of time using cWGS as a first line diagnostic test to produce precise condition diagnoses and treatment pathways. The
project would be required to report test results annually, such reports to include related diagnosis revisions and treatment pathway alterations. The project will demonstrate the value of cWGS in Medi-Cal compared to current standards of newborn and pediatric

healthcare assessments, screenings or tests. In addition to the current five participating sites (Valley Children's Hospital, Children's Hospital Oakland, UC Davis Medical Center, Children's Hospital Orange County, and Rady Children's Hospital San Diego), at least an additional five participating sites will be recruited to the project's next phase.

Project Timeline: Commencing October 1, 2020, the second quarter of the new fiscal year of 2020 – 2021 through July 1, 2024, or the exhaustion of the budget allocation and state agency and legislative receipt of the final summary of each preceding annual report.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Waldron and the Rady Children's Institute for Genomic Medicine present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 6: MANAGED CARE ORGANIZATION PROVIDER TAX (AB 115) BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Jacob Lam**, Principal Policy Budget Analyst, Department of Finance
- **Luis Bourgeois**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Capitated Rates Development Division (CRDD) and Third Party Liability and Recovery Division (TPLRD), requests three-year, limited-term (LT) resources equivalent to 2.0 positions and expenditure authority of $280,000 ($140,000 General Fund (GF); $140,000 Federal Fund (FF)) in fiscal year (FY) 2020-21 and $262,000 ($131,000 GF; $131,000 FF) in FY 2021-22 and FY 2022-23. This will enable DHCS to support continuing implementation and oversight of the managed care enrollment tax, as implemented by Assembly Bill (AB) 115 (Committee on Budget, Chapter 348, Statutes of 2019).

The following chart identifies the resources requested and organizationally where they are located within DHCS:

Division	Request	Activity
CRDD	Three-year LT resources equivalent to: • 1.0 Associate Governmental Program Analyst (AGPA)	• Fund management • Capitation rate development • Financial and policy analysis
TPLRD	Three-year LT resources equivalent to: • 1.0 AGPA	• Tax collection • Repayments, penalties • Financial and policy analysis

BACKGROUND

The administration provided the following background information:

Medi-Cal provides health care services to more than 12.9 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 (QIF) on Medi-Cal managed care organizations (MCO). 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 GF. 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 GF. Changes in federal law resulted in the need for 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 (Chapter 11, Statutes of 2011) until July 1, 2012 and updated the sharing percentages for DHCS and MRMIB. Finally, Senate Bill (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 costs 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 non-federal share of managed care rates for health care services for children, seniors and persons with disabilities, and persons dually eligible for Medi-Cal and Medicare, 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.

SB 2 of the 2015-16 Second Extraordinary Session (SBX2 2) implemented 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 included a replacement managed care enrollment tax for the tax expiring on June 30, 2016 and other taxes paid by the health plan industry. The managed care enrollment tax was effective for July 1, 2016 through June 30, 2019.

SBX2 2 stabilized funding for the Medi-Cal program and provided rate increases for providers of Medi-Cal and developmental services. SBX2 2 was 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.
- Comply with federal Medicaid requirements applicable to permissible healthcare related taxes.

AB 115 (Committee on Budget, Chapter 348, Statutes of 2019) re-established a managed care enrollment tax, using a modified tiered taxing model, effective for July 1, 2019 through December 31, 2022. Implementation of the tax is projected to generate a net state GF benefit of approximately $7 billion over the three-and-a-half-year duration of the tax. The federal Centers for Medicare and Medicaid Services (CMS) reviewed this tax proposal and denied approval of it. In response, DHCS revised the proposal to address CMS concerns and resubmitted it to CMS for review.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and provide an explanation of CMS's denial of the tax proposal and how the new proposal addresses their concerns.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 7: COUNTY ELIGIBILITY OVERSIGHT AND MONITORING BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Cathy Senderling**, Deputy Executive Director, County Welfare Directors Association
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Hinnaneh Qazi**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Medi-Cal Eligibility Division (MCED) requests $279,000 ($140,000 General Fund (GF); $139,000 Federal Fund (FF)) in fiscal year (FY) 2020-21 and ongoing to convert 2.0 existing limited-term (LT) resources to permanent. Resources are needed to continue the implementation of programs pursuant to Senate Bill (SB) 28 (Hernandez, Chapter 442, Statutes of 2013), Affordable Care Act (ACA). A number of changes have taken place in the Medi-Cal program, and more specifically in the county administration aspect of the program. The budget for county administration has grown to over $2 billion dollars, and as a result, the associated workload and oversight for counties has continually grown.

Based on the outcome of Control Section 4.11, DHCS proposes to reclassify historically vacant positions as opposed to requesting additional position authority in the 2020-21 Governor's Budget. As such, the Department is requesting expenditure authority but not additional position authority in this budget change proposal.

BACKGROUND

The administration provided the following background information:

Since the inception of the Medi-Cal program, California's 58 county social service agencies have been responsible for Medi-Cal eligibility case management, and administer the Medi-Cal program based upon federal and state statutes, regulations and policies. With the implementation of the ACA in 2014, the Medi-Cal program has expanded to cover a greater number of individuals and families, which has directly affected the caseload and work carried out by the eligibility workers and staff at the counties. With the numerous changes in 2014 to rapidly operationalize the policies under the ACA, counties made modifications to business processes in order to effectively administer and undertake the significant increase in workload in the Medi-Cal program.

Since then, various federal and state audits have cited deficiencies in county performance and eligibility determinations as it relates to application and renewal processing timelines, and automation discrepancies. In an effort to address the audit recommendations and the corrective action plans (CAPs) imposed on DHCS and to improve program integrity, DHCS is putting forward this proposal.

Currently, the MCED County Administration Expense Unit (CAEU), which houses the two LT resources in this proposal, is responsible for auditing county expenditures, facilitating budget development, and disbursing quarterly county allocations to counties for Medi-Cal eligibility determinations. As DHCS moves forward in meeting its goals of increased program accountability, oversight, and monitoring of county performance, these resources' roles and responsibilities will increase significantly, and will be integral in collaborating with the County Welfare Directors Association (CWDA) and county stakeholders on increased county oversight and reinstatement of county performance standards.

The current LT resources equivalent to 1.0 Staff Services Manager (SSM) I and 1.0 Associate Governmental Program Analyst (AGPA) were authorized via 4260-016-BCP2017-GB, "County Administration Budgeting Methodology Staffing Extension", and expire on June 30, 2020.

The SSM I position currently serves as the manager of the CAEU within MCED. This position currently oversees the county administrative funding functions, which includes coordination with CWDA to fund counties for the administration of the Medi-Cal program, performing analysis of county expenditure patterns, and providing all information on county expenditure and funding history requested by intra-departmental staff, Department of Finance, California Health and Human Services Agency, and CWDA. If this proposal is approved, the SSM I will lead the county oversight initiative under the direction of DHCS senior leadership, and serve as the managerial liaison to external stakeholders on the development of a long-term plan for various oversight activities linked to performance metrics. The LT AGPA position has previously taken on the role of analytical support for county expenditure validation as well as performing fiscal analyses for new county initiatives. In alignment with DHCS' vision of increased county oversight, this position will evolve into tracking state and federal audit-related findings, recommendations, and CAPs imposed on DHCS as it relates to county performance and supporting the SSM I in the engagement with external stakeholders on a long-term county oversight plan.

Legislative Analyst's Office

The LAO included a review of state oversight of county eligibility administration in their *2020-21 Analysis of the Medi-Cal Budget*. The LAO concludes that: 1) counties continue to struggle with performance goals; 2) increased oversight and transparency of county

performance is warranted; and 3) the current county administration budgeting practice lacks strong analytical basis. In light of these conclusions, the LAO recommends:

1. Withhold action on making temporary resources permanent;
2. Require DHCS and counties to update the Legislature at Budget Committee hearings on current performance and plans for future changes*; and
3. Adopt a plan for revising Medi-Cal county administration budgeting methodology.

*LAO specifically recommends that DHCS and counties report to the Legislature on the following:

- The status of state and county efforts to address recent audit findings.
- The administration's thinking in regards to timing of required revisions to the county Medi-Cal administration budgeting methodology.
- How county spending patterns have changed in recent years as the caseload has stabilized and some IT-related challenges have been resolved.
- Which additional performance measures should be considered.
- How planned and in-process changes to major IT systems used in eligibility and enrollment functions affect plans for increased county oversight and potential future changes to the budgeting methodology for county Medi-Cal administration.

County Welfare Directors Association

CWDA explains that the implementation of, and ongoing process of repairing, CalHEERS has been challenging, slow, and arduous with many "manual workarounds" that still have to be used to this day. CWDA also states that the stakeholder process associated with implementing the CalHEERS repair roadmap has been challenging, explaining that DHCS has often been dismissive of CWDA concerns, and has backtracked on many agreements. For example, CDWA writes:

> *"The pushing-back of these changes continues, as well. In November 2019, the governing body that includes the sponsors and CWDA agreed that two aspects of the phase 3 changes would go into the September 2020 release. However, at the February 2020 meeting of the same group – just two months later – these changes were shifted to the February 2021 release, over CWDA's objections."*

Moreover, CWDA explains that the lengthy delays in fully repairing CalHEERS create significant increases in county eligibility workload, and therefore costs, creating a still-unstable environment to be implementing a new budgeting methodology. In response to this situation, CWDA is seeking trailer bill language that: 1) specifies a timeline for known eligibility-related issues to be fixed; 2) provides greater accountability on the part of the Administration for delays and workarounds; 3) sets forth a more inclusive, statutory

governance process for the system; and 4) suspends the onset of county penalties until needed eligibility fixes have been implemented.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests: 1) DHCS present this proposal; 2) LAO provide an overview of their analysis of these issues; and 3) CWDA provide their responses and perspectives on the administration's proposal, the status of the state's budgeting methodology and the LAO's assessment and recommendations.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 8: MANAGED CARE ALTERNATIVE ACCESS STANDARDS (AB 1642) BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Jacob Lam**, Principal Policy Budget Analyst, Department of Finance
- **Luis Bourgeois**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Managed Care Quality and Monitoring Division (MCQMD) and Medi-Cal Behavioral Health Division (MCBHD), requests resources of $1,449,000 ($500,000 General Fund (GF); $949,000 Federal Fund (FF)) in fiscal year (FY) 2020-21 and $1,413,000 ($482,000 GF; $931,000 FF) in FY 2021-22 and ongoing equivalent to 4.0 positions. The resources are necessary to implement the requirements associated with Assembly Bill (AB) 1642 (Wood, Chapter 465, Statutes of 2019). Within the expenditure authority requested, $900,000 ($225,000 GF; $675,000 FF) will be used annually for External Quality Review Organization (EQRO) contract funding.

