AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 28, 2022

2:30 PM, STATE CAPITOL, ROOM 127

We encourage the public to provide written testimony before the hearing. Please send your written testimony to: BudgetSub1@asm.ca.gov. Please note that any written testimony submitted to the committee is considered public comment and may be read into the record or reprinted. All are encouraged to watch the hearing from its live stream on the Assembly's website at https://www.assembly.ca.gov/todaysevents.

The hearing room will be open for attendance of this hearing. Any member of the public attending a hearing is strongly encouraged to wear a mask at all times while in the building. The public may also participate in this hearing by telephone.

To provide public comment, please call toll-free:
877-692-8957 / Access Code: 131 51 27

ITEMS TO BE HEARD

NON-PRESENTATION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

4260 DEPARTMENT OF HEALTH CARE SERVICES

PANEL 1: CALAIM – OVERSIGHT, 2022 PROPOSALS, TBL

PANEL 1 - PRESENTERS

- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sandra Sinz**, Chief Deputy, Behavioral Health, Solano County
- **Ryan Quist**, Behavioral Health Director, Sacramento County

PANEL 1 – Q&A ONLY

- **Guadalupe Manriquez**, Assistant Program Budget Manager, Department of Finance
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Laura Ayala**, Principal Program Budget Analyst, Department of Finance
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Kendra Tully**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 2: EXTEND THE DURATION OF SUSPENSION OF MEDI-CAL BENEFITS FOR ADULT INMATES TBL

PANEL 2 – PRESENTERS

- **René Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services

PANEL 2 – Q&A ONLY

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 3: SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM APPROVAL, OVERSIGHT, AND MONITORING BCP, AND PROGRAM SUPPORT FOR IMD EXCLUSION TRANSITION

PANEL 3 – PRESENTERS

- **Kelly Pfeifer**, MD, Deputy Director, Behavioral Health, Department of Health Care Services

PANEL 3 – Q&A ONLY

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 4: SKILLED NURSING FACILITY FINANCING PROPOSAL

PANEL 4 – PRESENTERS

- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Tiffany Whiten**, Senior Government Relations Advocate, California State Council of SEIU
- **Anthony Chicotel**, Staff Attorney, California Advocates for Nursing Home Reform
- **Jennifer Snyder**, Legislative Advocate, California Association of Health Facilities

PANEL 4 – Q&A ONLY

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Alek Klimek**, Staff Finance Budget Analyst, Department of Finance
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 5: MEDI-CAL DENTAL POLICY EVIDENCE-BASED PRACTICES TBL AND DENTAL MANAGED CARE EXTENSION TBL

PANEL 5 – PRESENTERS

- **René Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Monica Montano**, PhD, Regulatory and Legislative Advocate, California Dental Association

PANEL 5 – Q&A ONLY

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: CALAIM – OVERSIGHT, 2022 PROPOSALS, TBL

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- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

DHCS requests expenditure authority of $1.2 billion ($495.9 million General Fund and $693.6 million federal funds) in 2021-22 and $2.8 billion ($1.1 billion General Fund and $1.7 billion federal funds) to implement the California Advancing and Innovating in Medi-Cal (CalAIM) initiative, which seeks to transform the Medi-Cal delivery, program, and payment systems to improve beneficiary health outcomes and result in long-term cost savings. This expenditure request includes implementation of the following components of CalAIM:

- Enhanced Care Management (ECM)
- Community Supports (previously In-Lieu of Services)
- Managed Care Plan Incentives
- Medi-Cal Providing Access and Transforming Health (PATH)
- Dental Initiatives
- Population Health Management
- Various Transitions of Populations Between Fee-for-Service and Managed Care

- Behavioral Health Quality Improvement Program
- Designated State Health Programs

In addition, DHCS proposes trailer bill language (see issue #2 in this agenda) to make statutory changes necessary to implement the components of the CalAIM initiative.

BACKGROUND

During the fall of 2019, the Administration released a comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program, known as the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. Due to the pandemic, the Administration delayed implementation of CalAIM in the 2020-21 fiscal year. The 2021 Budget Act included 69 positions and expenditure authority of $1.6 billion ($675.7 million General Fund and $954.7 million federal funds), and the Legislature approved trailer bill language to authorize implementation of CalAIM.

CalAIM is an ambitious effort to incorporate evidence-based investments in prevention, case management, and non-traditional services into the Medi-Cal program. Many of these investments were piloted during the state's most recent 1115 Waiver, "Medi-Cal 2020," and CalAIM incorporates many of these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for Medi-Cal managed care plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD) and qualify for federal matching funds, and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity.

CalAIM represents a significant transformation of the health care delivery systems that provide physical health, behavioral health, and oral health care services to Medi-Cal beneficiaries. However, DHCS states that CalAIM also represents an opportunity to build into the foundations of the Medi-Cal program an incentive structure that achieves a healthier Medi-Cal population with a comprehensive, whole-person approach that addresses the social determinants of health and avoids cross-cutting impacts and cost shifts to other state or local social service and public safety agencies.

New Federal Waiver Authority

CalAIM will transition many of Medi-Cal's existing programs into managed care benefits under a new 1915(b) Waiver, maintain some programs under the previous 1115 Waiver authority, and make other changes through amendments to the State Plan. The federal Centers for Medicare and Medicaid Services (CMS) approved California's 1115 Waiver and 1915(b) Waiver applications implementing CalAIM reforms on December 29, 2021. Both Waivers were approved until December 31, 2026. While the managed care authorities provided by the two Waivers are similar, there are key differences. For example, while 1115 Waivers require budget neutrality (federal expenditures must not be greater under the Waiver than they would have been without the Waiver), 1915(b) Waivers only require the demonstration of cost effectiveness and efficiency: actual expenditures cannot exceed projected expenditures.

Enhanced Care Management

DHCS requests expenditure authority of $197.8 million ($66.1 million General Fund and $131.7 million federal funds) in 2021-22 and $575.8 million ($192.8 million General Fund and $383 million federal funds) in 2022-23 to support a new enhanced care management benefit. Under the previous waiver authority, Medi-Cal 2020, DHCS implemented Whole Person Care (WPC) pilot programs to coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. The 25 approved WPC pilots targeted services to individuals with chronic conditions, with behavioral health needs, experiencing or at-risk of homelessness, or who are justice-involved. The pilots provided eight categories of service to these individuals, including: 1) outreach, 2) care coordination, 3) housing support, 4) peer support, 5) benefit support, 6) employment assistance, 7) sobering centers, and 8) medical respite.

Beginning January 1, 2022, CalAIM expands the Whole Person Care delivery concept statewide through implementation of a mandatory enhanced care management (ECM) benefit and voluntary community supports benefits delivered by Medi-Cal managed care plans in each county. ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Medi-Cal beneficiaries with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high touch, and person-centered. Medi-Cal beneficiaries will be eligible for ECM if they are included in one of the following populations of focus:

<u>Children and Youth Populations of Focus</u>

- Children (up to age 21) experiencing homelessness
- High utilizers
- Children with serious emotional disturbance or identified to be at clinical high risk for psychosis

- California Children's Services (CCS) with additional needs beyond CCS qualifying conditions
- Involved in, or with a history of involvement in, child welfare
- Youth transitioning from incarceration

Adult Populations of Focus

- *Individuals and Families Experiencing Homelessness*. Individuals who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes or decreased utilization of high-cost services.
- *High-Utilizers*. Adult high-utilizers including those with five or more avoidable emergency room, or three or more avoidable, unplanned hospital or short-term skilled nursing facility stays in a six-month period.
- *SMI/SUD*. Adults with serious mental illness (SMI) or substance use disorders (SUD), with at least one complex social factor influencing their health (e.g. food, housing, or economic insecurity; history of Adverse Childhood Experiences, former foster youth, justice-involvement), and are at high risk for institutionalization, overdose and/or suicide; use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care; experienced two or more emergency department or hospital visits due to SMI or SUD in the past 12 months; or are pregnant or post-partum.
- *Individuals Transitioning From Incarceration*. Adults transitioning from incarceration within the past 12 months with at least one of the following conditions: chronic mental illness, SUD, chronic disease, intellectual or developmental disability, traumatic brain injury, human immunodeficiency virus (HIV), or pregnancy.
- *Individuals at Risk for Institutionalization*. Adults at risk of institutionalization eligible for long-term care services who, in the absence of services and supports, would otherwise require care for 90 days or more in an inpatient nursing facility.
- *Nursing Facility Residents Seeking Community Transition*. Adults residing in nursing facilities who desire to transition back to the community and are likely to make a successful transition.

ECM requires Medi-Cal managed care plans and their contracted ECM providers to deliver the following core services:

- *Outreach and Engagement*. Medi-Cal managed care plans are required to develop comprehensive outreach policies and procedures that can include, but are not limited to:

- Attempting to locate, contact, and engage Medi-Cal beneficiaries who have been identified as good candidates to receive ECM services, promptly after assignment to the plan.
- Using multiple strategies for engagement including in-person meetings, mail, email, texts, telephone, community and street-level outreach, follow-up if presenting to another partner in the ECM network, or using claims data to contact other providers the beneficiary is known to use.
- Using an active and progressive approach to outreach and engagement until the beneficiary is engaged.
- Documenting outreach and engagement attempts and modalities.
- Utilizing educational materials and scripts developed for outreach and engagement.
- Sharing information between the managed care plan and ECM providers to assess beneficiaries for other programs if they cannot be reached or decline ECM.
- Providing culturally and linguistically appropriate communications and information to engage members.

- *Comprehensive Assessment and Care Management Plan*. Medi-Cal managed care plans must conduct a comprehensive assessment and develop a comprehensive, individualized, person-centered care plan with beneficiaries, family members, other support persons, and clinical input. The plan must incorporate identified needs and strategies to address those needs, such as physical and developmental health care, mental health care, dementia care, SUD services, long-term services and supports (LTSS), oral health services, palliative care, necessary community-based and social services, and housing.

- *Enhanced Coordination of Care*. Enhanced coordination of care includes coordination of the services necessary to implement the care plan. This coordination could include:
  - Organizing patient care activities in the care management plan.
  - Sharing information with the care team and family members or support persons.
  - Maintaining regular contact with providers, including case conferences.
  - Ensuring continuous and integrated care, with follow-up with primary care, physical and developmental health care, mental health care, SUD treatment, LTSS, oral health care, palliative care, necessary community-based and social services, and housing.

- *Health Promotion*. Medi-Cal managed care plans must provide services to encourage and support lifestyle choices based on healthy behavior, such as: identifying and building on successes and support networks, coaching, strengthening skills to enable identification and access to resources to assist in

managing or preventing chronic conditions, smoking cessation or other self-help recovery resources, and other evidence-based practices to help beneficiaries with management of care.

- *Comprehensive Transitional Care*. Medi-Cal managed care plans must provide services to facilitate transitions from and among treatment facilities, including developing strategies to avoid admissions and readmissions, planning timely scheduling of follow-up appointments, arranging transportation for transitional care, and addressing understanding of rehabilitation and self-management activities and medication management.

- *Member and Family Supports*. Medi-Cal managed care plans must ensure the beneficiary and family or support persons are knowledgeable about the beneficiary's conditions, including documentation and authorization for communications, providing a primary point of contact for the beneficiary and family or support persons, providing for appropriate education of the beneficiary and family or support persons, and ensuring the beneficiary has a copy of the care plan and how to request updates.

- *Coordination of and Referral to Community and Social Support Services*. Medi-Cal managed care plans must ensure any present or emerging social factors can be identified and properly addressed, including determining appropriate services to meet needs such as housing or other community supports services, and coordinating and referring beneficiaries to available community resources and following up to ensure services were provided.

ECM will phase in based on which counties implemented Home Health Programs and Whole Person Care pilots, and for certain populations, as follows:

- January 1, 2022 – Counties with Home Health Programs (HHP) or Whole Person Care (WPC) pilots must provide ECM services to the following populations of focus:
    - Individuals and Families Experiencing Homelessness
    - High Utilizer Adults
    - Adults with SMI/SUD

- July 1, 2022 – Counties without HHP or WPC pilots must provide ECM services to the following populations of focus:
    - Individuals and Families Experiencing Homelessness
    - High Utilizer Adults
    - Adults with SMI/SUD

- January 1, 2023 – All counties must provide ECM services to the following populations of focus:
    - Individuals Transitioning from Incarceration (Children and Adults)
    - Individuals at Risk for Institutionalization
    - Nursing Facility Residents Seeking Community Transition

- July 1, 2023 – All counties must provide ECM services to all other Children and Youth

Community Supports

DHCS requests expenditure authority of $66.5 million ($21.6 million General Fund and $44.9 million federal funds) in 2021-22 and $162.8 million ($52.8 million General Fund and $110 million federal funds) in 2022-23 to support implementation of community supports services. Previously known as In-Lieu of Services, community supports are services or service settings that Medi-Cal managed care plans may offer as a medically appropriate, cost-effective alternative to traditional Medi-Cal eligible services or settings. Provision of community supports is voluntary for Medi-Cal managed care plans to provide and voluntary for Medi-Cal beneficiaries to receive. Plans may change their election of which community supports they provide every six months. Plans may provide the following community supports:

- *Housing Transition Navigation Services* – These services assist beneficiaries with obtaining housing and include assessing a beneficiary's housing needs, developing a housing support plan, navigating housing options and applications, assisting with advocacy and securing available income and housing subsidy resources, assisting with reasonable accommodation and move-in readiness, and coordinating necessary environmental modifications.