Based on the outcome of Control Section 4.11, DHCS proposes to reclassify historically vacant positions as opposed to requesting additional position authority in the 2020-21 Governor's Budget. As such, the Department is requesting expenditure authority but not additional position authority in this budget change proposal.

BACKGROUND

The administration provided the following background information:

Network Adequacy and Alternative Access Standards
In accordance with federal regulations, DHCS established network adequacy standards to promote the timely availability and accessibility of services for Medi-Cal beneficiaries receiving services through DHCS' contracting Managed Care Organizations (MCOs), including Medi-Cal managed care health plans (MCPs), county Mental Health Plans (MHPs), and Drug Medi-Cal Organized Delivery System (DMC-ODS) plans. These network adequacy standards include the requirement that MCOs maintain networks of providers that are located within time and distance standards set forth in state law, for a variety of provider types, based on county population density. For example, MCO

networks in Los Angeles County must include adult and pediatric specialists who are located up to 15 miles or 30 minutes from the member's place of residence, while MCO networks in Butte County must include adult and pediatric specialists who are located up to 45 miles or 75 minutes from the member's place of residence.

DHCS monitors its contracting MCOs for compliance with network adequacy standards, including time and distance standards through a monitoring activity known as the Annual Network Certification (ANC). The ANC provides a prospective look at the MCO's network in the upcoming contract year (CY). DHCS defines a "network" as Primary Care Physicians (PCPs), specialists, hospitals, pharmacies, ancillary providers, facilities, and any other providers that enter into a contract with an MCO for the delivery of Medi-Cal covered services. MCOs are required to annually submit documentation to DHCS demonstrating their capacity to serve the anticipated membership in its service area in accordance with state law and federal regulations. DHCS reviews all MCO network submissions and provides evidence of compliance to the Centers for Medicare and Medicaid Services (CMS) before the CY begins. As permitted by state and federal law, DHCS may grant exceptions, known as Alternative Access Standards (AAS), to the state-established time and distance standards under specified circumstances. MCOs must submit AAS requests to DHCS for approval as part of the ANC.

AB 1642 builds upon existing state and federal law that requires DHCS to monitor MCOs for compliance with established time and distance standards by including additional details about monitoring activities, particularly for MCOs with an approved AAS request. The bill establishes new data submission requirements that will result in a significant increase to the workload associated with the ANC. The bill specifies that DHCS must review and validate supporting documentation submitted by MCOs regarding justification for AAS requests, member access to transportation services, telecommunication services provided, and member requests for out-of-network services or providers associated with each DHCS-approved AAS.

EQRO Contract Expansion

Additionally, AB 1642 builds upon state law requiring DHCS to conduct quality reviews of MCOs as set forth in federal regulations. In order to conduct these quality reviews, DHCS engages in contracts with two separate EQROs: one to conduct quality reviews of MCOs and Dental Managed Care plans, and another to conduct quality reviews of MHPs and DMC-ODS plans. The EQRO contractors are required to report to DHCS on the findings of the quality reviews in an annual technical report, which DHCS makes available on its public website. The annual technical report details various quality and performance metrics in order for DHCS to address any deficiencies in the delivery of covered Medi-Cal services. State and federal law detail required elements of the EQRO annual detailed technical reports. DHCS utilizes this information for various reasons, such as determining

the need for Corrective Action Plans (CAPs), sanctions, technical support, or other action in response to recurrent quality performance issues.

AB 1642 requires DHCS to expand the annual detailed technical report to include additional information related to the reasons for AAS requests. The report's analysis of justifications for DHCS-approved AAS requests will include identification of whether: (1) there was not a provider located in the specified ZIP code, or (2) the MCO was unable to enter into a contract with a provider or providers in the requested ZIP code. DHCS must provide to the EQRO contractor with a justification analysis for AAS requests. This will enable the EQRO contractor to publish the justification information in the EQRO annual technical report.

California and its health plans face numerous unique challenges in implementing federal network adequacy standards, such as population scarcity and topological diversity in certain regions of the state, the low number of providers available in the certain regions of the state, and the number of providers willing to enter into contracts to provide services to Medi-Cal beneficiaries throughout the state, either with an MCO as a managed care provider or with DHCS as a fee-for-service (FFS) provider. In the event that an MCO does not have an adequate network, DHCS allows MCOs to submit AAS requests to provide MCOs with an appropriate level of flexibility in providing their members with appropriate access to care.

On August 6, 2019, the California State Auditor (CSA) published a report evaluating access to health care services for MCOs in certain rural areas of California and DHCS' administrative assessments of network adequacy for these rural MCOs. The report concluded that MCOs in rural areas often do not provide the appropriate level of access to health care services due to excessive time and distance standards, scarcity of health care providers, and ineffective oversight from DHCS. Additionally, the report concluded that DHCS did not hold MCOs operating in rural areas properly accountable to time and distance standards and did not properly educate these rural MCOs on the managed care delivery system. In order to mitigate these findings from the CSA, DHCS coordinated with the Legislature on AB 1642 in order to improve access reporting and AAS considerations.

AB 1642 is a comprehensive bill. Along with standardizing and increasing DHCS sanction authority, it aims to increase access to services for Medi-Cal beneficiaries receiving care through DHCS' contracting MCOs by improving the AAS process, requiring MCOs to assist beneficiaries who are required to travel farther than established time and distance standards, and reporting on the reasoning for AAS requests. The requested resources will support the following activities related to DHCS' implementation of AB 1642:

- Developing standardized reporting templates;
- Developing data collection methodologies and sampling processes;

- Reviewing more robust deliverables from MCOs;
- Providing increased technical assistance, when requested, to MCOs implementing the new requirements of AB 1642;
- Develop a data sharing relationship with various DHCS contractors;
- Support the administrative activities of DHCS contractors; and
- Expand the annual EQRO technical report to include more comprehensive information, as specified.

As a result, DHCS will better understand the nature and type of AAS requests DHCS receives from MCOs and, therefore, be better able to take action to ensure that MCO members have appropriate access to medically necessary services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 9: OFFICE OF ORAL HEALTH OVERSIGHT

PANEL

- **Dr. Jayanth Kumar**, State Dental Director, Office of Oral Health, Department of Public Health
- **Jack Zwald**, Principal Policy Budget Analyst, Department of Finance
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED REDUCTION IN FUNDING

Prior to the 2016 passage of Proposition 56 (tobacco tax), the Office of Oral Health had a budget of approximately $3 million General Fund. Proposition 56 includes a defined allocation of $30 million specifically to the state dental program at CDPH. However, Proposition 56 allows for reductions to direct allocations to reflect reductions in overall Proposition 56 revenue, and therefore the 2019 Budget Act includes a reduction to the Office of Oral Health as does the proposed 2020-21 budget, as follows:

2017-18: $35,045,000
2018-19: $30,048,000
2019-20: $26,749,000
2020-21: $26,449,000 (proposed)

BACKGROUND

The following background on the Office of Oral Health was copied from the CDPH website:

The Office of Oral Health (OOH) has a mission to improve the oral health of all Californians through prevention, education, and organized community efforts. To achieve these goals, the OOH is providing strategic advice and leadership to oral health stakeholders throughout the state, building oral health workforce capacity and infrastructure, and implementing and evaluating evidence-based best practices in oral disease prevention. Initial steps to build capacity and address the burden of oral disease are to develop a State Burden Report, a California Oral Health Plan, and an oral health surveillance plan. The state plan serves as a roadmap to identify priorities, short term, intermediate, and long term goals and objectives along with recommendations to address

the burden of disease, increase access to oral health services for high risk populations, and to increase the oral health status of all Californians.

The CDPH Oral Health Program has several projects focused on improving the oral health of all Californians:

CALIFORNIA CHILDREN'S DENTAL DISEASE PROGRAM
The California Children's Dental Disease Prevention Program (CCDDPP) is a school-based prevention program. The mission of the CCDDPP is to assure, promote, and protect the oral health of California's school-aged children by increasing their oral health awareness, knowledge, and self-responsibility by developing positive, life-long oral health behaviors. The program is targeted to children who are unlikely receive preventive services otherwise. The criterion is based on the proportion of Free and Reduced School Lunch Program participation for each participating school. Funding for the CCDDPP was restored in fiscal year 2016-2017.

COMMUNITY WATER FLUORIDATION PROGRAM
The Community Water Fluoridation Program provides scientific and technical expertise to communities interested in fluoridating their drinking water. California's fluoridated drinking water act, Assembly Bill 733, became law in 1995, authorizing water systems with 10,000 or more service connections to fluoridate once money from an outside source is provided.

INTEGRATING ORAL HEALTH INTO MATERNAL, CHILD, AND ADOLESCENT PROGRAMS
The Maternal, Child, and Adolescent Health (MCAH) Branch at the California Department of Health Care Services is collaborating with the Oral Health Program to promote effective oral health practices among parents, caregivers, childcare providers, MCAH programs, and primary health care providers. The goal of the project is to increase the number of children receiving preventive dental services and increase local capacity to collect data on the population's oral health needs. This project includes providing technical assistance to local health departments and MCAH programs to help them include more oral health activities in their programs, policy development, and community outreach efforts.

ORAL HEALTH WORKFORCE
CDPH was awarded a grant from the Health Resources and Services Administration (HRSA) to expand the Virtual Dental Home (VDH) system to three additional sites to bring oral health services to vulnerable and underserved populations and pilot a Value-Based Incentive program. The VDH is an innovative delivery system, which has demonstrated the ability to reach populations that do not traditionally receive oral health services or access services until they have advanced disease. The system uses telehealth-

connected teams to reach traditionally underserved populations and dental hygienists to provide community-based prevention and early intervention services.

The development of the VDH delivery system has been led by the Pacific Center for Special Care at the University of the Pacific (Pacific), Arthur A Dugoni School of Dentistry. Pacific has extensive experience working in community sites, analyzing, understanding, and working with the unique environments presented by various populations, community delivery systems, and educational, social, and general health agencies. The success of the VDH delivery system has, in large part, been driven by the ability to foster interprofessional practice to integrate oral health services in community locations and includes cultural and linguistic competency, and customizes the system to the unique needs of each community and agency. For additional information on the VDH delivery system, please visit the University of Pacific's Virtual Dental Home System of Care webpage.

PERINATAL AND INFANT ORAL HEALTH QUALITY IMPROVEMENT PROJECT
CDPH was awarded the Perinatal and Infant Oral Health Quality Improvement (PIOHQI) Expansion Grant from the HRSA for project years 2015 through 2019. The goal of California's PIOHQI Project is to improve the oral health of high-risk pregnant women and infants through increased utilization of oral health care services. By integrating oral health care into the primary care delivery system, the oral health and overall health of pregnant women and infants will be improved.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present an overview of the Office of Oral Health and its proposed 2020-21 budget. How will the proposed funding reduction be absorbed by the Office?

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 10: MEMBER/STAKEHOLDER PROPOSAL: OFFICE OF ORAL HEALTH PROPOSITION 56 BACKFILL - GARCIA, C.

PANEL

- **Brianna Pittman-Spencer**, Legislative Director, California Dental Association

Public Comment

PROPOSAL

The California Dental Association (CDA) requests approval of an ongoing backfill for the CDPH Office of Oral Health (OOH) to cover the declining revenue from Proposition 56 through budget year 2022-23, to align with the proposed extension of the Prop 56 Medi-Cal provider rates. Proposition 56 allocated $30 million annually to the Office of Oral Health within the Department of Public Health. Of the $30 million, $18 million is provided directly to local health jurisdictions to implement programs and interventions in their communities. Starting in budget year 2019-20, this funding has been reduced due to the declining revenue from the sale of tobacco products

BACKGROUND

Stakeholders provided the following background information:

The Prop 56 funds are being used to achieve the goals of the California Oral Health Plan (COHP), a 10-year blueprint for improving California's oral health. COHP objectives include school-based dental disease prevention, expanded access to fluorides, dental sealants, tobacco-use counseling, and developing programs that promote oral-health literacy and greater access to services. Local health jurisdictions are charged with ensuring all kindergarten children receive oral health assessments and are linked to a source of dental care and implementing school-based dental disease prevention programs using a best practice model. The ultimate goal is to connect children with a regular source of dental care and deliver healthy children to schools so that they are ready to learn.

The COHP has set a target to reduce the prevalence of tooth decay in 3rd grade children by no more than 56.5% from the baseline of 70.5%. Local oral health programs are working towards achieving these targets using Proposition 56 funding.

In addition to cuts to local health jurisdiction funding, reductions to the state OOH portion of the funding will undercut the foundational work happening to implement the COHP. Funding for community water fluoridation and support of school-based dental sealant program will be reduced. The data needed to assess oral health and track progress toward California Oral Health Plan will not be collected or available in a timely manner. The plan to provide funding for demonstration programs for addressing the needs of older adults will see a reduction in the scope.

The proposed reduction to OOH funding is $3.5 million in budget year 2020-21. CDA sees the proposed vaping tax as a potential source of revenue, as it make up for the fact that Prop 56 under-taxes e-cigarettes and vaping pods when compared to combustible cigarettes. As a declining revenue source, it makes sense to put this new tobacco tax towards programs already funded by Prop 56 rather than creating new programs. Without new revenue from the vaping tax, CDA would like this funded with General Fund. Matching funds are not available.

The reduction to OOH funding in budget year 2019-20 was $3.3 million, meaning a much smaller annual reduction after the first initial drop. This aligns with the reduction in smoking, which took a bit hit in the first few years after the tobacco tax passed, but has been much smaller in out years. Assuming a continued reduction in Prop 56 OOH funding of approximately $2 million annually, CDA estimates the needed backfill to fully fund the OOH to be as follows:

- $3.5 million in 2020-21
- $3.7 million in 2021-22
- $3.9 million in 2022-23

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the California Dental Association present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 11: MEDI-CAL DENTAL AND CALAIM

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

California Advancing and Innovating Medi-Cal (CalAIM), is a multi-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reform across the Medi-Cal program. DHCS formally released the CalAIM proposal on October 29, 2019, and facilitated an extensive stakeholder engagement process over the past several months. CalAIM covers a wide range of proposals affecting a variety of aspects of the Medi-Cal program, and Sub 1 will discuss various components of CalAIM at various hearings this spring. This issue is just for the purpose of discussing the dental components of CalAIM. Specifically, CalAIM includes the following two dental proposals:

1) New benefit: Caries Risk Assessment Bundle and Silver Diamine Fluoride for young children; and

2) Pay for Performance for adult and children preventive services and continuity of care through a Dental Home.

The proposed 2020-21 budget includes $225 million to cover the costs of these proposals.

BACKGROUND

The dental components of CalAIM can be viewed as an extension, expansion, and continuation of aspects of the Dental Transformation Initiative (DTI) which was a project under the state's current 1115 Waiver. The DTI has a focus on children, whereas CalAIM expands improvement efforts to both children and adults.

The following is from the CalAIM Executive Summary:

The Department has set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. In order to progress towards achieving that goal, and based on our lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide:

- Add new Dental Benefits based on the outcomes and successes from the Dental Transformation Initiative that will provide better care and align with national dental care standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high risk and institutional populations; and

- Continue and expand Pay for Performance Initiatives initiated under the Dental Transformation Initiative that reward increasing the use of preventive services and establishing/maintaining continuity of care through a Dental Home. These expanded initiatives would be available statewide for children and adult enrollees.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of Medi-Cal Dental Services, updates to the program, and describe the dental components of CalAIM.

The administration has not proposed trailer bill to implement the dental components of CalAIM; is legislation not needed?

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 12: DENTAL SERVICES PROGRAM PROCUREMENTS ADMINISTRATIVE SERVICES ORGANIZATION BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Medi-Cal Dental Services Division (MDSD) and Office of Legal Services (OLS), requests three-year limited-term (LT) resources equivalent to 4.0 positions and expenditure authority of $661,000 ($331,000 General Fund (GF); $330,000 Federal Fund (FF)) in fiscal year (FY) 2020-21 and $625,000 ($313,000 GF; $312,000 FF) in FY 2021-22 and FY 2022-23 to oversee and support a major procurement effort, contract transition, and related efforts, to obtain a new Administrative Services Organization (ASO) contract for the Medi-Cal Dental FeeFor-Service (FFS) delivery system.

BACKGROUND

The administration provided the following background information:

DHCS is the single state agency responsible for administering the State's Medicaid program (also known as Medi-Cal), which includes the provision of dental services. MDSD administers the Medi-Cal dental benefit through two delivery systems: Dental FFS and Dental Managed Care (DMC). The dental FFS delivery system is supported by both a contracted dental ASO (Delta Dental of California) and dental Fiscal Intermediary (FI) (DXC Technology). Jointly, these contracts process over seven million claims annually for approximately 12.9 million members, which total over $1.5 billion in payments to FFS Medi-Cal dental providers.

The dental ASO contract provides administrative services supporting the provision of dental benefits for Medi-Cal providers and members, which includes oversight and operation of a call center, provider outreach and training, member care coordination, assisting members with locating a dental provider and/or scheduling a dental appointment, processing provider enrollment applications, and other related efforts to increase provider participation and member utilization of dental services. The ASO is also

responsible for processing and adjudicating dental Treatment Authorization Requests (TARs) and performing various program oversight and integrity functions, such as statistical profiling of providers to identify potential fraud, waste, and abuse and the provision of resources to support DHCS on member-facing State Hearing and Conlan cases. The ASO works closely with, and is dependent on, the FI contract to support all of the operational processes for delivering Medi-Cal dental FFS benefits. The FI's primary role is to operate and maintain the California Dental Medicaid Management Information System (CD-MMIS), which is a decades-old, legacy system. Decisions made on the Scope of Work for this ASO contract will have impact on the existing CDMMIS, the FI contract and its future procurement. Resources obtained through this proposal will be utilized for future procurement cycles, including the upcoming Medi-Cal dental FFS FI contract procurement, which is set to begin immediately following the successful assumption of operations (AOO) of this ASO procurement.

From 1966 to 1972, all claims for dental health care services rendered to Medi-Cal members were submitted, processed, and paid by a single FI. In 1974, the State entered into a four-year pilot project to provide dental care services on a prepaid, at-risk basis. Legislative action allowed extension of the pilot project, leading to the first of several competitively bid contracts under a prepaid, at-risk model. During the 2014 dental FI reprocurement, the Centers for Medicare and Medicaid Services (CMS) voiced concerns with certain elements of the Dental FI contract, including the fact that California operates two MMIS. In order to address CMS' concerns, and with DHCS evaluating alternatives for the eventual migration to a single MMIS, DHCS removed the underwriting and at-risk basis from the contract. In the 2016 procurement, DHCS awarded two individual contracts, ASO and FI, to administer the Medi-Cal dental FFS benefit. The bifurcation of the FI contract into two separate, individual FI and ASO contracts has demonstrated progress towards DHCS' and CMS' goals to increase competition among vendors and facilitate eventual consolidation of CD-MMIS with the California Medicaid Management Information System (CA-MMIS). This strategy, however, has significantly increased the DHCS' workload.

The dental ASO is a one-year contract, with up to five optional one-year extensions. The FI contract is a four-year contract with up to five optional one-year extensions. The contract base and extension years are strategically staggered to accommodate a second ASO procurement before the end of the current FI contract, which, with all extension years exercised, the maximum term runs through June 30, 2026. With all ASO extension years exercised, the maximum term of the ASO contract runs through June 30, 2023. Therefore, a new ASO procurement must be completed, the contract fully executed, contracted functions "turned over" to the awarded vendor, and the new vendor must assume business and administrative operations for the contracted services, by that date. The procurement process for a contract of this magnitude (i.e., current contract is $280 million)

is a minimum of two years, and turnover and AOO is a minimum of another full year, for a total re-procurement period of approximately three years from start to finish.