- *Housing Deposits* – These services assist beneficiaries with securing or funding one-time housing services that do not constitute room and board including security deposits, setup fees or deposits for utilities or other services, first month coverage of utilities, first and last month's rent if required for occupancy, health and safety services such as pest eradication or cleaning upon moving in, and medically necessary adaptive aids and services such as air conditioners or air filters.

- *Housing Tenancy and Sustaining Services* – These services assist beneficiaries in maintaining safe and stable tenancy after housing is secured including early identification and intervention for behaviors that may jeopardize housing, education and training on rights and responsibilities of tenants and landlords, coordination and assistance to maintain relationships with landlords and resolve disputes, advocacy and linkage to community resources to prevent eviction, health and safety visits, unit habitability inspections, and training for independent living and life skills.

- *Short-Term Post-Hospitalization Housing* – These services may include supported housing in an individual or shared interim housing setting and are designed to assist beneficiaries who are homeless and who have high medical or behavioral health needs with the opportunity to continue their recovery immediately after exiting an inpatient hospital, substance abuse or mental health treatment facility, custody facility, or recuperative care.
- *Recuperative Care (Medical Respite)* – These services provide short-term residential care for beneficiaries who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, the service would include interim housing with a bed and meals with ongoing monitoring of the beneficiary's condition. The service may also include limited or short-term assistance with activities of daily living, coordination of transportation to post-discharge appointments, connection to other necessary health and human services benefits or housing, or stabilizing case management relationships and programs.

- *Caregiver Respite* – These services provide relief to caregivers of beneficiaries who require intermittent temporary supervision and may be provided by the hour on an episodic basis, by the day or overnight, or include services that attend to the beneficiary's basic self-help needs or other activities of daily living.

- *Day Habilitation Programs* – These services assist beneficiaries in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the beneficiary's natural environment. These services may include training or assistance with the use of public transportation, personal skills development in conflict resolution, community participation, developing and maintaining interpersonal relationships, daily living skills, community resource awareness (e.g. police, fire, other local services), selecting and moving into a home, locating and choosing suitable housemates, locating household furnishings, settling disputes with landlords, managing personal financial affairs, managing needs for personal attendants, dealing with and responding to governmental agencies and personnel, asserting rights through self-advocacy, and coordinating health and human services benefits.

- *Nursing Facility Transition/Diversion to Assisted Living Facilities* – These services assist beneficiaries to live in the community or avoid institutionalization by transitioning to a Residential Care Facility for Elderly and Adult (RCFE) or Adult Residential Facility (ARF). These services, which do not include room and board, may include assessing housing needs and presenting options, assessing onsite service needs at the RCFE or ARF, assisting in securing a residence, communicating with facility administration and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other community services necessary for stable housing.

- *Nursing Facility Transition to a Home* – These services assist beneficiaries to live in the community and avoid institutionalization by transitioning to a private residence. These services, which do not include room and board, may include assessing housing needs and presenting options, assisting in securing housing, communicating with landlords and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other community supports necessary for stable housing.

- *Personal Care and Homemaker Services* – These services assist beneficiaries with activities of daily living such as bathing, dressing, toileting, ambulation, or feeding. These services also assist beneficiaries with instrumental activities of daily living such as meal preparation, grocery shopping and money management. These services are provided in addition to any approved In-Home Supportive Services (IHSS) benefits approved by the county or during any IHSS waiting period.

- *Environmental Accessibility Adaptations (Home Modifications)* – These services provide physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a beneficiary, or enable the beneficiary to function with greater independence in the home. Adaptations may include installation of ramps and grab-bars, doorway widening for beneficiaries who require a wheelchair, installation of stair lifts, bathroom or shower accessibility, installation of specialized electric or plumbing systems to accommodate medical equipment or supplies, installation and testing of a Personal Emergency Response System for beneficiaries who are alone for significant parts of the day without a caregiver and otherwise require routine supervision.

- *Meals/Medically Tailored Meals* – These services help beneficiaries achieve nutrition goals at critical times to help them regain and maintain their health and may include meals delivered to the home immediately following discharge from a hospital or nursing facility, or medically-tailored meals provided to the beneficiary at home to meet the unique dietary needs of a chronic condition.

- *Sobering Centers* – These services provide a safe, supportive environment to become sober for individuals found to be publicly intoxicated and who would otherwise be transported to an emergency department or jail. These services also include medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, homeless care support services, and screening and linkage to ongoing supportive services.

- *Asthma Remediation* – These services are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home without acute asthma episodes that could result in emergency utilization or hospitalization. These services

would include allergen-impermeable mattress and pillow dustcovers, high-efficiency particulate air filtered vacuums, integrated pest management, de-humidifiers, air filters, other moisture-controlling interventions, minor mold removal and remediation, ventilation improvements, asthma-friendly cleaning products and supplies, and other interventions identified to be medically appropriate and cost-effective.

The availability of community supports in each county, by date of implementation, vary between January 1, 2022 and January 1 2024, depending on the specific community support and various other county circumstances.

Managed Care Plan Incentives

DHCS requests expenditure authority of $300 million ($150 million General Fund and $150 million federal funds) in 2021-22 and $600 million ($300 million General Fund and $300 million federal funds) in 2022-23 for managed care plan incentives. Beginning January 1, 2022, Medi-Cal managed care plans are eligible for incentive payments for investing in expanding and improving delivery of ECM and community supports. Federal regulations allow a percentage above a Medi-Cal managed care plans capitation payment to be allocated for quality improvement programs. To receive incentive payments, Medi-Cal managed care plans must improve delivery system infrastructure, build provider capacity for ECM and community supports services, and achieve certain quality benchmarks.

Medi-Cal Providing Access and Transforming Health (PATH)

DHCS requests expenditure authority of $389.7 million ($194.8 million General Fund and $194.8 million federal funds) in 2021-22 and $706.7 million ($353.3 million General Fund and $353.3 million federal funds) in 2022-23 for the Medi-Cal Providing Access and Transforming Health (PATH) initiative. The Medi-Cal PATH initiative is intended to provide a smooth transition between current waiver pilots and statewide services and capacity building, including for effective pre-release care and coordination with justice agencies. PATH funding would support the transition from Whole Person Care pilots to ECM and community supports, including funding for counties, community-based organizations, and other providers to build the capacity and infrastructure necessary for these new statewide services. In addition, PATH funding would help ensure jails and prisons are ready for service delivery for the justice-involved, including mandatory Medi-Cal applications; behavioral health referrals, linkages, and warm hand-offs from county jails to Medi-Cal managed care plans and county behavioral health departments; “in reach” services up to 90 days prior to release, and the re-entry ECM benefit available in January 2023. PATH funding would also support workforce development for the homeless and home- and community-based services systems of care, including outreach, training in evidence-based practices, information technology for data sharing, and training stipends.

Dental Initiatives

DHCS requests expenditure authority of $120.7 million ($58.5 million General Fund and $62.2 million federal funds) in 2021-22 and $243.2 million ($117.7 million General Fund and $125.5 million federal funds) in 2022-23 to support incentive payments to improve dental care for Medi-Cal beneficiaries, available through the Medicaid State Plan. During the previous 1115 Waiver, DHCS implemented the Dental Transformation Initiative (DTI), which included four dental "domains", including: 1) incentive payments for increasing preventive services utilization in children; 2) incentive payments for caries risk assessment and disease management; 3) incentive payments to encourage continuity of care; and 4) local dental pilot projects. Beginning January 1, 2022, DHCS has transitioned the three incentive payments programs of the DTI into the State Plan and included coverage of silver diamine fluoride as a dental benefit for certain populations. The department reports it has set an initial goal of achieving a 60 percent dental utilization rate for eligible Medi-Cal children and adults.

Population Health Management

DHCS requests expenditure authority of $75 million ($7.5 million General Fund and $67.5 million federal funds) in 2021-22 and $225 million ($22.5 million General Fund and $202.5 million federal funds) in 2022-23 to support implementation of a Population Health Management (PHM) service. The PHM service would utilize Medi-Cal administrative and clinical data and information for the department, Medi-Cal managed care plans, counties, providers, beneficiaries, and other partners to use in support of the delivery of care for Medi-Cal beneficiaries. According to DHCS, this service would also allow for identification of potential gaps in care, provider or care manager information, information on social determinants of health, as well as allow for population health analytics, health education, and tips for beneficiaries. The PHM system would also provide Medi-Cal beneficiaries with access to their administrative and clinical information.

Transitions of Populations between Fee-for-Service and Managed Care

CalAIM includes several changes to how certain populations of Medi-Cal beneficiaries would access certain benefits. CalAIM seeks to standardize which benefits are available through the managed care delivery system and which are available through the fee-for-service delivery system. Similarly, CalAIM seeks to standardize the populations of Medi-Cal beneficiaries that would receive services through managed care or through fee-for-service.

Benefit Standardization. CalAIM standardizes which Medi-Cal benefits are provided in the managed care delivery system and which benefits are provided in another delivery system. The proposed changes are as follows:

Managed Care Benefits ("Carved In")

- Long-term care – Effective January 1, 2023, all institutional long-term care services would become the responsibility of a beneficiary's managed care plan including

skilled nursing facilities, pediatric and adult subacute care facilities, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, and specialized rehabilitation in a skilled nursing facility or intermediate care facility.

- Organ transplants – Effective January 1, 2022, all major organ transplants are the responsibility of a beneficiary's managed care plan.

Fee-for-Service Benefits ("Carved Out")

- Pharmacy – Under the department's Medi-Cal Rx initiative, all prescription drugs and/or pharmacy services billed on a pharmacy claim are provided in the fee-for-service delivery system as of January 1, 2022. This carve-out does not apply to SCAN Health Plan, Programs for All-Inclusive Care for the Elderly (PACE), Cal MediConnect plans, and the Major Risk Medical Insurance Program (MRMIP).
- Specialty mental health services (Solano and Sacramento) – Effective July 1, 2023, specialty mental health services currently the responsibility of Kaiser health plans in Solano and Sacramento counties, would be provided by the county mental health plans.
- Multipurpose Senior Services Program – Effective January 1, 2022, the Multipurpose Senior Services Program, which had previously been scheduled to become the responsibility of Medi-Cal managed care plans in Coordinated Care Initiative counties, will instead remain a benefit under the existing 1915(c) Home- and Community-Based Services Waiver.

Standardization of Mandatory Managed Care and Fee-for-Service Populations. CalAIM will also standardize which categories of Medi-Cal beneficiaries would be required to enroll in a managed care plan to receive benefits and which beneficiaries would be required to receive benefits in the fee-for-service delivery system. According to DHCS, standardization will enhance coordination of care and reduce complexity across the Medi-Cal program. The populations transitioning from each system are as follows:

Transitions from Fee-for-Service to Mandatory Managed Care. Populations currently receiving benefits in the fee-for-service delivery system that would be required to enroll in a Medi-Cal managed care plan are as follows:

- Trafficking and Crime Victims Assistance Program beneficiaries, except those with a share of cost
- Individuals participating in accelerated enrollment
- Breast and Cervical Cancer Treatment Program (BCCTP) – non-dual beneficiaries
- Beneficiaries with other health care coverage
- Beneficiaries living in rural ZIP codes
- Individuals eligible for long-term care services, including those with a share of cost, beginning January 1, 2023

- All dual-eligible beneficiaries, not including those with a share of cost or with restricted-scope benefits, beginning January 1, 2023

Transitions from Managed Care to Mandatory Fee-for-Service. Populations currently receiving benefits in the managed care delivery system that would be required to receive benefits in the fee-for-service delivery system:

- Individuals receiving restricted-scope benefits
- Individuals with a share of cost, including in county organized health systems, Coordinated Care Initiative counties, Trafficking and Crime Victims Assistance Program, but excluding long-term care
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal, not including Medi-Cal Access Infant Program enrollees
- Omnibus Budget Reconciliation Act (OBRA) beneficiaries currently in managed care in Napa, Solano, and Yolo counties

According to DHCS, enrollment requirements for foster care children and youth will remain unchanged pending discussions and recommendations of its Foster Care Workgroup on future delivery system reforms for this population.

Long-Term Services and Supports Integration

Under CalAIM, DHCS will make several changes to the delivery system for long-term services and supports (LTSS) that build upon the state's duals demonstration project, the Coordinated Care Initiative (CCI). DHCS intends to use selective contracting to move toward aligned enrollment in a Medi-Cal managed care plan and a dual-eligible special needs plan (D-SNP) operated by one integrated organization. In the seven CCI demonstration counties, all MediCal beneficiaries in a Cal MediConnect plan would transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product, beginning January 1, 2023. Aligned enrollment would occur in non-CCI counties by 2026. Dual-eligible beneficiaries already in a non-aligned D-SNP (not affiliated with their managed care plan) would be allowed to maintain their enrollment, but new enrollment in non-aligned D-SNPs would be closed. DHCS will also limit enrollment in Medicare Advantage plans that are D-SNP "look-alikes" beginning in 2022.