If the procurement and/or takeover projects and processes exceed the estimated timelines, DHCS has a one-time (emergency) six to 12-month extension authority (maximum June 30, 2024), as a contingency to maintain ASO contract operations. Therefore, DHCS must start its re-procurement efforts to replace the current ASO contract no later than July 2020, in order for a new ASO contract to be in place to meet critical business needs and for the dental FFS delivery system to remain operational. If this contract is not executed timely, Medi-Cal FFS members may not have access to dental services and dental providers may be unable to receive reimbursement for dental services rendered.

MDSD is required to lead the ASO re-procurement efforts to develop the detailed Request for Proposals (RFP), participate in all phases of the re-procurement cycle, and oversee the procurement/contract process through completion of the takeover and AOO by the new ASO vendor. All existing MDSD resources are fully dedicated to administering the Medi-Cal dental benefit; including oversight and management of the current ASO and FI contracts, which together total $3.8 billion in full operations mode. During the Takeover/Turnover of the prior ASO and FI contracts, DHCS' Budget Change Proposal (BCP) 4260-303-SFL-DP-2016-A1 authorized 7.0 three-year LT resources (2.0 MDSD/4.0 EITS/1.0 OLS) to support the project and management of three overlapping contracts (incumbent, ASO, and FI). In FY 2019-20, BCP 4260-016- BCP-2019-GB approved the conversion of 4.0 LT resources to permanent positions (1.0 MDSD/2.0 EITS/1.0 OLS). These positions are now seasoned and dedicated staff, some of which are subject-matter experts, who are responsible for supporting existing Medi-Cal dental workload and business operations, as well as providing valuable knowledge, experience, and lessons-learned related to the FI and ASO operations oversight, which is workload that is separate and apart from the ASO re-procurement and takeover activities described in this proposal. The other three LT resources, 1.0 Associate Governmental Program Analyst (AGPA) and 2.0 Information Technology Specialist Is (ITS Is), expired on June 30, 2019, leaving MDSD with no dedicated program or IT staff to support the procurement and Turnover/Takeover workload.

MDSD does not currently have sufficient resources to conduct a procurement of this size and complexity. Senior level staff are key to ensuring that strategic decisions made during this procurement consider all program impacts to the dental benefit under Medi-Cal; as well as impacts to automation projects in flight, such as provider enrollment automation and CA-MMIS Replacement, CA-MMIS consolidation, and the future disposition of the dental FI contract.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 13: MEDI-CAL DENTAL PROGRAM INTEGRITY BUDGET CHANGE PROPOSAL

PANEL

- **Erika Sperbeck**, Chief Deputy Director of Policy and Program Support, Department of Health Care Services
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Audits and Investigations Division (A&I) requests resources of $1,067,000 ($534,000 General Fund (GF); $533,000 Federal Fund (FF)) in fiscal year (FY) 2020-21 and $1,004,000 ($502,000 GF; $502,000 FF) in FY 2021-22 and ongoing equivalent to 7.0 positions to support the federally-mandated program integrity functions of the Dental Fee-for-Service (FFS) and Dental Managed Care (DMC) plans.

Based on the outcome of Control Section 4.11, DHCS proposes to reclassify historically vacant positions as opposed to requesting additional position authority in the 2020-21 Governor's Budget. As such, the Department is requesting expenditure authority but not additional position authority in this budget change proposal.

BACKGROUND

The administration provided the following background information:

DHCS is the single state department responsible for administering the Medi-Cal program, which includes dental services for Medi-Cal recipients. Within DHCS, the Medi-Cal Dental Services Division (MDSD) provides oversight and management of the dental program. Dental services are provided to eligible beneficiaries through two delivery systems, Dental FFS and DMC servicing approximately 12.9 million beneficiaries. As of FY 2018-19, under the Medi-Cal Dental FFS delivery system, there are 10,591 enrolled rendering dental providers and 5,874 service locations.

Historically, Medi-Cal Dental FFS audits were performed by Delta Dental of California (Delta Dental), which also acted as the program's Fiscal Intermediary (FI). In 2011, the Centers for Medicare and Medicaid Services (CMS) concluded Delta Dental's dual role in performing as the FI and providing audit and program integrity oversight was a conflict of interest. At the direction of the CMS, DHCS separated out the functions of the existing

Medi-Cal Dental contractor. In 2015, two new contracts were successfully executed to administer the Medi-Cal Dental program for the FI and Administrative Services Organization (ASO). The ASO contract also transitioned audit and recovery functions to A&I and Third Party Liability and Recovery Division, respectively.

Historically, DMC plan audit functions were performed by the Department of Managed Health Care (DMHC). The interagency contract between DHCS and DMHC expired in June 2017 and A&I's Medical Review Branch (MRB) became designated to perform the DMC plan audit functions. Pursuant to Welfare and Institutions Code, Section 14456, every DMC plan must be audited annually.

In the May 2015 audit report, issued by the United States Health and Human Services, Office of the Inspector General (OIG), the report recommended that DHCS: (1) increase its monitoring of dental providers to identify patterns of questionable billing; (2) closely monitor billing by providers in dental chains; (3) review its payment processes for orthodontic services; and (4) take appropriate action against dental providers with questionable billing. DHCS concurred with all four of OIG's recommendations and continues to work on the resolution of the Corrective Action Plan (CAP).

Furthermore, DHCS 2016 Activities Relating to the Medi-Cal DMC Report to the Legislature in July 2017 cited that all three DMC plans received CAPs for non-contract compliance. General findings requiring a CAP consisted of grievance, appeals, State Fair Hearings processes and procedures, language assistance, translated documents and retrospective denials. In addition, deficiencies were found with the DMC plans quality management programs and disaster recovery programs.

In FY 2018-19, A&I started performing the DMC plan audit functions. As a result of the new dental workload, A&I diverted staff that were working on Enrollment Reviews, Field Audit Reviews (FAR) and Audits for Recovery (AFR), which has caused a backlog with these audits. These audits would have translated to approximately $4.5 million Return on Investment (ROI).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 14: MEDI-CAL DENTAL PROGRAM WORKLOAD BUDGET CHANGE PROPOSAL

PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Medi-Cal Dental Services Division (MDSD) requests resources of $1,116,000 ($437,000 General Fund (GF); $679,000 Federal Fund (FF)) in fiscal year (FY) 2020-21 and $1,062,000 ($414,000 GF; $648,000 FF) in FY 2021-22 and ongoing equivalent to 6.0 positions. The resources will provide MDSD with sufficient baseline staff to efficiently and comprehensively perform monitoring and oversight of all contracted vendors, establish quality improvements within existing and planned contracts, and address the significant ongoing workload increases.

Based on the outcome of Control Section 4.11, DHCS proposes to reclassify vacant positions as opposed to requesting additional position authority in the FY 2020-21 Governor's Budget. As such, DHCS is requesting expenditure authority but not additional position authority in this proposal.

BACKGROUND

The administration provided the following background information:

DHCS is the single state agency responsible for administering the state's Medicaid program (called Medi-Cal), which includes the provision of dental services. MDSD administers the Medi-Cal dental benefit through two delivery systems: Dental fee-for-service (FFS) and Dental Managed Care (DMC). As of 2018, the Dental FFS delivery system is supported by both a contracted Dental Administrative Service Organization (ASO) and a Dental Fiscal Intermediary (FI), prior it was contracted with a single FI. Jointly, FFS and DMC contracts approve over seven million claims annually for approximately 12.9 million members.

The ASO contract provides administrative services supporting the provision of dental benefits for Medi-Cal providers and members, which includes oversight and operation of a call center, provider outreach and training, member care coordination, assisting members with locating a dental provider and/or scheduling a dental appointment, processing provider enrollment applications and other related efforts to increase provider participation and member utilization of dental services. The ASO is also responsible for processing and adjudicating Treatment Authorization Requests (TARs) and performing various oversight and integrity functions related to Medi-Cal dental services, such as statistical profiling of providers to identify potential fraud, waste, and abuse and the provision of resources to support DHCS on member-facing State Hearing and Conlan cases.

The FI contract provides fiscal intermediary services, maintenance and management of the CA Dental Medicaid Management Information System (CD-MMIS), and supporting mid-range systems. Examples of information stored and managed in CD-MMIS include patient procedure history, enrolled provider information, provider payment history, programming logic for auto-adjudication of claims, and quality management/contract management reports. The FI is also responsible for the operation and staffing of the print and scan center for Medi-Cal dental services. In this capacity, the FI is responsible for processing all incoming documentation and scanning it into CD-MMIS as well as the mailing of all external documentation to either providers or members. The FI also maintains a mid-range system, FormWorks, to support their print and scan responsibilities. In addition, the FI works closely with both the ASO and DHCS to provide the necessary systems group support for any changes to CD-MMIS that support the operational processes for delivering Medi-Cal dental FFS benefits.

With the FFS delivery system now being supported by two contractors versus the previous single dental FI, MDSD workload has increased significantly due to increased oversight and monitoring of contractual compliance of ASO and FI contracts. Through lessons learned from the previous contract, there has been an emphasis on oversight and implementing proper internal controls to justify proper approval of invoices and contract deliverables.

Historically, contract oversight has been identified as a risk in various internal audits. One example of a lack of contract oversight is the ASO provider enrollment functions, where deficiencies have recently surfaced. Specifically, applications are currently returned multiple times for deficiencies, conflicting with oversight statutory and regulatory authority, specifically Welfare and Institutions Code Section 14043.26 and California Code of Regulations Title 22 Section 51000.50. Furthermore, current provider enrollment timeframes range from 14 to more than 400 days, a violation of enrollment timeframes. From 2017 to 2018, there has been a 17 percent increase in provider enrollment applications. Naturally, an increase of applications will result in an increase of provider

enrollment directive requests from the ASO to MDSD. These directives, which were rarely provided to MDSD in the past, will need to be reviewed by analysts to oversee appropriate application of denial authority is consistent with current regulatory requirements. This is new workload as MDSD works to improve its internal controls of the provider enrollment function and oversight of the ASO. Additionally, MDSD is working on establishing a process for screening levels per the Affordable Care Act (ACA). The ASO is in violation of mandates set forth in the ACA, as all dental providers are being screened at a "limited" risk review. There is no process for dental providers who are elevated to a high-risk level, which must include an onsite review and a criminal background check. This heightens the risk of liability to DHCS and contradicts DHCS' program integrity commitment.

In addition to existing provider enrollment processes, MDSD will begin work on transitioning dental provider enrollment into the Provider Application and Validation for Enrollment (PAVE) system. The impending PAVE project will require devoted managerial and staff resources to successfully prepare, adopt, and implement PAVE electronic enrollment. The pre-mapping process in collaboration with contractors, for dental's integration into PAVE, will take place over the next year but has already begun impacting the overburdened workload in Provider Services Unit.

Another example of historical contractual mismanagement has been the ASO's telephone service center (TSC) abandonment rates. Per the contract, rates should be no more than 5 percent. For the month of May 2019, the abandonment rate for member calls was 16 percent and provider calls was at 28 percent; more than 3 to 5 times the allowable rates. Historically, MDSD has not had stable resources to exercise contract enforcement mechanisms such as invoice withholds and corrective action plans.

Since the implementation of a new dental FI contract in 2018, a new data system (DSS) was also developed by the vendor to house dental data for FFS claims, which is then transferred to the DHCS' data warehouse (MIS/DSS) on a regularly scheduled basis. Because of the communication between both systems, there is a lag, which causes variance in data. DSS houses the most up-to-date dental data and is relied upon as the source for frequent data queries for various purposes, such as media requests, legislative inquiries, policy analysis, November and May Estimate processes, Public Records Acts (PRA), and much more. Due to DSS data being "real-time" as it is pulled directly from CD-MMIS, it continues to be the preferred data source when building queries. However, due to a lack of resources, MDSD has not had the time to fully understand DSS and use it to its full capacity for reliable data necessary for the dental program on a continual basis. This has caused unnecessary delays in mission critical assignments, as well as an overreliance on MIS/DSS as a sole data resource. In the past seven months, MDSD received 110 ad hoc data requests, and completed 101 with nine requests in progress. The breakdown of data sources used to complete the requests are:

- 80 percent from MIS/DSS;
- 2 percent from DSS; and,
- 18 percent from other systems/sources, such as data and reports posted on websites as appropriate.

MDSD's goal is to take full advantage of DSS as a tertiary source, and transition to DSS for all data queries for the most current information.

MDSD also maintains the Current Dental Terminology (CDT) code set and has an obligation to maintain them so the CD-MMIS is updated within one year of the federal release of CDT codes. MDSD is attempting to bring the CDT code set current from six years behind. MDSD has been unable to retain clinical resources due to various workload priorities and constant staff turnover. In addition to this, MDSD lacks specialty clinical expertise, which adds a layer of inefficiency to monitoring TAR adjudication processes and Fair Hearing cases. There is a lack of quality control as it currently goes outside the scope of knowledge of current general practitioner consultants. As it pertains to Fair Hearing cases, MDSD is unable to provide expert witnesses due to a lack of subject matter knowledge and adequate resources. As a result, MDSD is unable to have sufficient representation on behalf of DHCS with these cases that can result in negative outcomes when DHCS is unable to substantiate actions taken based on its own policies. The volume of state hearings has grown; for FY 2017-18, MDSD received 1,408 state hearing cases. In FY 2018-19, MDSD received 1,857 state hearing cases; this is a 32 percent increase.

Without the necessary clinical resources, MDSD is unable to establish a critical quality management resource and has delegated this function to the ASO with state oversight. Given the potential conflict of interest, it is paramount that MDSD own the quality management function using a state resource. When the ASO contract was originally bid, the expectation was that TAR volumes would start at a maximum of 710,000 documents and would grow over the full contract extension period to 765,000 documents processed each FY. However, with the restoration of adult dental, Proposition 56 supplemental payments, and other dental initiatives, by the end of FY 2018-19, the ASO is processing approximately 1.5 million documents – over a 96% increase – practically double the 765,000 projected. This increase in workload does not only affect the ASO, but also represents a significant increased workload for the two Dental Program Consultants (DPCs) currently resourced to MDSD, a capacity that was historically staffed by five DPCs.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 15: RESTORATION OF DENTAL FEE-FOR-SERVICE IN SACRAMENTO AND LOS ANGELES COUNTIES TRAILER BILL

ADMINISTRATION/LAO PANEL

- **Jacey Cooper**, Chief Deputy Director of Health Care Programs & State Medicaid Director, Department of Health Care Services
- **Laura Ayala**, Principal Policy Budget Analyst, Department of Finance
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

STAKEHOLDER PANEL

- **Amir Neshat, DDS**, Chief Executive Officer and Founder, Liberty Dental Plan
- **Dave Meadows**, Senior Vice President, Liberty Dental Plan
- **Dr. Stephanie Sandretti**, Chair, California Dental Association Government Affairs Council
- **Brianna Pittman-Spencer**, Legislative Director, California Dental Association
- **Linda Nguy**, Policy Advocate, Western Center on Law and Poverty

Public Comment

PROPOSAL

This proposal would transition the delivery of Medi-Cal dental services from managed care to fee-for-service (FFS) in Sacramento and Los Angeles counties, no sooner than January 1, 2021.

BACKGROUND

The administration provided the following background information:

DHCS is responsible for providing dental services to eligible Medi-Cal beneficiaries, and offers services through two delivery systems, FFS and Dental Managed Care (DMC). FFS was the exclusive and original delivery system offered in California's 58 counties. In 1995, DHCS implemented DMC in Sacramento and Los Angeles Counties to explore the effectiveness of DMC as a delivery system of dental services. DHCS maintains six DMC contracts with three separate contractors. In Sacramento, enrollment is mandatory, with few exceptions. In Los Angeles, a beneficiary must opt-in to participate in DMC. As of September 2019, there are approximately 791,651 Medi-Cal beneficiaries enrolled in DMC between the two counties.

Dental utilization measures have been and continue to be an effective tool for DHCS to compare and monitor dental utilization of Medi-Cal beneficiaries enrolled in the two delivery systems. DMC plans are contractually required to send encounter data to DHCS, which is analyzed to determine statewide annual dental visits and preventive services. The Dental FFS delivery system continues to maintain higher utilization than DMC for both children and adults. For example, based on Calendar Year (CY) 2018 Encounter Data, dental FFS utilization for annual dental visits (ADV) for children ages zero to 20 was 6.19 percentage points higher than DMC utilization. Similarly, dental FFS utilization for preventive services for children ages zero to 20 was 8.46 percentage points higher than DMC utilization. The utilization lag is larger in Sacramento County where DMC enrollment is mandatory, with FFS utilization 8.25 percentage points and 10.83 percentage points higher for ADV and preventive services utilization for children ages zero to 20, respectively. The table below depicts data comparison of ADV and preventive services utilization in dental FFS and DMC.

Dental FFS and DMC Utilization Comparison – CY 2018

Delivery System	Annual Dental Visit		Preventive Services	
	Children (0-20)	Adults (21+)	Children (0-20)	Adults (21+)
FFS	48.05%	23.46%	44.60%	14.03%
Sacramento	39.80%	20.38%	33.77%	8.27%
Los Angeles	44.42%	21.14%	39.09%	9.53%
DMC (Combined)	41.86%	20.78%	36.14%	8.93%
DMC Combined Utilization Lag	-6.19%	-2.68%	-8.46%	-5.10%

Since the beneficiary utilization rates in DMC continually lag behind dental FFS, DHCS seeks to restore the delivery of Medi-Cal dental services in both Sacramento and Los Angeles counties to a FFS system. DHCS believes that this restoration will result in increased beneficiary utilization.

DHCS is committed to increasing Medi-Cal beneficiary utilization of dental services statewide. Transitioning DMC to a purely FFS environment will allow DHCS to implement more effective and uniform provider and beneficiary outreach plans on a statewide basis with the anticipated outcome of increasing the dental service utilization.

Specifically, this proposal would:

- Commencing no sooner than January 1, 2021, as specified, require Sacramento and Los Angeles counties to transition and exclusively offer Medi-Cal dental services through a FFS delivery system.

- Require the existing sections governing dental managed care plans to become inoperative upon the effective date specified by the Director's Certification and be subsequently repealed six months after the date of such certification.

- Require DHCS to undertake all activities it deems necessary to transition the delivery of Medi-Cal dental services from managed care to FFS, including, but not limited to, the termination of the dental managed care contracts and any other related contracts.

- Require DHCS to develop a transition plan for transferring enrollees from managed care to FFS and provide the transition plan to the applicable fiscal and policy committees of the Legislature no later than 90 days prior to the start date of the transition as identified by DHCS. DHCS would be prohibited from transitioning enrollees until at least 90 days after the transition plan has been provided to the Legislature.

- Require DHCS to consult with interested stakeholders, including, but not limited to, beneficiaries, providers, Medi-Cal dental FFS contractors and dental managed care plans, in the development of the transition plan.

- Require, effective July 1, 2020, and until the Director certifies that the transition of enrollees are complete, FFS and managed care dental contractors, as specified, to report to DHCS, within 30 days of any request by DHCS, any information identified as applicable to implement this section. DHCS would be required to specify the required form, manner and frequency of information reported by the dental contractors.

- Require DHCS to implement the transition consistent with the Medi-Cal dental enrollment process to the extent those provisions remain applicable.

- Require DHCS to seek any federal approvals it deems necessary and to implement only to the extent any necessary federal approvals have been obtained, and federal financial participation is available and not otherwise jeopardized.

- Require DHCS Director to certify in writing when the transition of enrollees is complete. The certification is required to be posted on DHCS' internet website and a copy of the certification provided to the Secretary of State, Secretary of the Senate, Chief Clerk of the Assembly, and Legislative Counsel.

- Authorize DHCS to implement, interpret or make specific the transition by means of information notices, plan letters, or other similar instructions, without taking regulatory action.

Dental Managed Care Plans

The dental managed care plans make the following four key arguments against ending the managed care model in Sacramento and Los Angeles:

"Utilization comparison is misleading:

- Denti-Cal's utilization data includes preventive services delivered by any qualified healthcare practitioner providing dental services —example being pediatrician in a medical office. Dental managed care data may only include dentists and/or dental hygienists. This means there cannot be on apples-to-apples comparison of utilization data and if you back out the non-dental provider services (9.9% of these services in 2018), the dental managed care utilization is actually higher.

- Comparing the State of California's utilization data In FFS (56 of 58 counties) to the performance of two counties in DMC is an improper comparison. Some counties have utilization above and others have utilization below the DMC counties. Regional analysis of utilization is more appropriate and shows the DMC counties have performance similar to and better than neighboring counties.