DHCS will require all D-SNPs to use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. D-SNPs would be required to: 1) develop and use integrated member materials, 2) include consumers in existing advisory boards, 3) establish joint contract management team meetings for aligned D-SNPs and managed care plans, 4) include dementia specialists in care coordination efforts, and 5) coordinate carved-out LTSS benefits

including in-home supportive services (IHSS), MSSP, and other home- and community-based services waiver programs.

Beginning January 1, 2023, DHCS would implement mandatory enrollment of full- and partial-benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible long-term care residents. Long-term care benefits would be integrated into Medi-Cal managed care statewide. Cal MediConnect plans and the Coordinated Care Initiative will be discontinued at this time.

Behavioral Health Payment and Medical Necessity Reform

DHCS requests General Fund expenditure authority of $21.8 million in 2021-22 and $45.4 million in 2022-23 to support the Behavioral Health Quality Improvement Program (BH-QIP). CalAIM seeks to reform behavioral health payment methodologies in a multi-step process from the current cost-based reimbursement process to a rate-based and value-based structure using intergovernmental transfers to fund the non-federal share of services. The first step in the process, supported by the BH-QIP, will transition behavioral health services from the current claims coding system, Healthcare Common Procedure Coding System (HCPCS) Level II, to HCPCS Level I. According to DHCS, this transition would allow for more granular claiming and reporting of services provided, as well as more accurate reimbursements.

DHCS expects that, concurrent with the transition to HCPCS Level I, DHCS will transition to a rate-setting process for behavioral health services by peer groups of counties with similar costs of doing business. The non-federal share of rates would be provided by counties via intergovernmental transfer (IGT), rather than the current, cost-based certified public expenditure (CPE) process. DHCS would make annual updates to established rates to ensure reimbursement reflects the costs of providing services. DHCS would, at first, make payments to counties on a monthly basis, and would eventually transition to a quarterly payment schedule.

CalAIM also seeks to modify the existing medical necessity criteria for behavioral health services to ensure behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties. These changes will separate the concept of eligibility for services from that of medical necessity, allow counties to provide services to meet a beneficiary's behavioral health needs prior to diagnosis of a covered condition, clarify that treatment in the presence of a co-occurring substance use disorder is appropriate and reimbursable when medical necessity is met, implement a standardized screening tool to facilitate accurate determinations of which delivery system (specialty mental health, Medi-Cal managed care, or Medi-Cal fee-for-service) is most appropriate for care, implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system in which they seek care, and make other revisions and technical corrections. These changes will ensure that eligibility criteria, largely being driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social

continuum, will be the driving factor for determining the delivery system in which a beneficiary should receive services. These changes are being phased in, beginning January 1, 2022.

Kaiser Specialty Mental Health Carve-Out
Specialty mental health services (for serious mental illness) in Medi-Cal are provided by County Mental Health Plans, with the exception of Kaiser Medi-Cal beneficiaries in two counties: Sacramento and Solano. As mentioned above, this carve-out will be discontinued as a component of CalAIM. These two counties are not opposed to the carve-out ending, however they have significant concerns about the process and costs.

These counties point out that treatment for this population is expensive and the 2011 realignment was calculated based on them not being required to care for these populations. Sacramento County reports that they will receive 4,836 new patients, currently under Kaiser's care, at an estimated cost of $36 million. Solano County expects to receive 2,091 new patients, at an estimated cost of $16 million.

In addition to increased resources, these two counties are requesting a phased transition of this population, and sufficient time to ramp up preparation for the transition. CalAIM plans for the carve-out to end July 2023, coinciding with the implementation of behavioral health payment reform. The counties are requesting language that stipulates that the transition occur "no sooner than July 2023," contingent on county readiness. Without these safeguards, the counties assert that individuals will be hurt by this transition.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of CalAIM, its implementation and timeline, and respond to the following:

- Please describe any performance/outcome measures that have been built into CalAIM and how DHCS will be monitoring and measuring these performance/outcome measures over time. How will DHCS share these with the Legislature and public?
- Are the counties that were required to provide ECM on January 1, 2022 all providing it at this point in time?
- What does DHCS know about the extent to which Medi-Cal managed care plans intend to offer community supports, and which ones?
- Please respond to the concerns raised by Sacramento and Solano Counties.
- Sacramento and Solano Counties state that DHCS has confirmed that the state has been paying Kaiser for these populations, outside of managed care rates.

Could you please clarify and explain this? How much funding does the state currently pay Kaiser specifically for specialty mental health care in these two counties?

The Subcommittee requests Sacramento and Solano County provide an explanation of their concerns regarding the transition from the Kaiser mental health carve out in their counties.

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

ISSUE 2: EXTEND THE DURATION OF SUSPENSION OF MEDI-CAL BENEFITS FOR ADULT INMATES TBL

PANEL 2 – PRESENTERS

- **René Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services

PANEL 2 – Q&A ONLY

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Diana Vazquez-Luna**, Finance Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

Effective January 1, 2023, DHCS seeks to extend the duration of suspension of Medi-Cal benefits for adult incarcerated individuals from a one-year time-limited suspension to a suspension that remains in effect until the individual is no longer incarcerated within a public institution, if otherwise eligible. The proposal requires DHCS, in consultation with stakeholders, including the County Welfare Directors Association of California and advocates, to update and implement a redetermination of eligibility, to the extent required by federal law.

BACKGROUND

According to federal law, benefits may be suspended for some individuals who are enrolled in Medi-Cal at the time of the individuals' incarceration. Under current state law, the suspension shall end on the date the individual is no longer an inmate of a public institution or one year from the date that the individual becomes an inmate of a public institution, whichever is sooner.

To provide continuity of care for incarcerated persons being released from a correctional facility, DHCS, in conjunction with the California Department of Corrections and Rehabilitation (CDCR) and stakeholders, implemented the inmate pre-release policy described in All County Welfare Directors Letters (ACWDLs) 07-34 (January 2, 2008), 14-24 (May 6, 2014) and 14-24E (June 25, 2014).

The above referenced ACWDLs guide counties and justice-involved entities, with whom the counties work, on processing pre-release Medi-Cal applications for state and county

inmates. The pre-release application process strives to prevent lapses in health coverage after the release of eligible inmates.

Currently, the state inmate pre-release Medi-Cal application process is operational in all 58 counties. As part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative-Justice-Involved Initiative, per SEC 346 of AB 133 (Chapter 143, Statutes of 2021), no sooner than January 1, 2023, DHCS, in consultation with specified stakeholders, is required to develop and implement a mandatory process by which county jails and county juvenile facilities coordinate with Medi-Cal managed care plans and Medi-Cal behavioral health delivery systems to facilitate continued behavioral health treatment in the community for county jail inmates and juvenile inmates that were receiving behavioral health services before their release. Upon release from a state prison, county jail, or county juvenile facility, Medi-Cal eligible-individuals would receive needed medical and behavioral health services in the community via Medi-Cal managed care plans and Medi-Cal behavioral health delivery systems.

The CalAIM Justice Involved Initiative will also help streamline and create administrative efficiencies to county welfare departments' workload. No sooner than July 1, 2022, DHCS, in consultation with representatives of county welfare departments, the Statewide Automated Welfare Systems (CalSAWS), and other interested stakeholders, shall initiate the planning process to prioritize the automation of Medi-Cal suspensions for incarcerated individuals into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). This change will be reflected in the CalHEERS 24-Month Roadmap Initiatives and the County Eligibility Worker Dashboard (SEC. 366 of AB 133).

If an individual with suspended Medi-Cal benefits is released before the one-year suspension period ends, their benefits are reactivated without a new application being submitted, unless the county has sufficient information available to determine that the individual is no longer eligible for Medi-Cal. If an individual's Medi-Cal coverage is discontinued, the individual is required to submit a new application upon release from prison or jail, which may cause a significant delay in receiving needed health care coverage and needed medical services, which include but are not limited to: medical prescriptions, behavioral health treatment, doctors' appointments, and other reasonable and necessary life-saving services. According to DHCS, terminating benefits before release, rather than leaving individuals in a suspended status, increases the gap in health care services, which are critical in the first weeks and months post-incarceration.

In October 2018, H.R. 6 (Public Law 115-271 Section 1001) the "Substance Use- Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act" was signed into law, which requires that juveniles who are inmates of public institutions not have a time-limited suspension for Medicaid. The SUPPORT Act defines an eligible juvenile as an individual under 21 years of age or former foster care youth under 26 years of age. As part of the Budget Act of 2020, statutory changes in state

law were made in SEC 49 of AB 80 (Committee on Budget, Chapter 12, Statutes of 2020) to conform to federal law.

The existing one-year limit on suspension of Medi-Cal benefits for adult inmates potentially delays access to medical care for eligible incarcerated persons after release from a public institution and is burdensome for county Medi-Cal eligibility workers who must process new Medi-Cal applications for an otherwise eligible individual upon their release from incarceration. Access to health care benefits provided prior to and during incarceration must also be available immediately upon release to allow for uninterrupted services.

DHCS states that continuity of care is vital in reducing recidivism, promoting positive health outcomes, and successfully reintegrating individuals into their communities. Studies have shown that interruption in access to care increases an individual's risk of a lapse in medication intake, which could lead to a greater chance of recidivism and readmission.

DHCS argues the following in support of this proposal:

- The proposal will provide more incarcerated persons with access to life-saving-medications and treatments following their release without delays.

- As of July 23, 2021, approximately 11.75 percent of all incarcerated persons in California were enrolled in Medi-Cal. The proposal will increase efficiencies to county Medi-Cal eligibility workers by providing a more timely and streamlined process to reinstate Medi-Cal coverage upon an incarcerated person's release.

- According to the National Association of Counties, terminating benefits prior to release, rather than leaving individuals in a suspended status, increases the gap in health care services, which are critical in the first weeks and months post-incarceration. The Kaiser Family Foundation released a report stating that improved access to services and better management of health conditions immediately after release from jail or prison has shown to reduce rates of recidivism, particularly among individuals with mental health and substance abuse disorders. Studies published by the American Psychiatric Association show that incarcerated persons who were enrolled in Medicaid at the time of release had 16% fewer incidents of recidivism compared to those not enrolled at the time of release.

- The proposal will provide efficient continuity of care for justice-involved individuals who are going to be released from incarceration and will provide uninterrupted access to health coverage to support the high-risk, high-need, justice-involved population in receiving much-needed care as they transition back to their communities.

- The proposal will improve health outcomes for vulnerable populations, by decreasing the need for costlier health care services down the road, and increase rates of successful community reintegration.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal, and explain the rationale for the 1-year time-limit in current law.

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

ISSUE 3: SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM APPROVAL, OVERSIGHT, AND MONITORING BCP, AND PROGRAM SUPPORT FOR IMD EXCLUSION TRANSITION

PANEL 3 – PRESENTERS

- **Kelly Pfeifer**, MD, Deputy Director, Behavioral Health, Department of Health Care Services

PANEL 3 – Q&A ONLY

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

Short-Term Residential Therapeutic Program Approval, Oversight, and Monitoring BCP

DHCS requests nine positions and expenditure authority of $1.3 million ($661,000 General Fund and $661,000 federal funds) annually to provide oversight, monitoring, and reviews of short-term residential therapeutic programs, mental health program approval, and children's crisis residential programs.

Short-Term Residential Therapeutic Program Support for IMD Exclusion Transition

DHCS requests General Fund expenditure authority of $712,000 in 2021-22 and $6 million in 2022-23 to support Medi-Cal services provided to Medi-Cal beneficiaries in short-term residential therapeutic programs classified as Institutes for Mental Disease.

BACKGROUND

Continuum of Care Reform (CCR) requires DHCS, the California Health and Human Services Agency, the Department of Education, the Department of Social Services, the Legislature and stakeholders to collaborate, in a transparent manner, and make statutory, regulatory, and administrative changes to improve timely access for children to available level of care options. In particular, CCR requires a state-level focus on increasing access to children's residential and community-based services to better meet therapeutic, outpatient, and inpatient behavioral health needs.

Consequently, the intended outcome for children and youth when placed in a short-term residential therapeutic program (STRTP) with a mental health program approval (MHPA) is greater access to available services, reduction in lengths of stay in residential

placement, improved health outcomes, and a defined established pathway, especially for those in California's foster care system, to family reunification or adoption in a home-based community setting.

DHCS, or its delegated county mental health plan (MHP), is required to approve initially and annually thereafter the MHPA for STRTPs. Prior to 2020, 11 of the 57 MHPs accepted delegation of the MHPA but, subsequently, two relinquished delegation. As a result, only nine of the 57 MHPs currently maintain their delegation of the MHPAs. Due to the low amount of counties accepting delegation, DHCS is tasked with the review of applications and all documents required as part of the program statement, initial onsite reviews, and annual onsite reviews for all of the STRTP providers throughout the remaining 48 counties, as well as overseeing the nine delegate counties to meet compliance with mental health program standards.

DHCS oversight activities may include interviews with residing children and clinical staff as well as reviewing any complaint files. When applicable, DHCS also takes administrative actions against STRTPs, including the denial, suspension, or revocation of MHPA approvals or imposition of sanctions or corrective action plans. Other actions undertaken by DHCS may include carrying out formal complaint investigations and due process functions resulting from provider informal disputes or appeals regarding identified deficiencies or corrective action plan findings resulting from DHCS or delegate compliance review.