- Comparisons also ignore fundamental differences in program requirements which directly affect utilization such as the requirement for the plans to administer a comprehensive fraud, waste, and abuse (FWA) Program Integrity plan. The Federal Office of the Inspector General's 2016 Report on CA Medi-Cal Children estimates FWA accounts for as much as 25% of the utilization totals.

Dental managed care provides case management; FFS does not.

- Case management is a critical service that helps members access dental providers and overcome barriers to care, resulting in improved quality outcomes. The DMC plans provide case management to vulnerable member populations including persons with special needs and pregnant women, and any persons having difficulty locating a provider.

- In FFS, out of a program serving over 12 million people, only 34 Individuals accessed case management over the last 3 months of 2019. In FFS, the burden is on the member to locate a provider and the lack of coordination results in provision of episodic care.

- In DMC (2 counties), data from 2 of the 3 participating plans shows over 2,000 beneficiaries accessed case management in 2019, and 455 individuals did so during the last quarter of 2019.

Dental managed care has greater provider participation than FFS.

- The participation rate among dentists is greater in DMC than FFS due to enhanced support and reduced administrative burden. The American Dental Association estimates the statewide California Medicaid dental participation rate is 15.4%. According to DMC plan estimates, approximately 33.8% of practicing dentists in Sacramento County participate in DMC.

- Comparing the number of providers is problematic because certain geographic areas have fewer dentists per capita. For example, there are fewer dentists per capita in Sacramento County than California as a whole (1:1,325 in Sacramento, compared to 1:1,200 statewide according to County Health Rankings) and this is one of the reasons the DMC program was created so members could access care.

Dental managed care reduces provider burden.

- DMC offers reduced provider burden; rather than implementing authorization and documentation requirements across the board in a "one-size, fits-all" approach, requirements can be applied to individual providers based on their performance. This flexibility allows DMC plans to reward high-performing, cost-effective providers with reduced administrative burden, while continuing to verify performance using safeguards such as retrospective reviews.

- There is a quicker resolution time frame in DMC — average decisions are reached almost 2 days faster, meaning beneficiaries can get the care they need more quickly.

- The rate of approvals is 6.3 points higher in DMC than FFS and the rate of denials is 2.3 points lower.

- Another example of administrative burden in FFS is related to deferred decisions; when decisions are deferred, providers are asked to submit additional documentation and the decision is delayed. 4% of treatment authorization requests in FFS resulted in deferred decisions, but due to turnaround time requirements applied to the DMC plans, there were almost no deferred decisions in DMC."

Western Center on Law and Poverty

WCLP is neutral on this proposal, but is concerned about sufficient consumer protections should this transition occur. To this end, WCLP requests the following consumer protections: network adequacy protections, continuity of care, and strengthened ombudsman resolution process.

Network Adequacy

WCLP provided information on access challenges in dental fee-for-service. Specifically, they write: “there are 8 counties with no Medi-Cal dental provider including Alpine, Amador, Calaveras, Inyo, Mariposa, Mono, Sierra, and Trinity and 7 counties with only one provider including Colusa, Glenn, Lassen, Plumas, Siskiyou, Tehama, and Yuba.”

WCLP points out that dental managed care plans are statutorily required to provide dental services within 10 miles or 30 minutes from the enrollee’s residence. They recognize the challenges in applying these standards statewide due to regional variations, and therefore recommend a regional approach with longer distance and travel times for less densely populated areas.

Ombudsman Resolution Process

WCLP explains: “There is no strong mechanism for the state to take action against dental providers who have frequent quality of care violations including upselling non-covered services, third-party credit/balance-billing issues for these non-covered services, and refusal to complete Treatment Authorization Request for covered services. DHCS’ quality of care and billing complaint categories do not include these issues, raising questions about the accuracy of complaint data reported and the department’s response.

Rather, FFS patients are left with the state fair hearing process, which can be intimidating and lengthy. The state fair hearing process is also not equipped to take any action against frequent dental providers with violations. Therefore, we recommend the state accurately capture consumer issues by including quality of care violations, specifically upselling non-covered services, third-party credit/balance-billing for non-covered services, and refusal to complete Treatment Authorization Request, and the state, on its own or through its Administrative Services Organization, follow-up directly with providers and take action based on frequency and severity of complaint, rather than merely referring patients to the Dental Board (which lacks enforcement authority on these issues).”

WCLP further comments that patients have reported difficulty finding a Medi-Cal dental provider accepting new patients or scheduling an appointment that is not months in advance. Patients in dental plans have the options of filing a plan grievance when they cannot find a provider. Although Medi-Cal maintains a provider directory that purportedly indicates whether dentists are currently accepting new patients, patients have no recourse when the providers they contact will not schedule an appointment. Therefore, WCLP recommends that the state require contracted providers to report monthly whether they are accepting new patients, so that the publicly accessible list of Medi-Cal dental providers is accurate.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and the speakers on the stakeholder panel provide responses to the proposal. Please also respond to the following questions:

DHCS:

1. Please respond to the claims made by the DMC plans, and please also provide responses to the WCLP recommendations.

2. Please also explain the purpose of requiring the transition of patients no sooner than 90 days after delivery of the DHCS transition plan to the Legislature; i.e., will the Legislature have a way to modify the plan?

Dental Managed Care Plans:

1. DMC utilization rates have been criticized for many years; have the plans collected cost, utilization, and quality data that clearly demonstrates the value of dental managed care?

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 16: STAKEHOLDER PROPOSAL: REDISTRIBUTION OF DISPROPORTIONATE SHARE HOSPITAL FUNDS

PANEL

- **Sherreta Lane**, Senior Vice President Finance Policy, District Hospital Leadership Forum

Public Comment

PROPOSAL

The District Hospital Leadership Forum requests approval of a new distribution methodology of existing state and federal funding for disproportionate share hospitals.

BACKGROUND

Stakeholders provided the following background information:

The non-designated public hospital (NDPH) fund was initially known as the Emergency Services and Supplemental Payments Fund (also known as "SB 1255," statutes of 1989). This program originally supplemented Medi-Cal disproportionate share hospitals (DSH) in the form of higher rates during annual negotiations with the California Medical Assistance Commission (CMAC). Hospitals that did not contract with CMAC, were reimbursed by Medi-Cal at Medi-Cal allowable costs.

In January 2014, district/municipal public hospitals (DMPHs) transitioned away from cost-based and CMAC-negotiated rates for Medi-Cal and instead began to be reimbursed via the methodology known as all patient refined diagnostic resource groups (APR-DRGs). This change was done on a five-year transition. This basically means today all DMPHs are reimbursed similarly (on a case basis determined by procedures and diagnoses).

Due to the change in reimbursement for all DMPHs, we propose this funding ($1.9 million state GF/$3.8 million total funds annually) be distributed to the most economically fragile DSH-eligible DMPHs since the hospitals previously receiving the funding are now reimbursed via the same methodology as all hospitals. Specifically, the proposal is that district hospitals that are Medi-Cal DSH-eligible and either 1) critical access hospitals (CAHs) or 2) level I or level II trauma centers would receive the funding on a pro-rata basis based on the Medi-Cal utilization rate (MUR) to the total MUR of eligible hospitals. The DSH eligibility list changes from year-to-year based on patients served, but below is an example of the distribution for 18-19:

		MUR Methodology		
OSHPD ID	Hospital Name	Medicaid Utilization Rate (MUR) SFY 2018/19 Final	MUR Allocation Percentage	MUR Allocation $
106190034	ANTELOPE VALLEY HOSPITAL MEDICAL CTR	39.6	23.76%	$ 902,699.46
106361110	BEAR VALLEY COMMUNITY HOSPITAL	14.7	8.82%	$ 335,092.98
106320859	EASTERN PLUMAS HEALTH CARE	25.7	15.42%	$ 585,842.83
106121031	JEROLD PHELPS COMMUNITY HOSPITAL	18.5	11.10%	$ 421,715.66
106150737	KERN VALLEY HEALTHCARE DISTRICT	15.6	9.36%	$ 355,608.88
106250956	MODOC MEDICAL CENTER	10.1	6.06%	$ 230,233.95
106361266	MOUNTAINS COMMUNITY HOSPITAL	20.8	12.48%	$ 474,145.17
106320986	PLUMAS DISTRICT HOSPITAL	21.7	13.02%	$ 494,661.07
		166.7	100%	$ 3,800,000.00

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the District Hospital Leadership Forum present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

NON-DISCUSSION ITEMS

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 17: FAMILY HEALTH ESTIMATE

The Family Health Estimate estimates the non-Medi-Cal costs associated with three programs: the Genetically Handicapped Persons Program, the Every Woman Counts Program, and the California Children's Services Program. Some Medi-Cal beneficiaries are also eligible for these programs, and those costs are included in the Medi-Cal estimate.

GENETICALLY HANDICAPPED PERSONS PROGRAM ESTIMATE

The proposed 2020-21 Genetically Handicapped Persons Program (GHPP) budget includes total funds of $112.3 million ($102.1 million General Fund), nearly identical to the current year estimate.

Genetically Handicapped Persons Program State-Only Estimate				
	2019-20 Estimate	2020-21 Proposed	CY to BY % Change	CY to BY % Change
General Fund	$102,704,200	$102,117,300	($586,900)	-0.6%
Enrollment Fees	$457,000	$457,000	$0	0%
Rebates Special Fund	$9,100,000	$9,748,000	$648,000	7.1%
TOTAL FUNDS	**$112,261,200**	**$112,322,300**	**$61,100**	**0.05%**
Caseload	622	623	1	0.2%

BACKGROUND

The goal of the GHPP program is to help individuals ages 21 and older with an eligible inherited condition achieve the highest level of health and functioning through early identification and enrollment into GHPP, prevention and treatment services from highly-skilled Specialty Care Center teams, and ongoing care in the home community provided by qualified physicians and other health team members. Hemophilia was the first medical condition covered by the GHPP and legislation over the years have added

other medical conditions including Cystic Fibrosis, Sickle Cell Disease, Phenylketonuria, and Huntington's disease. The last genetic condition added to the GHPP was Von Hippel-Lindau Disease. Unlike other programs, GHPP covers services even when they are not directly related to the treatment of the GHPP eligible medical condition; the approval of these services is subject to individual review based on medical need. There is no income limit for GHPP, however, GHPP clients may be required to pay an annual enrollment fee based on the client's adjusted gross income.