Although nine MHPs have delegated authority to issue MHPAs, DHCS continues to provide oversight and policy guidance to delegate counties to meet program consistency in meeting MHPA standards throughout the state. In addition, DHCS recently received interest from three counties to develop CCRP programs. CCRP is in a developmental phase, which includes updates to interim and final promulgation of regulations, application process, onsite review protocols, staff training, and technical assistance resources for STRTPs to convert or expand their programs.

The federal Families Firs Prevention Services Act (FFPSA), enacted in 2018, was intended to restrict the use of congregate care, unless absolutely necessary by limiting payments to specific types of congregate care settings meeting certain requirements. The act added Qualified Residential Treatment Programs (QRTPs) as an allowable congregate care setting for children and youth requiring a therapeutic placement as long as specific criteria are met. In California, regulatory requirements for short-term residential therapeutic programs (STRTPs) are similar to QRTPs. However, some of the definition criteria for QRTPs overlap with the criteria used to determine if a facility is an Institute for Mental Disease (IMD), for which federal matching funds are prohibited under Title XIX of the Social Security Act, which governs the Medicaid program.

In July 2020, CMS indicated that it could not provide a blanket assurance that all of the STRTPs operated in the state are not IMDs. As a result, DHCS must assess each STRTP to determine whether it meets the criteria as an IMD. In addition, DHCS reports that CMS has developed a waiver opportunity for states to receive federal funds for mental health services provided to populations with a serious mental illness or serious emotional disturbance. DHCS intends to apply for the waiver in fall 2022.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present these two proposals and respond to any questions raised by the Subcommittee.

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

ISSUE 4: SKILLED NURSING FACILITY FINANCING PROPOSAL

PANEL 4 – PRESENTERS

- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Tiffany Whiten**, Senior Government Relations Advocate, California State Council of SEIU
- **Anthony Chicotel**, Staff Attorney, California Advocates for Nursing Home Reform
- **Jennifer Snyder**, Legislative Advocate, California Association of Health Facilities

PANEL 4 – Q&A ONLY

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Alek Klimek**, Staff Finance Budget Analyst, Department of Finance
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

DHCS proposes to extend and reform the skilled nursing facility (SNF) funding framework to move from a primarily cost-based payment methodology to one that incentivizes value and quality. The current framework sunsets December 31, 2022.

AB 1629 (Chapter 875, Statutes of 2004) requires the Department to implement a facility specific rate methodology on Freestanding Skilled Nursing Facilities Level–B and Freestanding Subacute Nursing Facilities Level-B. Currently, the annual weighted increase across these facilities, not including add-ons, is capped at 2.4 percent. The methodology also imposes a Quality Assurance Fee (QAF) equivalent to approximately 6 percent of all facility revenue, which is used to increase rates and offset a portion of the General Fund cost for the rate increases. Chapter 717, Statutes of 2010 (SB 853), extended by AB 81 (Chapter 13, Statutes of 2020), further implemented a quality and accountability supplemental payment (QASP) program to incentivize quality of care improvements by providing supplemental payments for facilities that achieve various quality metrics.

While the administration announced in the January budget that this proposal would be forthcoming, DHCS still has not made the specific language public.

BACKGROUND

As has been covered extensively through research, media investigations, and legislative hearing agendas, the quality of care in skilled nursing facilities (SNFs) is of great concern to many people, and that was true even before the pandemic. With nursing homes the epicenter of COVID fatalities, the pandemic has shone a bright light on the deficiencies in SNF quality of care, and particularly with infection control. Federal Covid-19 nursing home data shows that as of February 27, 2022, 9,964 residents and staff in California's SNFs have died due to Covid-19.

It has also highlighted the many and deep resource deficits in SNFs, from sufficient levels of staffing (first and foremost) to adequate infection control expertise, and from easy access to personal protective equipment (PPE) to safe facilities. As was discussed recently at the joint Sub 1 and Sub 4 hearing on health care workforce on Monday, March 14, 2022, addressing workforce challenges and shortages in SNFs will be critical to changing the culture and significantly increasing the quality of care in SNFs. SEIU reports that California's skilled nursing industry has lost 16,000 workers since 2020, 11.3 percent of the entire workforce. SEIU also cites research that found that half of nursing home workers indicated a likelihood to leave their current positions. In 2020, an estimated 22 percent of all nursing home workers and their families in California fell below 200 percent of the federal poverty line. Research tells us that a combination of low wages, inadequate benefits (including health care coverage), physically demanding work, high-risk of infection, and general lack of respect from SNF management create an overall work environment that appeals to very few people.

The issues of quality of care, workforce, and Medi-Cal rates are inextricably linked, and therefore must be addressed all together in order to successfully transform California's nursing home industry into a health care system that offers the best care in the world to our most vulnerable population.

SEIU 2015 Proposal

SEIU has developed a proposal to establish a Skilled Nursing Facility Quality Standards Board. The objective is to create a worker-centric Board housed under the California Health and Human Services Agency that would address prevalent workplace and quality issues, as well as racial disparities, in the California nursing home industry by creating a set of standards for minimum wages, staffing levels, benefits, workplace protections, training standards, and conditions of resident care that must be met by all skilled nursing facilities throughout the state.

The main function of the Board would be to set an industry minimum wage standard, but would also address a number of other issues that impact nursing home workers. The standards would be set for statewide implementation, with the allowance for the creation of local standards boards. The Board would be required to create a work plan, identifying

the topics that would be addressed in the first two years of operation, and that work plan would be reviewed and updated every two years. Items to be addressed in the work plan would include, but not be limited to:

- Recruitment and retention of workers
- Minimum staffing levels
- Adequacy and enforcement of training requirements
- Job skills, potential accreditation or certification, and career ladders
- Paid sick leave, paid family leave, paid time off for bereavement, vacation
- Retirement benefits
- Affordable health care benefits that comply with the Affordable Care Act
- Access to worker's compensation and temporary disability insurance, including alternative ways to provide health insurance coverage for skilled nursing facility workers who are injured on the job but are not currently covered by state law
- Hiring agreements and contracts
- Notice or compensation requirements for changes to work schedules
- Worker and employer trainings required by the board standards
- Impact of systemic racism and economic injustice on workers, and efforts to relieve that impact
- COVID-19 policies to protect workers and residents
- The use of digital labor marketplaces to address workforce shortages
- Creation and administration of the systems, processes, and rules for nominating and electing a worker representative to the board
- Board and state agency outreach and enforcement strategies to facilitate compliance with laws, regulations, and board standards
- Other issues the board determines are necessary in fulfilling the board's purposes

The Board would commission a number of reports in consultation with policy think tanks and academic experts that would inform the policies set forth by the Board. The Board also would certify worker organizations that would provide mandatory training to skilled nursing facility workers regarding the standards established by the Board and other rights.

Finally, SEIU's proposal states that, starting in 2024, the Board would be responsible for creating a set of industry-wide standards that would serve as the minimum requirements that a skilled nursing facility must meet in order to participate in Medi-Cal managed care networks. Additionally, skilled nursing facilities that violate any of the quality standards established by the board would be subject to a civil penalty, with joint liability for its subcontractors' violations as well. A related party of a skilled nursing facility operator or skilled nursing facility employer shall be responsible for ensuring that the skilled nursing facility operator or employer complies with this law.

Advocacy Community Recommendations

California Advocates for Nursing Home Reform (CANHR) and many other advocacy organizations (including: Foundation Aiding the Elderly, Justice in Aging, Geriatric Circle, Disability Rights California, California Alliance for Retired Americans, and others) sent a letter and set of recommendations to the administration in November of 2021 on the reauthorization of the AB 1629 payment structure. The letter states:

> "AB 1629 is a failed system. Since enactment in 2004, it has not met any of its stated goals to ensure individual access to appropriate care, promote quality resident care, advance decent wages and benefits for nursing home workers, and support provider compliance with all applicable state and federal requirements. Instead, the extraordinarily expensive payment system has produced billionaire nursing home owners, scandalously poor care, and rampant discrimination against Medi-Cal beneficiaries. Annual payments to SNFs now exceed $5 billion."

The advocates raised the following issues and recommendations:

<u>Stop paying Medi-Cal rates based on inflated Medicare costs.</u>

- The AB 1629 rate system should be reformed to require that SNF Medi-Cal rates be based on spending on residents whose care is paid for by Medi-Cal.

<u>Ban self-dealing schemes to prevent diversion of public funds intended for care and staffing.</u>

- *Prohibit licensees from contracting with management or administrative service companies to circumvent their responsibilities to operate SNFs in accordance with state and federal requirements*. Such arrangements are often being used to enrich operators by funneling Medi-Cal payments to unregulated, unaccountable companies they own or control.
- *Close related party loopholes*. A 2020 administrative appeal decision narrowed the meaning of "related party" and expanded opportunities to hide profits and avoid transparency.
- *Impose strict caps on rents and lease back arrangements*. Operators commonly charge inflated rents or lease payments, often using layers of shell companies, to hide profits and maximize reimbursement.
- *End taxpayer reimbursement for worthless related party insurance*. Operators are paying exorbitant premiums to themselves for insurance provided by related parties. Reimbursement for insurance should be limited to fair market rates and only for policies from independent insurers that provide real liability coverage.
- *Prevent reimbursement of excessive interest rates*. Nursing home owners can profit at residents' expense by making loans to nursing home operating companies they control at excessive rates – some even at 10 percent or more.

- *Eliminate nursing home ownership draws*. Currently, owners may draw or take any amount out of the nursing home operating budget at their discretion, reducing available funds to care for residents and hiding profit taking by operators.
- *Prohibit reimbursement of nursing home association dues*. Nursing home associations are basically lobby organizations for the industry that are used to seek increased state funding, restrict state oversight and diminish enforcement. California should not pay for these dues.

Repeal the quality and accountability supplemental payment (QASP) program.

- Repeal the QASP system because it creates the illusion that payments are connected to quality without ensuring better care or staffing in SNFs that receive bonus payments.

Replace the QASP program with payments to support safe staffing levels, financial incentives to support living wages and enforcement measures on staffing compliance.

- *Set a safe staffing requirement for SNFs*. The minimum standard should be 4.1 total nursing hours per resident day (hprd), including at least 0.75 RN hprd, 0.55 LVN hrpd, and 2.8 CNA hprd, with minimum CNA hours increasing to 3.2 hprd for moderate resident acuity and 3.6 for high acuity residents. Require SNFs to have RNs engaged in direct care at all times.
- *Redirect QASP funds to pay costs of safe staffing requirements and establish effective penalties for SNFs that do not comply*. Penalties should include a ban on new admissions that is imposed until compliance is reached.
- Establish financial incentives for SNFs that pay workers a living wage.
- Establish payment incentives for SNFs that keep turnover levels below 25 percent.
- Eliminate the 95th percentile ceiling for the staffing cost center.
- Audit payroll-based journal (PBJ) staffing data and issue penalties for inaccurate and incomplete data.
- Use payroll-based journal (PBJ) data to monitor daily compliance with minimum staffing requirements and modernize staffing enforcement to ensure compliance 365 days per year.
- *Eliminate all staffing waivers for nursing shortages*. State personnel who process waivers should be trained and reassigned to enforce staffing requirements. The current staffing waivers resulted in poor care and high COVID infection and death rates. Moreover, they have the effect of keeping wages low and contributing to high staff turnover rates, which are also associated with higher COVID infection rates in California.

Require SNFs to give applicants on Medi-Cal equal access to admission.

- Codify the DHCS 9098 nondiscrimination agreement and establish a statutory enforcement system to promptly investigate and sanction Medi-Cal certified SNFs that fail to give applicants on Medi-Cal equal access to admission.

Invest some of the savings from AB 1629 reform measures to expand home and community-based services.

- Expand access to home and community-based services and the assisted living waiver program for those who would otherwise need nursing home care.

Fully ban reimbursement of legal fees when SNFs challenge governmental actions.

- Prohibit reimbursement of legal and consulting fees anytime a SNF challenges penalties or any other governmental action.

Repeal the requirement to reimburse SNFs for the cost of new state and federal mandates.

Ensure that Medi-Cal disallowances on audit reports are repaid to the state general fund.

California Association of Health Facilities (CAHF)

CAHF provided the following requests and recommendations to the administration regarding the AB 1629 reauthorization:

"*Assure continued Medi-Cal funding post-pandemic*

Skilled nursing facilities were provided a Medi-Cal rate enhancement during the COVID-19 pandemic to cover the extraordinary costs of care during the public health crisis. This rate enhancement of 10% will cease once the declared emergency expires April, 2022. These additional funds have been the lifeline for nursing facilities to weather the crisis as they continue to move mountains to provide the clinical care necessary to keep their residents safe and healthy. It is imperative that the Medi-Cal rate re-authorization continue the 10% add-on so there is not a cliff where facilities fall off without the funding.

Invest in labor by paying for SNF actual costs

Nursing facilities continue to struggle -especially under the current pandemic - to recruit and retain the quality workforce needed to sustain quality patient care. As of 2017, SNFs are required to maintain at least a minimum number of nursing hours per patient day of 3.5 and a patient to certified nursing assistant (CNA) ratio of 2.4 hours per patient day. These requirements along with the rising minimum wage and competitive employment environment has made it next to impossible for SNFs to recruit the nursing staff they need to provide quality patient care. Most facilities have been forced to reduce their census and reduced bed capacity for those patients in need of long term care.

The Medi-Cal program underpays nursing facilities for their labor costs. Its rate setting system sets prospective facility specific rates based on 3-year old cost data. The facility specific rates are further limited based on peer group caps for various cost categories (direct and indirect labor, non-labor, administration) and overall programmatic limitation on increases in skilled nursing rates imposed by the State. These limitations on timing and overall growth of Medi-Cal rates create budgetary pressure on SNFs, limiting how

much a SNF can afford in labor costs. At the same time, wages in many entry level service positions have increased greatly in the economy at large. Skilled Nursing facilities cannot keep up with wage pressure demand at current Medi-Cal rates. At the very least these facilities should be paid for their costs when they incur them. Medi-Cal should modify its current rate setting to pay SNFs their labor costs at the 100 percentile, without caps or budgetary adjustments and for those costs incurred during the same budget year.

Support incentives for quality and value in skilled nursing facility care

California leads the nation in quality for skilled nursing facilities in a number of areas. Centers for Medicare & Medicaid Services (CMS) measures performance in skilled nursing centers by tracking 18 quality measures including mobility, weight loss and falls among skilled nursing residents. In 2019, California providers improved outcomes for residents in 15 out of 18 categories and the state currently ranks No. 1, 2 or 3 in the nation in eight quality measures. CAHF supports the administration's proposal to hold nursing facilities accountable for quality patient care. It is important, however, that facilities are measured with transparent and achievable quality measures and there are not specific disqualifiers that make achieving quality payments impossible."

CAHF is forwarding a proposal called "The Drive to $25," to increase wages and make other improvements to SNFs. CAHF provided the following description of the proposal:

"1. Certified Nursing Assistant Wage Increases - DRIVE TO $25!

Nursing facility direct care staff are the cornerstone of quality care in a nursing facility. CAHF members are indebted and grateful for certified nursing assistants that care for elderly residents of our state. It is imperative that these CNAs receive wages that reflect the important care they provide to the state's sickest residents. Yet, the California Labor and Workforce Development Agency reports 51 percent of CNAs are eligible for public assistance.

CAHF is requesting that the Medi-Cal program establish a CNA minimum wage that will grow to $25 per hour in the next 3 years. Nursing facilities will be required to pay a specified minimum wage with Medi-Cal covering the costs of approximately two thirds of these wage increases. The rest will be covered by facility funds. The Medi-Cal share of this cost will be funded as a direct pass-through from the state to the employees at each facility. The new "CNA living wage" will not be discretionary, it will be required to be paid to all CNAs in SNFs.

2. Enhanced Registered Nursing in Skilled Nursing Facilities

Registered nurses are trained and licensed to provide the highest level of clinical nursing care in SNFs. Currently, California has recognized the clinical value of a 24-hour RN, 7 days a week, for larger nursing facilities (100 beds or more). Smaller buildings are required to have 8 hours of RN coverage, 7 days a week.

CAHF thinks that smaller SNFs should also have access to a higher RN coverage, which research supports. Thus, we propose that the RN nursing coverage be at least doubled for smaller SNFs. Specially, we propose that the current 24-hour RN requirement be extended to SNFs with 60 beds to 99 beds. This represents a three-fold increase in the nursing requirement for these SNFs. Very small SNFs—those with 59 beds or less—should have at least 16 hours of coverage, which would double their RN coverage requirement. The new requirement should be implemented over the next three years, with consideration of flexibilities on timing, depending on progress in training more RN staff for the SNF sector.

The Medi-Cal program should be required to cover these new costs as a new mandate and provide incentives for SNFs to hire additional 24-hour RNs as soon as possible.

3. Workforce Investment

It is imperative that the state prioritize the recruitment and development of nursing facility staff as it moves to invest in the future workforce of California. Without this investment, nursing facilities will continue to lack the workforce needed to provide the crucial care necessary for our state's most vulnerable seniors. CAHF is suggesting a sustained program to expand, fund, and support recruitment and retention solutions to increase the CNA, LVN and RN workforce quickly and efficiently.

CAHF is requesting $150 million to be spent over a 3-year period building on the successful implementation of the HCAI CNA workforce training funds allocated in the 2021-22 State Budget. ($43 million). These funds should be utilized to support existing facility-based training programs, support union led training programs, expand partnerships with local Workforce Investment Boards, community colleges, adult programs and ROP programs that have historically coordinated training programs with local nursing facilities. In addition, these funds should be utilized to invest in upskilling and other retention programs that have shown success.

4. Study to Establish Appropriate Levels of Clinical Care

Nursing home care is clinician-centered, and a growing body of evidence has shown that there is a strong relationship between the levels of clinical staffing and quality care for residents. However, the most frequently cited research calling for staffing ratios is more than 20 years old. In addition, much of the past research did not appropriately account for numerous changes that have occurred in care delivery in recent years, or what we have learned from the COVID-19 pandemic.

CAHF supports a two-year study to establish evidence-based standards for specific minimum care requirements during times of normal and emergency nursing home operations. A temporary workgroup should be convened comprised of state officials, clinicians, operators, and direct care staff to manage the study. The study should be finalized and presented to the state by 2024 to help inform the process of staffing improvements."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present their SNF financing proposal, and respond to the following:

- When will a detailed proposal, including trailer bill language, be finalized?
- Which stakeholders is DHCS engaging with to develop this proposal?
- What impact does DHCS expect CalAIM (and the transition of LTSS to managed care) to have on the quality of care in SNFs?
- Please provide feedback and reactions to the concerns and recommendations raised by advocates that are included in the agenda.
- Please respond to, and explain, the claim made by advocates that Medi-Cal costs reflect Medicare costs.
- Please describe the financial monitoring and auditing processes for SNFs that the state has in place. Do you believe that they are adequate? Would they uncover either fraud or legal financial accounting that allows for Med-Cal funding to be profitable?

The Subcommittee requests SEIU and CANHR to present their recommendations and proposals on improving the quality of care in SNFs.

The Subcommittee requests CAHF respond to the concerns and recommendations of advocates, present its own recommendations and proposals on improving the quality of care in SNFs, and respond to the following:

- Please describe the fiscal monitoring, auditing and oversight of SNFs by the state. Would SNFs welcome additional oversight?
- Can you provide evidence that SNFs are not profiting from Medi-Cal funding?
- Could SNFs pay higher wages now given the high Medicare reimbursement rates?

Staff Recommendation: Hold open to allow for additional discussion and consideration of the administration's and stakeholders' proposals.

ISSUE 5: MEDI-CAL DENTAL POLICY EVIDENCE-BASED PRACTICES TBL AND DENTAL MANAGED CARE EXTENSION TBL

PANEL 5 – PRESENTERS

- **René Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Monica Montano**, PhD, Regulatory and Legislative Advocate, California Dental Association

PANEL 5 – Q&A ONLY

- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Andrew Duffy**, Principal Program Budget Analyst, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PROPOSAL

Evidence-Based Practices Resources and Trailer Bill

DHCS requests expenditure authority of $37.1 million ($12.9 million General Fund and $24.2 million federal funds) to support implementation of evidence-based dental practices, including laboratory processed crowns on posterior teeth for adult Medi-Cal beneficiaries beginning in 2022-23.

DHCS also proposes to update existing law to align standards of dental care with evidence-based practices and nationally recognized guidelines, consistent with the American Academy of Pediatric Dentistry and the American Dental Association, for the Medi-Cal population.

Dental Managed Care Extension Trailer Bill

DHCS proposes trailer bill language to extend the operation of existing dental managed care contracts in Sacramento and Los Angeles Counties from December 31, 2022 until December 31, 2023, and to require DHCS to procure and execute new contracts to continue the dental managed care delivery system in these counties through the end of the 1915(b) waiver period.

BACKGROUND

Evidence-Based Practices Resources and Trailer bill

The Medi-Cal program currently covers stainless steel crowns for adult beneficiaries, but does not cover laboratory-processed crowns, which are consistent with guidelines from the American Association of Pediatric Dentists and the American Dental Association.

According to DHCS, the use of stainless steel crowns can lead to decay and possible damage to the gum tissue around the tooth because the margins of the stainless steel crowns are not custom fitted to the tooth. Laboratory-processed crowns, which are custom fitted to the tooth, are currently covered for children, but not adults.

According to DHCS, current state statute that regulates the standards of dental care for Medi-Cal is outdated and inconsistent with current dental standards of care. W&I Code Section 14132.88(c) states, "For persons 21 years of age or older, laboratory-processed crowns on posterior teeth are not a covered benefit except when a posterior tooth is necessary as an abutment for any fixed or removable prosthesis." Stainless steel crowns or very large fillings are the reimbursable treatment solutions if the affected tooth is not an abutment for a fixed or removable prosthesis.

According to the American Academy of Pediatric Dentistry and the American Dental Association guidelines, a laboratory-processed crown is recommended for custom-fit and long-lasting treatment to restore a tooth to normal function when there is not enough healthy tooth structure remaining to accommodate either a silver filling or tooth colored filling. In standard practice, the stainless steel crown is typically a temporary solution for a permanent tooth until a laboratory-processed crown can be produced.

In addition, existing law requires DHCS to reduce the utilization rate of subgingival curettage and root planing by 41 percent for all Medi-Cal beneficiaries except those residing in a Skilled Nursing Facility (SNF) or an Intermediate Care Facility for the Developmentally Disabled (ICF-DD) (W&I Code Section 14132.88(e)). This provision was implemented during the State's fiscal crisis. Subgingival curettage and root planing benefits were subsequently eliminated along with adult dental benefits as part of the optional benefits exclusion.

Full adult dental benefits, including subgingival curettage and root planning, were restored effective January 1, 2018. DHCS states that these services are important to reduce the higher costs of more advanced and costly periodontal procedures and to reduce the need for extractions due to periodontal disease.

Specifically, this proposal would do the following:

- Clarify that for persons 21 years of age or older, laboratory-processed crowns on posterior teeth are a covered benefit when medically necessary to restore a posterior tooth to normal function per the criteria in the Medi-Cal Dental Manual of Criteria (MOC).
- Require covered dental benefits and accompanying criteria for receipt of services be located in the Medi-Cal Dental MOC.
- Notwithstanding emergency and essential diagnostic and restorative dental services, as specified, require all covered benefits to consider evidence-based

practices consistent with the American Academy of Pediatric Dentistry and the American Dental Association guidelines.
- Remove outdated requirement for DHCS to reduce the rate of subgingival curettage and root planning by 41 percent for beneficiaries, as specified.
- Expand DHCS' authority to implement by bulletin regarding pretreatment documentation to apply to the entire section.
- Require the section be implemented only to the extent any necessary federal approvals are obtained and federal financial participation is available.

Dental Managed Care (DMC) Extension Trailer Bill

DHCS is responsible for providing dental services to eligible Medi-Cal beneficiaries, and offers services through two delivery systems, Fee-for-Service (FFS) and 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 October 2021, there are approximately 896,000 Medi-Cal beneficiaries enrolled in DMC between the two counties. The Budget Act of 2021 and corresponding health omnibus budget trailer bill required DHCS to extend dental managed care contracts to December 31, 2022, as specified in SEC. 372 of AB 133 (Committee on Budget, Chapter 143, Statutes of 2021).

The extension timeline of DMC will correspond to the timeframe needed by DHCS to procure new contracts via a competitive procurement process. Specifically, this proposal would:
- Extend the operations period of the existing DMC contracts from December 31, 2022, to December 31, 2023, as specified, and allow for a competitive procurement process (proposed Welfare and Institutions (W&I) Code Section 14087.46 (k)(1)).
- Require DHCS to conduct a competitive bid, procure and execute new contracts no sooner than January 1, 2024 (proposed W&I Code Section 14087.46 (k)(3)).

In 2020 and 2021, the Administration proposed to eliminate dental managed care in Sacramento and Los Angeles Counties to allow for a more effective and uniform provider and beneficiary outreach on a statewide basis. In addition, DHCS had concerns about lower rates of dental utilization for dental managed care, particularly among children, compared to the fee-for-service delivery system. However, to avoid changes to dental coverage for a significant number of Medi-Cal beneficiaries during the COVID-19 pandemic, the Legislature adopted trailer bill language to extend the dental managed care contracts for one year, until December 31, 2022.

Stakeholder Concerns:

The California Dental Association (CDA) has several concerns with the Governor's budget proposals:

- CDA states that, while they support the proposed expansion to the lab-processed crowns benefit, they believe that the reimbursement rate is woefully inadequate as this is an expensive procedure. CDA is requesting $13 million ongoing to right-size the reimbursement rate.

- CDA explains that under CalAIM, the 1915b Waiver Special Terms and Conditions (STC) require dental managed care to perform at parity with fee-for-service, and therefore CDA recommends that DHCS do more aggressive monitoring and tracking of dental managed care performance measures.