EVERY WOMAN COUNTS PROGRAM ESTIMATE

The proposed 2020-21 budget includes $42.3 million total funds ($14.7 million General Fund) for EWC, nearly identical to the current year estimate.

Every Woman Counts Estimate
(*Dollars in Millions*)

Funding	2019-20 Estimate	2020-21 Estimate	CY to BY $ Change	CY to BY % Change
General Fund	15.1	14.7	($0.4)	-2.6%
Proposition 99	14.5	14,5	$0	0%
Breast Cancer Control Account	8.0	8.0	$0	0%
Federal (CDC) Funds	5.1	5.1	$0	0%
TOTAL FUNDS	**42.8**	**42.3**	**($0.5)**	**-1.2%**
Caseload	27,934	27,719	(215)	-0.8%

BACKGROUND

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

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

underserved populations of African-American, Asian-Pacific Islander, American Indian, older, and rural women. EWC covered benefits and categories of service include office visits, screening, diagnostic mammograms, and diagnostic breast procedures, such as ultrasound, fine needle and core biopsy, pap test and HPV co-testing, colposcopy and other cervical cancer diagnostic procedures and case management.

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

Caseload

The following table shows the caseload estimates for the past several years. The dramatic decrease in 2016 reflects the increase in comprehensive health care coverage resulting from implementation of the Affordable Care Act:

YEAR	EWC Caseload
2013-14	292,914
2014-15	275,219
2015-16	161,000
2016-17	25,030
2017-18	26,820
2018-19	26,963
2019-20	27,934
2020-21	27,719

CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM ESTIMATE

The proposed 2020-21 non-Medi-Cal CCS budget includes total funds of $83.1 million ($77.6 million General Fund), nearly identical to the current year estimate.

Non-Medi-Cal CCS Budget
(Dollars in Millions)

	2019-20 Estimate	2020-21 Proposed	CY to BY $ Change	CY to BY % Change
General Fund	76.8	77.6	$0.8	1.0%
Federal Fund	5.5	5.5	$0	0%
TOTAL FUNDS	**82.3**	**83.1**	**$0.8**	**1.0%**
Caseload	14,497	14,497	0	0%

BACKGROUND

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

"State-only" children, who are not eligible for Medi-Cal, qualify for CCS by being in a family for which their estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income. The CCS program is administered as a partnership between county health departments and DHCS. For CCS-eligible children in Medi-Cal, their care is paid for with state-federal matching Medicaid funds. The cost of care for CCS-Only children is funded equally between the State and counties. The cost of care for CCS children who had been in the Healthy Families program was, and continues to be, funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds, despite the fact that these children have transitioned into Medi-Cal.

Caseload

After several years of dramatic decreases with increases in CCS-Medi-Cal reflecting the Medi-Cal expansion to cover all eligible children regardless of immigration status, adopted through SB 75 (2015 budget trailer bill), caseload is expected to be stable in the state-only CCS program, at approximately 15,000 children in both 2019-20 and 2020-21.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns with the Family Health Estimate at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration, and updates to the Estimate.

ISSUE 18: CALIFORNIA 1115 WAIVER – MEDI-CAL 2020 BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS, Managed Care Quality Monitoring Division (MCQMD) requests a two-year extension of 2.0 limited-term (LT) funded resources and associated expenditure authority of $283,000 ($142,000 General Fund (GF); $141,000 Federal Fund (FF)) in fiscal year (FY) 2020-21 and FY 2021-22. These resources are necessary for continued support of reporting, monitoring and evaluation activities for Whole Person Care (WPC), Senior and Persons with Disabilities (SPDs), and California Children's Services (CCS) pilot programs.

BACKGROUND

The administration provided the following background information:

California's Section 1115(a) Medicaid Waiver Renewal entitled "California Medi-Cal 2020 Demonstration" (2020 Waiver), was approved by the Centers for Medicare & Medicaid Services (CMS) on December 30, 2015, and is effective through December 31, 2020. The 2020 Waiver is an extension of the Bridge to Reform (BTR) Section 1115 Waiver that expired on October 31, 2015. BTR enabled California to implement an early expansion of Medicaid under the Affordable Care Act (ACA), improve care coordination for vulnerable populations by mandatorily enrolling SPDs into Medi-Cal Managed Care as well as provide funding for health care delivery system reform and uncompensated care in designated public hospital systems. The five-year extension, which continues to include the managed care system for SPDs and the Coordinated Care Initiative (CCI), allows transformation and continuance to improve the quality of care and efficiency of health care services for managed health care beneficiaries. CMS approval is conditioned on continued compliance with the 2020 Waiver Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project.

MCQMD is responsible for monitoring and overseeing California's Medi-Cal managed care health plans, and its Cal MediConnect health plans. Priorities such as performance monitoring, data analysis, compliance oversight and overall quality improvement efforts aid MCQMD in creating appropriate policies for improving the health outcomes of beneficiaries and promoting access to high quality health care to beneficiaries. MCQMD evaluates MCP data to verify that program expenditures are based on complete, accurate, reasonable, and timely encounter data, and beneficiary access to health care services.

Waiver programs, including the Pilot programs mentioned above contain a required external evaluation. Each Pilot program has developed and submitted a formal evaluation design to CMS for approval and has contracted with an external entity to conduct the analysis as required by the STCs. In order to support the external contractor(s) with activities associated the evaluation, including project management, contracting, data sharing, administrative items, and other essential tasks, MCQMD staffing is required.

Previous LT funded resources were authorized via 4260-008-BCP-2018-GB, "California 1115 Waiver – Medi-Cal 2020 (2020 Waiver)", and expire on June 30, 2020. DHCS requests continuation of the funding equivalent to the previously authorized 2.0 LT funded resources in order to extend the department's ability to retain subject matter experts and allow a continued work for evaluations support and oversight.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 19: DATA TRANSPARENCY WORKLOAD BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS requests resources of $1,548,000 ($774,000 General Fund (GF); $774,000 Federal Fund (FF)) in fiscal year (FY) 2020-21 and $1,458,000 ($729,000 GF; $729,000 FF) in FY 2021-22 and ongoing equivalent to 10.0 positions to address departmental data transparency efforts. Data transparency efforts have resulted in: 1) increased data publishing and release, requiring departmental support of data de identification that is compliant with the Health Insurance Portability and Accountability Act (HIPAA); 2) data management and reporting to the California Health and Human Services (CHHS) Open Data Portal and CHHS GeoHub; 3) data requests to the DHCS Data and Research Committee (DRC) by researchers and state and county public health authorities; 4) data requests to respond to subpoenas, audits, and public record act (PRA) requests; 5) data sharing between DHCS programs and other departments at the federal, state and local levels; and 6) the need to coordinate and maximize the use of DHCS existing data analytic tools. The resources equivalent to positions will serve in two different divisions within DHCS, the Information Management Division (IMD) and the Enterprise Innovation and Technology Services Division (EITS), and will address specific data transparency tasks.

Based on the outcome of Control Section 4.11, DHCS proposes to reclassify historically vacant positions as opposed to requesting additional position authority in the 2020-21 Governor's Budget. As such, the Department is requesting expenditure authority but not additional position authority in this budget change proposal.

BACKGROUND

The administration provided the following background information:

The IMD and EITS have symbiotic roles in data transparency efforts. IMD leads improvements to data management and data reporting necessary to support business and evaluation requirements at DHCS. EITS supports the systems and data feeds used by IMD and departmental programs. The IMD is led by the Chief Data Officer (CDO) (formerly titled the Chief Medical Information Officer (CMIO)) and includes the Office of the CDO (OCDO), the Office of HIPAA Compliance (OHC), and the Office of Health Information Technology (OHIT). The title of CMIO transitioned to CDO beginning in October 2019 to better represent the responsibility associated with the full range of DHCS' data. The OCDO supports performance monitoring and data transparency efforts. The data transparency efforts are currently supported by four staff. As the workload to support departmental data transparency efforts increases, current staffing are not able to keep up

and a backlog is developing as evidenced by the increased processing times noted below. Current workload is tracked using SharePoint lists and dedicated functional emails.

Data transparency efforts include the following activities:

(1) Data de-identification that is compliant with the HIPAA.

Data that is to be released outside the Department must be reviewed and approved in one of two ways:

a) Confidential data release supported by a data sharing agreement and approved through the Data Release Approval Process, or

b) Public data that is de-identified and reviewed by the CDO.

For data that will be released outside the Department as public data, data deidentification in compliance with the HIPAA standard must be performed. The HIPAA standard is met using either the Safe Harbor Method or the Expert Determination method. The Safe Harbor method requires removal of 18 data elements which are considered identifiers and the assurance that what remains cannot be used by the recipient of the data to identify an individual. The Expert Determination method requires review, analysis and documentation of data proposed for release by individuals "with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable" [45 CFR Section 164.514(b)(1)]. In August 2014, DHCS established Public Aggregate Reporting for DHCS Business Reports (PAR-DBR) Guidelines to support public reporting that requires the Expert Determination method. A significant amount of public reporting and data release does not meet criteria for the Safe Harbor method and thus requires the Expert Determination method under the HIPAA standard for de identification. In particular, reporting for geographies that are more specific than the state, including county, and more specific time periods than a year, such as quarterly, requires the Expert Determination method. In November 2016, the PAR-DBR Guidelines were updated to the DHCS Data De-identification Guidelines (DDG) version 2.0, which were based on the CHHS Data De-identification Guidelines (DDG).

(2) Data management and reporting to the CHHS Open Data Portal and CHHS GeoHub.