- According to CDA, DHCS identified a $40 million shortfall associated with services provided under the Dental Transformation Initiative (DTI), which will result in some providers not getting reimbursed or getting under-reimbursed for some services. CDA states that this was the state's error and therefore providers should be penalized in this way.

STAFF COMMENTS/QUESTIONS

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

- Please explain the reasons for proposing to extend the DMC contracts after proposing to end the program in both 2020 and 2021.

- Please provide reactions to the concerns raised by CDA.

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

NON-PRESENTATION ITEMS

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 6: HEALTH CARE COVERAGE: DEDUCTIBLES AND OUT-OF-POCKET EXPENSES (SB 368) BCP

PROPOSAL

The Department of Managed Health Care (DMHC) requests 2.0 positions and limited term expenditure authority (equivalent to 0.5 position) and $591,000 from the Managed Care Fund in 2022-23, 2.0 positions and limited term expenditure authority (equivalent to 0.5 position) and $571,000 in 2023-24, 2.0 positions and $456,000 in 2024-25 and ongoing to review health care service plan documents as specified pursuant to SB 368 (Limón, Chapter 602, Statutes of 2021), which requires health care service plans to provide an enrollee with their accrual balance toward their deductible and their out-of-pocket maximum for covered benefits.

The following table notes the requested positions and equivalent positions by program and classification:

Program/Classification	2022-23/ongoing	2022-23 and 2023-24 Equivalent Positions
Office of Plan Licensing		
Attorney III	2.0	0.0
Office of Legal Services		
Attorney III	0.0	0.5
Total	**2.0**	**0.5**

BACKGROUND

SB 368 requires health plans and insurers to monitor and provide to an enrollee the accrual toward their annual deductible or out-of-pocket maximum. Plans and insurers must provide this information to enrollees every month in which benefits are used until the accrual balance equals the full deductible amount or full maximum out-of-pocket amount. Plans and insurers must also establish and maintain a system to allow an enrollee to request their most updated accrual balances.

According to DMHC, the department currently ensures health plans comply with existing provisions of the Knox-Keene Health Care Service Plan Act of 1975 that require plans to inform enrollees of the amount of their cost-sharing, including deductibles and out-of-pocket maximums, in an evidence of coverage or disclosure form. The additional health plan requirements imposed by SB 368 require DMHC to do the following:

- Promulgate a regulation to clarify the scope and parameters of the system health plans must implement to allow an enrollee to request their updated accrual balances, the standards for how a plan informs enrollees of their accruals, and the requirements for how plans must monitor this accrual.

- Establish through regulation what constitutes a violation of SB 368 and potential penalties.

- Annually review health plan documents, including evidence of coverages, disclosure forms, summary of benefits, and subscriber contracts to ensure compliance with SB 368.

- Annually review provider contracts and plan-to-plan contracts to ensure compliance with SB 368.

- Annually review policies and procedures, including the health plan's system that allows an enrollee to request their updated accrual balances.

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

ISSUE 7: HEALTH CARE COVERAGE: EMPLOYER ASSOCIATIONS (SB 255) BCP

PROPOSAL

DMHC requests one position and expenditure authority from the Managed Care Fund of $237,000 in 2022-23 and $229,000 annually thereafter to conduct annual reviews of Multiple Employer Welfare Arrangement (MEWA) documents, pursuant to SB 255 (Portantino, Chapter 725, Statutes of 2021). Specifically, DMHC requests the following position and resources:

Office of Plan Licensing – One position

One Attorney III position would conduct legal research and review annual MEWA and large group health care plan submissions for compliance with SB 255.

Software Licensing Costs - $2,000

DMHC requests expenditure authority from the Managed Care Fund of $2,000 annually to support software licensing costs for the development and implementation of a new solution in the department's Necessary Infrastructure Modernization for Business Unified Services (NIMBUS) platform for MEWAs to register and submit annual compliance findings.

BACKGROUND

SB 255 allows a multiple employer welfare arrangement (MEWA), an association of employers, to offer a large group health plan contract or health insurance policy if the following conditions are met:

- The association was established prior to March 23, 2010.
- The association provides an equivalent to or greater level of coverage than the platinum level offered through the Covered California health benefit exchange.
- The association provides the essential health benefits.
- The association includes coverage for job categories on a project-by-project basis for one or more participating employers, for at least 101 employees.

SB 255 also requires the association to file an application for registration with DMHC or the Department of Insurance on or before June 1, 2022, and annually file evidence of ongoing compliance.

According to DMHC, SB 255 would require the following workload:

- Develop a MEWA registration process by June 1, 2022.

- Create processes for MEWA registration including research, checklist for requirements for documentation, registration application form, annual compliance requirement process or form, and any necessary outreach to stakeholders.

- Issue guidance to MEWAs regarding registration requirements and ongoing compliance with state laws and regulations, as well as advise health plans of MEWA eligibility criteria.

- Review initial applications for the exemption to determine whether required documentation was submitted and if the documentation supports approval of the registration.

- Annually review each MEWA for ongoing compliance with SB 255.

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

ISSUE 8: HEALTH CARE COVERAGE: SMALL EMPLOYER GROUPS (SB 718) BCP

PROPOSAL

DMHC requests expenditure authority from the Managed Care Fund of $313,000 in 2022-23 and $301,000 in 2023-24 through 2026-27. If approved, these resources would allow DMHC to receive and review Multiple Employer Welfare Arrangement (MEWA) documents for compliance with SB 718 (Bates, Chapter 736, Statutes of 2021). Specifically, DMHC requests the following resources:

Office of Plan Licensing

- Resources equivalent to one Attorney III position
- Resources equivalent to 0.5 Associate Governmental Program Analyst

BACKGROUND

SB 718 creates an exception from Knox-Keene Act requirements that a small employer cannot purchase large croup health care coverage through an association health plan (AHP) or multiple employer welfare arrangement (MEWA). SB 718 requires a MEWA that intends to offer large group coverage to its members to meet the following requirements:

- The association is headquartered in California, was established prior to March 23, 2010, has been in continued existence since, and is a bona fide association or group of employers that may act as an employer under ERISA.

- The association is the sponsor of a multiple employer welfare arrangement (MEWA), and the MEWA is fully insured and is in full compliance with all applicable state and federal laws.

- The MEWA has offered a large group health plan contract or health insurance policy since January 1, 2012, in connection with an employee welfare benefit plan.

- The large group health plan contract or health insurance policy offers to employees a level of coverage having an actuarial value greater than or equivalent to the platinum level of coverage available through Covered California and covers essential health benefits, as specified.

- The large group health plan contract or health insurance includes coverage of common law employees, and their dependents, who are employed by an association member in the biomedical industry and whose employer has operations in California.

- The large group health plan contract or health insurance policy offers only fully insured benefits through an insurance contract with an insurance carrier licensed by CDI or with a health maintenance organization licensed by DMHC.

- Association members purchasing health coverage have a minimum of four full-time common law employees and are current employer members of the association sponsoring the plan. Employer members subsidize employee premiums by at least 51 percent.

- The association is an organization with business and organizational purposes unrelated to the provision of health care benefits and existed prior to the establishment of the MEWA offering the employee welfare benefit plan.

- The participating employers have a commonality of interests from being in the same industry, unrelated to the provision of health care benefits.

- Membership in the association is open solely to employers, and the participating employers, either directly or indirectly, exercise control over the employee welfare benefit plan, the large group health plan contract or health insurance policy, both in form and substance.

- The large group health plan contract or health insurance policy is treated as a single-risk-rated contract that is guaranteed issued and renewable for member employers, as well as their employees and dependents. An employee or dependent is not charged premium rates based on health status and is not excluded from coverage based upon any preexisting condition. Employee and dependent eligibility are not directly or indirectly based on health status or claims of any person.

- An employer otherwise eligible is not excluded from participating in a MEWA, or offering or renewing the large group health care service plan contract based on health status or claims of any employee or dependent.

- The MEWA at all times covers at least 101 employees.

In addition to meeting these requirements, the MEWA must file an application for registration with DMHC or the Department of Insurance on or before June 1, 022, and submit annual filings of ongoing compliance with SB 718. SB 718 sunsets on January 1, 2026.

According to DMHC, SB 718 would require DMHC to do the following:

- Develop a MEWA registration process by June 1, 2022.

- Create processes for MEWA registration including research, checklist for requirements for documentation, registration application form, annual compliance requirement process or form, and any necessary outreach to stakeholders.

- Issue guidance to MEWAs regarding registration requirements and ongoing compliance with state laws and regulations, as well as advise health plans of MEWA eligibility criteria.

- Review initial applications for the exemption to determine whether required documentation was submitted and if the documentation supports approval of the registration.

- Annually review each MEWA for ongoing compliance with SB 255.

- Review end of exemption filings to wind down changes adopted under SB 718 prior to the sunset date of January 1, 2026.

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

ISSUE 9: HEALTH CARE COVERAGE: STEP THERAPY (AB 347) BCP

PROPOSAL

DMHC requests 12 positions and expenditure authority from the Managed Care Fund of $3.1 million in 2022-23, and $3 million annually thereafter to address step therapy requirements implemented pursuant to AB 347 (Arambula, Chapter 742, Statutes of 2021). Specifically, DMHC requests positions and resources as follows:

Office of Plan Licensing – Three positions

- Two Attorney III positions would design filing review guidelines for internal review, summarize and review plan documents for legal compliance, prepare deficiency comment letters, conduct teleconferences with plans to resolve issues, submit periodic written and oral reports, coordinate weekly review, and provide annual compliance training.
- One Associate Governmental Program Analyst (AGPA) would assist with developing the structure of the compliance project, identifying specific compliance requirements within plan disclosure documents, creating and maintaining weekly tracking reports, conducting initial administrative file review of plan submissions, participating in compliance training, and assisting with the annual review of plan documents.

Office of Plan Monitoring – Four positions

- Two Attorney III positions would develop regulations, provide ongoing legal review and consultation, revise survey tools, provide legal guidance for medical surveys, and draft enforcement referrals for uncorrected AB 347 deficiencies.
- One Health Program Specialist II position would review health plan amendment filings and survey findings, develop survey scope of work, conduct analysis of health plan information related to AB 347 requirements, review and validate deficiency findings in medical surveys, and assist with drafting enforcement referrals for uncorrected AB 347 deficiencies.
- One AGPA would develop, implement, and maintain administrative and analytical program activities to monitor compliance with AB 347.

Office of Enforcement – Three positions

- 0.5 Assistant Chief Counsel position would oversee complex enforcement referrals, attend trials, oversee review of settlement negotiations or judgments, meet with primary attorneys, review details of referrals, consult with experts to evaluate the referral and prepare for trial and hearings, and address staffing and training due to the nature of the investigations and subsequent prosecutions.
- Two Attorney III positions would provide legal support to evaluate enforcement referrals, including drafting and sending investigative discovery, recommending course of action, negotiating settlement and corrective action, preparing

appropriate course of resolution, and conducting pre-trial preparations, court order status conference briefs, settlement conference statements, attendance and preparation for trial and hearings, post-trial briefings, and enforcement of verdicts.
- 0.5 AGPA would prepare an attorney log and a monthly report, manage all enforcement action settlement documents, manage the administrative side of the Office's contract and procurement needs, prepare resolution summary reports, and conduct administrative tasks.

Office of Administrative Services – One position

- One AGPA would provide administrative support for these new positions, including accounting, budgeting, human resources, training, organizational effectiveness, and business management.

Office of Technology and Innovation – One position

- One Information Technology (IT) Specialist I position would provide IT support including application and system development and support, procurement and management of IT assets, and data security and support for staff members' IT needs.

Consultant Funding – $681,000

- $583,000 (Managed Care Fund) annually for a clinical consultant to assist the Office of Plan Monitoring with review of amendments to health plan utilization management policies and conduct clinical assessments during medical surveys.
- $45,000 (Managed Care Fund) biannually to support a medical expert consultant for the Office of Enforcement.
- $53,000 (Managed Care Fund) annually to support trial-related costs for the Office of Enforcement.

BACKGROUND

Step therapy is a type of prior authorization for prescription drugs that begins medication for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary. The Knox-Keene Act authorizes a health plan to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition. The Act also requires health plans to issue a decision on a prior authorization request within 72 hours of receipt of the request, or within 24 hours in expedited cases.

AB 347 establishes a timeline for approval or denial of step therapy exception requests for prescription drugs based on the existing timeline for prior authorization requests for prescription drugs. Beginning January 1, 2022, a health plan or insurer must grant a request for exception from step therapy if a provider determines the use of the drug required under step therapy is inconsistent with good professional practice for the

provision of medically necessary covered services, while taking into consideration the enrollee's needs, medical history, and professional judgment. If a health plan requires additional information to make a determination, AB 347 requires notification to the prescribing provider. Once the health plan receives the requested information, the time period to approve or deny a prior authorization or step therapy request would begin. Enrollees may appeal to the health plan under existing grievance processes and providers may appeal under the health plan's utilization management procedures.

According to DMHC, AB 347 would require the department to do the following:

- Promulgate a regulation to clarify the requirements of AB 347.
- Develop new medical survey questions and procedures related to AB 347.
- Review the new internal appeals process and review any related revised grievance policies and procedures.
- Review revised prescription drug policies and procedures.
- Review provider contracts, administrative service agreements, and plan-to-plan agreements with utilization review organizations that perform utilization review or utilization management functions on a health plan's behalf.
- Review product formularies and prescription drug benefits charts for compliance with the step therapy and appeal requirements.
- Review health plan documents, including evidence of coverage and disclosure forms, utilization management data and health plan survey data to ensure compliance with AB 347.
- Investigate and take enforcement action or assess administrative penalties against health plans not in compliance with AB 347.

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

ISSUE 10: HELP CENTER WORKLOAD BCP

PROPOSAL

DMHC requests 21 positions and expenditure authority from the Managed Care Fund of $3.6 million in 2022-23 and $3.4 million annually thereafter to address the increased volume of workload in its Help Center's Consumer and Provider complaint sections including meeting mandated timeframes for complaint review, facilitating a more robust case-auditing process, and aligning supervisory staffing with department growth.

BACKGROUND

DMHC's Help Center educates consumers about their health care rights, resolves consumer complaints against health plans, helps consumers navigate and understand their coverage and assists consumers in getting timely access to appropriate health care services. The Help Center provides direct assistance in all languages to health care consumers through the department's website (www.HealthHelp.ca.gov) and a toll free number (1-888-466-2219). DMHC collects data on calls received by the Help Center to identify common challenges experienced by consumers to inform potential changes to health plan oversight, regulation, or statutory authority. Common complaints include cancellation of coverage, billing issues, quality of services, coverage disputes, and access complaints. The Help Center often addresses consumer issues through a three-way call between its staff, the consumer, and the health plan. Complaints involving serious or urgent medical issues are routed to nurses who provide immediate assistance 24 hours a day, seven days a week.

The Help Center also oversees the independent medical review (IMR) program. IMR is available to consumers if a health plan denies, modifies, or delays a request for a service as not medically necessary or as experimental or investigational. Independent physicians review these issues and make a determination about whether the service should be provided. If an IMR determines the consumer should receive the service, health plans must provide it promptly.

The Help Center also provides assistance to health care providers to ensure they receive timely and accurate payments from health plans. This assistance includes managing individual provider complaints, complaints with multiple claims, emergency service complaints, and non-emergency service complaints. The Help Center manages the Independent Dispute Resolution Process (IDRP) for emergency and nonemergency billing disputes, in which an external reviewer adjudicates between payers and providers to determine the appropriate payment rate.

According to DMHC, since the implementation of the Affordable Care Act, the Help Center's workload has continued to increase. Help Center staff are experiencing challenges answering incoming phone calls and addressing complaints and IMRs in a timely manner. DMHC states that, despite several initiatives in recent years to mitigate the workload, maximize efficiency, and leverage technological improvements, the department requires additional staff and resources to manage its increasing Help Center workload.

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

ISSUE 11: OFFICE OF PLAN LICENSING WORKLOAD BCP

PROPOSAL

DMHC requests three positions and expenditure authority from the Managed Care Fund of $628,000 in 2022-23, $604,000 in 2023-24, one additional position and $842,000 in 2024-25, and $834,000 annually thereafter to address additional workload in its Office of Plan Licensing related to major transaction reviews of health plans. Specifically, DMHC requests the following positions:

- One Associate Governmental Program Analyst (AGPA) would track and monitor submissions and responses to health plan undertakings, as well as provide administrative support for public meetings and posting and maintaining the public website.

- Three Attorney III positions would review plan documents for legal compliance, including preparing summaries of the filing or briefing memorandum, preparing memos regarding market impact analysis and participating in interdepartmental meetings to gather additional information necessary for AB 595 compliance. Two of the Attorney III positions would begin in 2022-23 and one would begin in 2024-25.

BACKGROUND

DMHC's Office of Plan Licensing reviews all aspects of a health plan's operations, including benefits and coverage, template contracts with doctors and hospitals, provider networks, mental health parity, and complaint and grievance systems. After a health plan is licensed the Office monitors the plan and any changes made to plan operations, including changes in service areas, contracts, benefits, or systems. The Office also periodically identifies specific licensing issues for non-routine focused examination or investigation.

AB 595 (Wood, Chapter 292, Statutes of 2018) requires a health plan that intends to merge or consolidate with another entity to provide notice and secure prior approval from the DMHC director. DMHC refers to these mergers and consolidations as "change of control transactions". Prior to passage of AB 595, a health plan regulated under the Knox-Keene Act was required to obtain DMHC approval prior to a change of control transaction. However, DMHC's review previously focused on organizational and administrative changes, health delivery system changes, changes to products and subscriber contracts, the effect on the health plan's financial viability, the financing for the transaction, and the merger's impact on consumers. DMHC's approval of a change of control transaction is also frequently contingent on the health plan fulfilling certain commitments, called undertakings, to benefit California enrollees. DMHC's previous merger review did not

include review for the impact on competition, as those considerations were outside of DMHC's authority.

AB 595 authorizes DMHC to disapprove a health plan merger or acquisition upon finding the merger either violates the Knox-Keene Act, substantially lessens competition in health care service plan products, or creates a monopoly in the state. AB 595 also clarifies DMHC's existing authority to review mergers and secure health plan undertakings to benefit consumers, and adds requirements to ensure transparency and public participation for major mergers. Specifically, AB 595 requires the following of plans and DMHC:

- Requires a health plan that intends to merge or consolidate with, or enter into an agreement resulting in its purchase, acquisition or control by, any entity, including another health plan or health insurer, to give notice to, and secure prior approval from, DMHC.

- Requires the health plan to provide all information necessary for DMHC to approve, conditionally approve, or disapprove the transaction or agreement.

- Allows DMHC to conditionally approve the transaction or agreement, contingent on the health plan's agreement to fulfill required undertakings to benefit enrollees or provide for a stable health care delivery system. DMHC must engage stakeholders in determining the measures for improvement included in the required undertakings.

- Requires DMHC to obtain an independent analysis of the impact of the transaction or agreement on subscribers and enrollees, the stability of the health care delivery system, and other relevant provisions of the Knox-Keene Act, for major transactions or agreements.

- Allows DMHC to disapprove a transaction or agreement if it fails to satisfy the Knox-Keene Act, substantially lessens competition in health care service plan products, or creates a monopoly in the state. DMHC may obtain an opinion from an expert consultant to assess the competitive impact of a transaction.

- Requires DMHC, prior to approving, conditionally approving, or denying a major transaction or agreement, to hold a public meeting on the proposal in accordance with the Bagley-Keene Open Meetings Act. DMHC must consider public comments and testimony from the meeting in making its decision regarding the proposed transaction or agreement.

- Requires DMHC to prepare a statement describing the transaction or agreement if the department determines a material amount of health plan assets is subject to

purchase, acquisition, or control, and to make the statement available to the public before any public meeting.

- Requires DMHC to specify fees and obtain reimbursement of reasonable costs payable by the health plans involved in the proposed transaction or agreement.

The 2019 Budget Act included expenditure authority from the Managed Care Fund of $1 million annually to allow DMHC to analyze and assess the impact of change of control transactions on subscribers, enrollees, provider networks, the overall stability of the health care delivery system, and anti-competitive impacts, pursuant to the requirements of AB 595. The funding was intended to support a contract with an external consultant to perform independent analyses of these transactions. In its request for these resources, DMHC assumed it would review 10 transactions per year at a cost of $100,000 per analysis. According to DMHC, the number of change of control transactions has exceeded the estimate in the 2019 Budget Act request for resources.

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

ISSUE 12: OFFICE OF PLAN MONITORING WORKLOAD BCP

PROPOSAL

DMHC requests 11 positions and expenditure authority from the Managed Care Fund of $3.3 million in 2022-23, and $3.2 million annually thereafter to address routine and follow-up medical surveys on an increasing number of licensed health plans, support increased rates charged by clinical consultants, and manage additional workload from an increase in network review volume, complexity, and technological expertise requirements.

BACKGROUND

DMHC's Office of Plan Monitoring monitors health plan networks and delivery systems. The office conducts routine surveys every three years, and conducts non-routine surveys when a specific issue or problem requires a focused review of a health plan's operations. The office also monitors health plan provider networks and the accessibility of services to enrollees by reviewing geographic standards, provider-to-patient ratios, and timely access to care. Additionally, the office reviews health plan block transfer filings when a contract terminates between a health plan and a hospital or provider group.

According to DMHC, the number of licensed health plans and covered lives under the department's jurisdiction has steadily increased from 121 licensed health plans and 25 million covered lives in 2015 to 132 licensed health plans and 27.7 million covered lives in 2020. This increase in plans and covered lives has driven additional survey workload in the Office of Plan Monitoring, including additional triennial routine medical surveys, follow-up surveys, non-routine surveys when necessary, final evaluations of corrective action plans, and review of quality assurance, utilization management, and language assistance policies and procedures. In addition, the increase in plans and covered lives has driven additional provider network oversight workload, including network reviews, oversight of restricted health plans and review of tiered networks.

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

ISSUE 13: ADMINISTRATIVE WORKLOAD BCP

PROPOSAL

DMHC requests 12 positions and expenditure authority from the Managed Care Fund of $3.5 million in 2022-23, $3.4 million annually between 2023-24 and 2028-29, and $2.2 million annually thereafter to support administrative workload including human resources, business services, legal services, information technology, support for addressing systemic racism in the workplace, and to align supervisory, analytical and professional staffing with department growth.

BACKGROUND

According to DMHC, the department's expenditure authority has grown more than 30 percent, from $80 million to $104 million, and its position authority more than 14 percent, from 451 employees to 516 employees, between 2017-18 and 2021-22. Much of this growth is due to the implementation of several different program responsibilities, pursuant to various federal and state laws and regulations. DMHC reports that as its staff and programs have grown, its administrative staff performing human resources and other administrative functions, information technology (IT) services, and legal services have not kept pace with this growth.

DMHC's Office of Administrative Services reports significant workload increases from procuring IT goods and services, processing payroll related transactions, implementing new personnel laws and regulations, and implementing policies to address systemic racism. The Office provides administrative support for budgets, business services, procurements and contracting, request for personnel actions (RPAs), recruitment, meeting preparation, legislative analysis, invoice processing, and administrative consultation.

DMHC's Office of Technology and Innovation reports significant increased workload to respond to new legislation and regulations. In particular, DMHC reports compliance with accessibility requirements pursuant to AB 434 (Baker, Chapter 780, Statutes of 2017), has driven increased workload. In addition, modernization projects driven by implementation of AB 315 (Wood, Chapter 905, Statutes of 2018), AB 2674 (Aguiar-Curry, Chapter 303, Statutes of 2018), and AB 290 (Wood, Chapter 862, Statutes of 2019), have resulted in increased workload to modernize the department's Provider Complaint System, implement a new Delegated Entity Registration System and a new Delegated Entity Electronic Filing System for Pharmacy Benefit Management organizations, and modernize the Risk Bearing Organization Electronic Filing System.
DMHC's Office of Legal Services conducts legal research, drafts legal analyses, and makes policy and operational recommendations consistent with those analyses. The Office also leads rulemaking activities including pre-notice stakeholder engagement,

drafting regulation language, creating the regulation packages, conducting public hearings, and responding to public comments. The Office also handles requests for information under the Public Records Act (PRA), Information Practices Act (IPA), and court subpoenas. These requests often cover records related to health plan filings, block transfers, timely access data and statistics, and rulemaking files. Since 2014, DMHC reports the Office has seen a constant increase in PRA and IPA requests, increasing by 52 percent since 2011.

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 14: HOME AND COMMUNITY-BASED ALTERNATIVES WAIVER AND HOME AND COMMUNITY-BASED SERVICES SPENDING PLAN

PROPOSAL

The Department of Health Care Services (DHCS) requests expenditure authority of $263.8 million ($131.9 million General Fund and $131.9 million federal funds) in 2021-22 and $304 million ($152 million General Fund and $152 million federal funds) in 2022-23 to support costs associated with the Home- and Community-Based Alternatives (HCBA) Waiver renewal, which would be effective January 1, 2022.

BACKGROUND

HCBA Waiver

The HCBA Waiver offers services in the home or community to Medi-Cal beneficiaries who would otherwise receive care in a skilled nursing facility. The Waiver delivers care management services provided by a multidisciplinary team comprised of a nurse and social worker. The team coordinates Waiver and other Medi-Cal services and arranges for other available long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's home or other community-based residence.

The current HCBA Waiver was implemented effective January 1, 2017, and expired on December 31, 2021. DHCS has submitted a waiver renewal application to the federal Centers for Medicare and Medicaid Services (CMS) for a new five-year term, from January 1, 2022, to December 31, 2026. The new waiver application requested the following new provisions:

- Increased number of slots available under the waiver
- Expansion of Community Transition Services, making it available to participants living in the community who require essential goods or services to make their community-based residence safe and keep them out of an institution.
- Adding Assistive Technology as a new waiver services.
- Increasing the rate paid to Personal Care Agencies that provider Waiver Personal Care Services, in compliance with increases in the state minimum wage.