The CHHS Open Data Portal was established in 2014 with initial data sets being posted by California Department of Public Health (CDPH) and Office of Statewide Health Planning and Development (OSHPD), followed by DHCS in 2015. Since the establishment of the CHHS Open Data Portal, the CHHS Geohub was added to support release of geographically based data such as facilities or summarized county data. The data that is mapped in the CHHS Geohub is also presented as a table in the CHHS Open Data Portal. The introduction of the CHHS Open Data Portal and CHHS Geohub filled an

important departmental need for a platform for data publishing. DHCS data is published to the CHHS Open Data Portal and CHHS Geohub to support transparency goals and the reusability of data. Data publishing to these portals is performed by the OCDO to maintain consistency and required reviews. The data posted to the CHHS Open Data Portal has grown from the first data set being added in 2015 to 94 data sets with over 130 data files in June 2019. Many data files are updated monthly, quarterly, or annually. Approximately 14 percent of data sets are updated monthly or bimonthly, 30 percent are updated quarterly, 45 percent are updated annually, and 11 percent are not routinely updated. Additionally, requests for information regarding the data posted on the CHHS Open Data Portal are received and must be responded to. Requests for additional information as represented by requests submitted to the DHCS Open Data Mailbox have increased steadily. DHCS data sets continue to be added to the CHHS Open Data Portal in response to programmatic public reporting requirements as well as stakeholder requests. The platforms are used to support routine programmatic activities.

(3) Data requests to the DRC by researchers and public health.

DHCS receives a consistent volume of requests for data that support various research and public health activities. DHCS' DRC oversees the DHCS' data request and evaluation process. The DRC has staff from programs throughout the Department and the Office of Legal Services Privacy Office. The DRC assesses the appropriateness of requests for protected data, assigns a priority status to each request, and recommends potential approval or denial action to the DHCS Director. There is a significant workload associated with communicating with potential requestors prior to a proposal being submitted to the DRC. This consists of conference calls to discuss data elements requested, methodological considerations of the data to be extracted, timelines, and establishment of the Data Use Agreements. Once a proposal is approved, there is workload associated with pulling the data, managing the release of the data, and providing support for the researchers as they work with the data and have questions.

(4) Data requests to respond to subpoenas, audits, and public record act (PRA) requests.

DHCS OCDO has been tasked to assist with an increased number of subpoenas, audits, and PRA requests. The OCDO works with programs throughout the Department with respect to the use and analysis of data. As such, OCDO is often asked to assist with requests that cross multiple program areas in the Department.

(5) Data sharing between DHCS programs and other departments at the federal, state and local levels.

DHCS must manage data use agreements and use of data within the Department that is controlled by those data use agreements. The OCDO assists in the management of data

use agreements that support data used by multiple DHCS programs. Over the past several years, the number of data use agreements managed by OCDO has increased to include agreements with Medicare, Department of Social Services, CDPH Vital Records, CDPH Office of AIDS, OSHPD, Department of State Hospitals, University of California Los Angeles, and other health care business associates. In May 2016, the departments and offices in the CHHS entered into the Intra-Agency Data Exchange Agreement (IDEA) to support improved processes for legal and secure sharing of confidential data between programs. The CDO serves as the Data Coordinator for DHCS to support the CHHS IDEA implementation. While the CHHS IDEA has streamlined the data request process, the overall amount of data sharing has increased to support business requirements.

(6) Implementing and improving data analytic tools and resources.

DHCS must have the capacity to optimize its data and effectively perform data analytics, which requires coordination across program areas. One of the data analytic tools used by DHCS is Statistical Analysis System (SAS) software. SAS can mine, manage and retrieve data from a source and performs statistical analysis. Users must have SAS programming and coding expertise to pull the desired data from the desired source(s). This expertise must include an understanding of the complexity of Medi-Cal in order to identify the data needed. In DHCS, staff with SAS expertise are located in various divisions with little opportunity for knowledge sharing and collaboration. Further, the SAS data environment, although on an enterprise platform, is siloed with separate libraries for different programs and projects. Another enterprise data analytic tool is Geographic Information Systems (GIS) mapping technology. It integrates many types of data and analyzes spatial location to organize layers of information into visualizations using maps and 3D scenes. This allows for insights into data such as geographic patterns and relationships that can be used for data driven decision-making. Similar to the SAS environment, although on an enterprise platform, the GIS data environment is siloed among programs. Coordination across programs is needed to maximize the effectiveness or data analysts across the Department.

EITS plays a critical role in driving and supporting the technical solutions for data transparency efforts. EITS is led by the Chief Information Officer and is responsible for architecting, building and delivering secure, innovative solutions and services that drive health care quality and for information technology strategy formulation, enterprise architecture, enterprise portfolio management, and enterprise governance. EITS establishes information technology policy and standards and confirms compliance with state and federal laws and regulations regarding the use of information technology and the safeguarding of electronic information. In doing so, EITS manages a complex portfolio of program systems, including the Management Information System/Decision Support System (MIS/DSS). EITS provides quality application and data services to DHCS programs; facilitates the successful completion of business and information technology

projects undertaken by DHCS; and manages the design, installation, upgrade, and support of a complex technology infrastructure, including network, servers, desktops, network devices, messaging systems, websites, web applications, and databases. EITS is directly responsible for the MIS/DSS. SAS enterprise services and GIS mapping technology, which are essential to data transparency efforts.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal**.**

ISSUE 20: PROGRAM AND POLICY LEAD SUPPORT FOR ELIGIBILITY AND ENROLLMENT PROJECTS BUDGET CHANGE PROPOSAL

PROPOSAL

DHCS, Medi-Cal Eligibility Division (MCED) requests three-year limited-term (LT) resources equivalent to 1.0 position and expenditure authority of $173,000 ($87,000 General Fund (GF); $86,000 Federal Fund (FF)) in fiscal year (FY) 2020-21 and $164,000 ($82,000 GF; $82,000 FF) in FY 2021- 22 and FY 2022-23. The requested resources are needed to holistically oversee and effectively manage the multitude of enterprise-wide, complex automation projects that have long-term programmatic impacts on the Medi-Cal program.

BACKGROUND

The administration provided the following background information:

The Statewide Automated Welfare Systems (SAWS) are the county-based eligibility and enrollment systems that support the eligibility determination, benefit calculation, and ongoing case management for Medi-Cal program recipients. These systems also support the administration of other California public assistance programs. The three SAWS support different counties statewide and will soon be consolidated into one statewide system, per federal and state direction. The implementation of this one system, California SAWS (CalSAWS), is targeted for 2023. CalSAWS is currently in design, development, and implementation (DD&I).

The California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) is the automated eligibility system that administers the Insurance Affordability Programs, which include a new form of Medi-Cal income eligibility based on the modified adjusted gross income (MAGI) methodology. CalHEERS also supports the state-based exchange, also known as the Covered California. CalHEERS is currently in maintenance and operations (M&O) but is anticipated to undergo a complex transition due to the selection of a new system integrator (SI) as a result of reprocurement. This new SI vendor will be taking over M&O activities over the next year with an anticipated phase of post-transition stabilization.

The Medi-Cal Eligibility Data System (MEDS) is managed by DHCS. MEDS is utilized for a variety of eligibility and reporting functions and serves as the system of record for claim processing and record retention. Currently, MEDS is undergoing a DD&I effort to modernize its core database and infrastructure to align with current technology.

With the advent of the Affordable Care Act and the modernizing of technology across the health and human services domain, the California Health and Human Services (CHHS) Agency is also seeking to streamline processes of obtaining verifications for public assistance programs in California. The State Verification Hub Project is a CHHS initiative led by the California Department of Social Services (CDSS), DHCS, and the Office of Systems Integration (OSI), to assess policy and programmatic opportunities to streamline verification methods and to build a state-based verifications hub for electronic State verification sources. Currently, this project is in the planning stage.

DHCS is a project sponsor for all the eligibility and enrollment systems and projects described above. MCED serves as the lead program division within DHCS and directs, oversees, and governs the policy and processes that drive the eligibility and enrollment systems and projects. Currently, MCED has a combination of limited-term (LT) and permanent positions, including first-level supervisory and analyst classifications, to support the planning, development, and implementation workload associated with these systems and projects. However, as these highly visible projects progress through their respective planning and development stages, MCED has identified staffing deficiencies at the managerial staffing levels that would significantly challenge MCED's ability to holistically oversee and effectively manage the dynamic and complex policy and programmatic aspects of each project.

Currently, MCED has to redirect senior-level managerial resources from other critical program and policy areas to fill in administrative gaps for these projects. These projects include the implementation of critical proposed budget items, including the Full Scope Expansion to Young Adults 19-25, and the transition of the County Children's Health Initiative Program into the Medi-Cal managed care delivery system. All these items require senior-level managerial resources to plan, direct, and fully execute. As such, this is not an effective and sustainable approach, as full time, dedicated resources are needed to maintain business continuity from the Medi-Cal programmatic perspective and to adeptly move these projects forward to future phases.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposal at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

ISSUE 21: ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM NAME CHANGE AND EXTENSION TRAILER BILL

PROPOSAL

This proposal would change the existing Electronic Health Record (EHR) Incentive Program name to the Medi-Cal Promoting Interoperability Program which will reflect the new emphasis of the program on data interoperability in compliance with new federal Centers for Medicare and Medicaid Services (CMS) requirements. The proposal would also extend the sunset date for the program from July 1, 2021 to January 1, 2024.

BACKGROUND

The administration provided the following background information:

The Medicaid EHR Incentive Program was established under the American Recovery and Reinvestment Act Health Information Technology for Economic and Clinical Health (HITECH) Act and codified in state law under SB 945 (Chapter 433, Statutes of 2011), to promote the adoption and meaningful use of EHR technology. On April 24, 2018, CMS, in its commitment to promoting and prioritizing interoperability of health care data, and improving patient access to health data, changed the name of the EHR Incentive Program to the Promoting Interoperability Program. The program had successfully promoted the adoption of EHRs by hospitals and professionals, but providers often failed to exchange information with each other or with health information exchanges. States were required to similarly change the names of their programs. The program is currently still named the Medi-Cal EHR Incentive Program in state statute and will need to be changed in accordance with CMS requirements. State statute designates the program as inoperative on July 1, 2021, and sunsets the program by January 1, 2022. In August 2018, newly enacted federal regulations governing the program extended funding for administrative closeout activities until September 30, 2022, and audit and appeals activities until September 30, 2023. The sunset date for the program in state statute should be extended accordingly to leverage this additional funding.

DHCS proposes to change the existing EHR Incentive Program name to the Medi-Cal Promoting Interoperability Program, which will reflect the new emphasis of the program in compliance with new CMS requirements. DHCS also proposes to extend the sunset date for the program from July 1, 2021 to January 1, 2024 to allow DHCS to take advantage of enhanced federal funding for administrative, audit, and appeal activities necessary for program close out, consistent with CMS expectations.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this proposed trailer bill at this time.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for further discussion and consideration of this proposal.

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