Home and Community Based Services (HCBS) Spending Plan

Section 9817 of the federal American Rescue Plan (ARP) Act provides qualifying states with a temporary 10 percentage point increase to federal matching funds for certain home- and community-based services (HCBS). The increased federal match is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to this increased federal match to enhance, expand, or strengthen HCBS under the state's Medicaid program. Unlike other federally funded programs, programs supported by this additional federal funding are eligible for federal matching funds in the Medicaid program as if they were supported by non-federal funding.

The 2021 Budget Act included Control Section 11.95, which authorized expenditure of $3 billion of HCBS funding received under the provisions of ARP. In July 2021, DHCS submitted California's $4.6 billion HCBS Spending Plan to the federal Centers for Medicare and Medicaid Services for review and approval. DHCS estimated that the $3 billion investment of HCBS funds would draw down an additional $1.6 billion of federal Medicaid matching funds. The HCBS Spending Plan included the following programs administered by DHCS:

- *Housing and Homelessness Incentive Program*. $161.1 million ($80.5 million HCBS funds) in 2021-22 and $644.2 million ($322.1 million HCBS funds) in 2022-23 supports payments to Medi-Cal managed care plans to incentivize investments and progress in addressing homelessness and keeping people housed.

- *Community-Based Residential Continuum Pilot*. $287.2 million ($106.1 million HCBS funds) in 2022-23 supports the Community-Based Residential Continuum Pilot, which will provide medical and supportive services in the home, independent living settings including permanent supportive housing and community care settings, to avoid unnecessary healthcare costs such as emergency services or skilled nursing.

- *Non-In-Home Supportive Services (IHSS) Care Economy Payments*. $12.5 million ($6.3 million HCBS funds) would provide a one-time incentive payment of $500 to each current direct care, non-IHSS provider of Medi-Cal home- and community-based services during a minimum of two months between March 2020 and March 2021.

- *Assisted Living Waiver Expansion*. $10.8 million ($3 million HCBS funds) in 2021-22 and $32.4 million ($8.9 million HCBS funds) would support expansion of the Assisted Living Waiver to eliminate the waiting list. This funding would support an additional 7,000 slots, with 5,000 from the community.

- *Contingency Management*. $3.6 million HCBS funds in 2021-22 and $23.1 million ($11.5 million HCBS funds) in 2022-23 would support contingency management as a service under the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Contingency management uses small motivational incentives combined with behavioral health treatment as the only effective treatment for stimulant use disorder.

- *CalBridge Behavioral Health Pilot Program*. $40 million HCBS funds in 2021-22 supports grants to acute care hospitals to hire trained behavioral health navigators in emergency departments to screen patients and offer intervention and referral to mental health or substance use disorder programs.

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

ISSUE 15: ENCOUNTER DATA IMPROVEMENT SUPPORT BCP

PROPOSAL

DHCS requests expenditure authority of $17.5 million ($15.7 million federal funds and $1.7 million reimbursements) in 2022-23 and $17.4 million ($15.7 million federal funds and $1.7 million reimbursements) in 2023-24 to advance improvements in data quality in managed care and county behavioral health.

BACKGROUND

DHCS has invested in various efforts to improve data quality for encounter data that is received from managed care plans and counties. These efforts have included the establishment of an Encounter Data Quality Unit, development of quality measures for encounter data, development and implementation of the Post-Adjudicated Claims and Encounters processing and validation system, quarterly reports comparing encounter data submission volumes to managed care plan submitted financial data (Stoplight Reports), yearly studies comparing DHCS' encounter data to beneficiary medical records (Encounter Data Validation Study), enforcement with the use of corrective action plans and fines. DHCS states that these efforts have resulted in significant improvements, however, additional research has demonstrated that there are still significant challenges to improvement, including:

- Lack of understanding and education among stakeholders regarding encounter data and its value;
- Insufficient incentives for providers to submit timely and complete encounter data;
- Inadequate training on data submission at the provider level;
- Technology challenges and variable technology across clinical settings;
- Variable quality control in encounter data submissions;
- Poor communication among all parties involved in the data submission;
- Lack of standardization – specifically around coding; and,
- Issues specific to Medi-Cal patients, such as increased likelihood of fragmented care, difficulty verifying coverage and encounter data gaps.

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

ISSUE 16: ELECTRONIC VISIT VERIFICATION PHASE II BCP

PROPOSAL

The Office of Systems Integration (OSI), the Department of Health Care Services (DHCS), and the Department of Developmental Services (DDS) request 16 positions (six at OSI, six at DHCS, and four at DDS) and total expenditure authority of $13 million ($3 million General Fund and $10 million federal funds) in 2022-23, $11.3 million ($3 million General Fund and $8.2 million federal funds) in 2023-24, $9.3 million ($2.5 million General Fund and $6.8 million federal funds) in 2024-25, $9.4 million ($2.6 million General Fund and $6.8 million federal funds) in 2025-26, and $9.1 million ($2.5 million General Fund and $6.7 million federal funds) in 202627 to continue the multi-departmental effort for the second phase (Phase II) of implementation of Electronic Visit Verification for personal care services and home health care services.

Program Funding Request Summary (CalHHS-OSI)		
Fund Source	**2022-23***	**2023-24****
9745 – CHHS Automation Fund	$10,342,000	$9,240,000
Total Funding Request:	**$10,342,000**	**$9,240,000**
Total Requested Positions:	**6.0**	**6.0**

* Transfers from other Departments (included below): DHCS: $5,171,000; DDS: $5,171,000
** Additional fiscal year resources requested for OSI: 2024-25: $7,567,000; 2025-26: $7,665,000; 2026-27: $7,413,000

Program Funding Request Summary (DHCS)		
Fund Source	**2022-23**	**2023-24****
0001 – General Fund	$710,000	$590,000
0890 – Federal Trust Fund*	$9,972,000	$8,240,000
Total Funding Request:	**$10,682,000**	**$8,830,000**
Total Requested Positions:	**6.0**	**6.0**

* Federal Trust Fund appropriation includes transfer of federal Medicaid matching funds to DDS, reflected below as Reimbursements.
** Additional fiscal year resources requested for DHCS: 2024-25: $7,247,000; 2025-26: $7,323,000; 2026-27: $7,128,000

Program Funding Request Summary (DDS)		
Fund Source	**2022-23**	**2023-24****
0001 – General Fund	$2,335,000	$2,424,000
0995 – Reimbursements*	$3,574,000	$2,934000
Total Funding Request:	**$5,909,000**	**$5,358,000**
Total Requested Positions:	**4.0**	**4.0**

* Reimbursements are the result of federal matching funds transferred from DHCS and are included in the totals attributed to the DHCS request.
** Additional fiscal year resources requested for DDS: 2024-25: $4,521,000; 2025-26: $4,570,000; 2026-27: $4,444,000

Project Team Staff Resources – $2.9 million. The Project Team is composed of a mix of state and consultant staff, including six positions at OSI, six positions and three position equivalents at DHCS, and four positions at DDS. These positions are conversions or extensions of resources received in the 2018-19, 2020-21, and 2021-22 fiscal years.

Consultant Contracts - $2.9 million. In addition to the positions and positions equivalents, OSI and DHCS are requesting $2.9 million consultant contracts for project management, business analysis, testing, technical support, solution certification services, independent verification and validation services, and interdepartmental consulting costs for the California Department of Technology Office of Statewide Project Delivery project oversight.

EVV Solution Vendor Services - $6.3 million. OSI is requesting $6.3 million to continue support for the EVV Phase II Solution contractor, which began implementation of the EVV Phase II project in September 2021. According to OSI, the amount requested is based on the vendor's proposed solution, implementation, and service operation costs for a five year contract.

Operating Expenses and Equipment (OE&E). OSI, DHCS, and DDS are also requesting $937,000 for other operating expenses and equipment, including general expenses, printing, communications, travel, training, facilities, and administrative support costs. Of this amount, OSI would receive $651,000, DHCS would receive $198,000, and DDS would receive $88,000.

BACKGROUND

The federal 21st Century CURES Act requires states to implement an electronic visit verification system for all Medicaid-funded Personal Care Services (PCS) by January 1, 2020, and for all Home Health Care Services (HHCS) by January 1, 2023. Federal law defines an electronic visit verification (EVV) system as a system under which PCS or HHCS visits are electronically verified, including the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends. Programs serving Medi-Cal beneficiaries that would be required to implement an EVV system include waiver services for individuals with developmental disabilities administered by DDS, In-Home Supportive Services (IHSS) administered by DSS, Waiver Personal Care Services and Home Health Care Services administered by DHCS, the Multipurpose Senior Services Program administered by DHCS and CDA, and AIDS Medi-Cal Waiver services administered by DHCS and CDPH. These services are offered under one of two models:

- Self-Directed Model – Services provided under a self-directed model are those in which the service recipient is responsible for hiring and managing direct care workers.
- Agency Model – Services provided under an agency model use a provider agency or vendor to recruit, hire, and manage direct care workers.

The Administration is implementing EVV in two phases. Phase I included implementation for the self-directed model components of the IHSS (DSS) and Waiver Personal Care Services (DHCS) programs, which currently use the Case Management Information and Payrolling Systems (CMIPS II) and Electronic Time Sheet (ETS) System. DSS reported that, as of October 2020, 95 percent of IHSS and Waiver Personal Care Services providers and recipients were enrolled in the EVV system.

Phase II includes non-IHSS and non-Waiver Personal Care Services self-directed model components, as well as the agency model components of the IHSS and Waiver Personal Care Services programs.

Electronic Visit Verification Phase II Programs:

Department	Program	Self-Directed	Agency Model	PCS	HHCS
DDS	1915 (c) DD Waiver	X	X	X	X
DDS	1915 (i) State Plan Services	X	X	X	X
DDS	1915 (c) Waiver Self-Determination Program	X	X	X	X
DHCS	1915 (c) Home- and Community-Based Alternatives Waiver	X	X	X	X
DHCS	Home Health Care Services		X		X
DHCS	Waiver Personal Care Services Agency Model		X	X	X
CDA/DHCS	MSSP 1915 (c) and 1115 Waivers		X	X	
DPH/DHCS	1915 (c) AIDS Medi-Cal Waiver		X	X	X
DSS	IHSS Agency Model		X	X	

Under the 21st Century CURES Act, states that did not adopt EVV for PCS programs by January 1, 2020, were subject to an incremental decrease in the federal match available for these programs of 0.25 percent in 2020, 0.5 percent in 2021, 0.75 percent in 2022, and one percent annually thereafter. States that do not adopt EVV for HHCS by January 1, 2023, would be subject to an additional decrease in federal match of 0.25 percent in 2023 and 2024, 0.5 percent in 2025, 0.75 percent in 2026, and 1 percent annually thereafter. The CURES Act allows a state to apply for a one-year exemption from the federal match reduction if the state made a good faith effort to comply and has encountered unavoidable delays. DHCS requested and the federal government approved a one-year exemption under this provision, delaying any reduction in federal matching funds until 2021. A state may only apply for a single, one-year exemption. According to DHCS, the state's failure to implement EVV by January 1, 2021, will result in the following reductions in federal matching funds for Medi-Cal services:

Electronic Visit Verification Delay – Federal Matching Fund Penalties by Department		
Department	**2020-21**	**2021-22**
Department of Social Services	($14,781,000)	($42,649,000)
Department of Developmental Services	($5,219,000)	($10,144,000)
Department of Health Care Services	($417,000)	($761,000)
Department of Aging	($31,000)	($55,000)
Department of Public Health	($11,000)	($20,000)
TOTAL	**($20,459,000)**	**($53,629,000)**

EVV Phase II Implementation Progress. According to OSI, the EVV Phase II project has been working towards implementation by January 1, 2022. The project completed its selection process for an EVV Solution contractor in May 2021 and submitted its Implementation Advanced Planning Document (IAPD) and draft EVV contract to the federal Centers for Medicare and Medicaid Services (CMS) for approval in June 2021. The project also submitted its Stage 4 Project Readiness and Approval documentation to the California Department of Technology, as part of its Project Approval Lifecycle (PAL) process, in June 2021. According to a presentation made by OSI and the affected departments to stakeholders, the EVV portal (CalEVV) is available for personal care services providers to register. All PCS providers must use either the CalEVV system or an alternate EVV system by January 1, 2022. HHCS providers will be required to use CalEVV or an alternate EVV system by January 1, 2023.

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

ISSUE 17: ALIGNING RECORD RETENTION REQUIREMENTS FOR PHARMACY PROVIDERS IN THE MEDICAL PROGRAM WITH FEDERAL LAW TBL

PROPOSAL

DHCS seeks to align state law with the ten-year record retention requirements for Medi-Cal pharmacy providers in federal law.

BACKGROUND

Existing state law requires Medi-Cal pharmacy providers to maintain records for three years for auditing purposes (Welfare and Institutions Code (WIC) Section 14170.8); however, this requirement is inconsistent with federal and state law governing the Medi-Cal program, which requires providers to maintain records for ten years (Title 42, Code of Federal Regulations Section 438.3 and WIC Sections 14124.1 and 14149.8).

DHCS seeks to amend the record retention requirements for Medi-Cal pharmacy providers in state law from three to ten years in order to align with federal and state law requirements for all Medi-Cal providers. This change will clarify that Medi-Cal pharmacy providers must comply with existing record retention requirements in federal law and assure that DHCS auditing activities can be implemented compliant with federal law and consistently across the Medi-Cal program.

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