Senate Budget and Fiscal Review – Mark Leno, Chair
SUBCOMMITTEE #3 on
Health & Human Services

Chair, Senator Holly J. Mitchell

Senator William W. Monning
Senator Jeff Stone, Pharm. D.

May 18, 2015

10:30 a.m.

Room 112, State Capitol

Agenda

(Michelle Baass)

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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VOTE ONLY

0530 Office of Systems Integration

1. CalHEERS Adjustment

Budget Issue. The May Revision proposes a decrease of $14 million for the Office of Systems Integration (OSI) to reflect a transfer of project management for the Unemployment Insurance Modernization project from OSI to the Employment Development Department. This decrease is partially offset by an increase of $2.4 million to reflect increased costs associated with the California Healthcare Eligibility, Enrollment, and Retention System and the implementation of the 24-month road map. This proposal also includes the following conforming changes to budget bill language:

Item 0530-001-9745, Provision 3:

> Of the funds appropriated in this item, ~~$160,242,000~~ $162,654,000 is for the support of activities related to the California Healthcare Eligibility, Enrollment, and Retention System project also known as CalHEERS. Expenditure of these funds is contingent upon review and approval of a plan submitted to the Director of Finance.

Subcommittee Staff Recommendation—Approve.

0977 California Health Facilities Financing Authority (CHFFA)

1. Investment in Mental Health Wellness Act of 2013

Budget Issue. As discussed at the April 9, 2015 Subcommittee No. 3 hearing, the CHFFA board is considering extending eligibility for its Mental Health Wellness Grants to peer respite programs to prompt small county interest in providing support to people at risk for, or experiencing, a mental health crisis. These peer respite programs provide a temporary stay at a residence staffed by professionally trained peers. Research indicates that peer respite programs are more affordable to operate and may fit the needs of many rural and suburban counties. Of the $149.8 million in Mental Health Wellness Grant funds appropriated to CHFFA, approximately $50 million in funds remain (if all third round grant applications are approved).

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt the placeholder trailer bill language below to allow CHFFA to use up to $3 million in unencumbered Mental Health Wellness Grant funds for peer respite programs.

Current law requires that these remaining unencumbered funds be used for crisis residential and crisis stabilization services. This language would provide CHFFA with the flexibility to allow this grant funding to be used to support peer respite programs if CHFFA finds that peer respite programs meet the intent of the Investment in Mental Health Wellness Act's goal to improve access to and capacity for mental health crisis services in California.

Proposed Placeholder Trailer Bill Language:

> For the 2015-16 fiscal year, the California Health Facilities and Financing Authority (CHFFA) may authorize up to $3 million in unencumbered funds as appropriated in Item 0977-101-0001 for Mental Health Wellness Grants, Chapter 20 (AB 110), Statutes of 2013, to develop peer respite sites.
>
> Any grant awards authorized by CHFFA for peer respite sites shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase bed capacity for peer respite support services. This may include, but not be limited to, the purchase of property, purchase of equipment, and the remodeling or construction of housing for the purpose of operating a peer respite site.
>
> Any recipient of a grant to develop peer respite sites shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.
>
> CHFFA may adopt emergency regulations relating to grants for peer respite sites, including emergency regulations that define eligible costs, and determine minimum and maximum grant amounts. The adoption of these regulations shall be in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) and shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

4260 Department of Health Care Services

1. May 2015 Medi-Cal Estimate (DOF Issue 501 and 502)

Budget Issue. The May Revision requests that the technical adjustments noted below be made to the following budget bill items to reflect a variety of caseload and cost changes not highlighted in the other Medi-Cal proposals:

- Item 4260-101-0001 be decreased by $184,978,000 and reimbursements be decreased by $189,645,000
- Item 4260-101-0890 be decreased by $8,264,259,000
- Item 4260-101-3168 be increased by $7,834,000
- Item 4260-101-3213 be increased by $1.3 million
- Item 4260-102-0001 be increased by $84,000
- Item 4260-102-0890 be increased by $84,000
- Item 4260-106-0890 be decreased by $5,728,000
- Item 4260-113-0001 be decreased by $336,814,000
- Item 4260-113-0890 be increased by $495,132,000
- Item 4260-117-0001 be decreased by $350,000
- Item 4260-117-0890 be increased by $70,000

Subcommittee Staff Recommendation— Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been, or will be, taken. This is a technical adjustment.

2. Eliminate Cost-of-Living Adjustment for County Eligibility Administration

Budget Issue. DHCS proposes trailer bill language to suspend the county administration cost-of-living adjustment (COLA) on a permanent basis.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Modify Trailer Bill Language. It is recommended to modify the proposed placeholder trailer bill language by suspending the county COLA for the budget year only and not on a permanent basis. The May Revision proposes increased funding for county eligibility administration (see item later in agenda).

3. Child Health and Disability Prevention (CHDP) Program Dental Referral

Budget Issue. DHCS proposes trailer bill language requiring CHDP programs and providers to refer all Medi-Cal-eligible children participating in CHDP who are one year of age and older to a dentist participating in the Medi-Cal program, rather than at age three.

The May Revision assumes annual costs of $1.6 million ($761,850 General Fund) for additional dental services for children referred to a dentist at one year of age or later.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language.

4. Health Care Reform – Workload Extension

Budget Issue. DHCS requests the extension of six limited-term positions and expenditure authority to support the continued implementation of and ongoing work required under the federal Affordable Care Act (ACA), including but not limited to the implementation of enhanced provider screening under the program integrity requirements and the support of the anticipated enhancements to the existing Medi-Cal Eligibility System (MEDS) and its sub-applications in order to meet the business needs of the health insurance-exchange, and county consortia including Electronic Health Information Transfer integration requirements.

The total limited-term expenditure authority request for 2015-16 is $716,000 ($129,000 General Fund and $587,000 federal funds) and for 2016-17 is $547,000 ($78,000 General Fund and $469,000 federal funds).

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

5. Medi-Cal Annual Open Enrollment Period

Budget Issue. DHCS proposes trailer bill language (TBL) to establish an Annual Health Plan Open Enrollment process for specified Medi-Cal managed care health plan (MCP) beneficiaries who are enrolled in counties that have more than one Medi-Cal managed care health plan (MCP) option. DHCS estimates that this proposal would result in a net General Fund savings of $1 million (and a total fund savings of $2 million). This savings comes from the reduction in the number of initial health assessments (IHAs) and reduced mailing costs to implement Annual Health Plan Open Enrollment.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Reject. The Legislature has denied similar proposals in the last few years because it found that it is important to ensure that Medi-Cal enrollees have the ability to change health plans at any time to ensure that his or her health needs are met. Although this proposal includes the ability for someone to switch plans if they have "good cause," having to demonstrate this and go through this process could be a barrier to ensuring timely treatment.

6. CalHEERS Electronic MAGI Determination Trailer Bill Language

Budget Issues. DHCS proposes trailer bill language to remove the sunset provision to allow for continued electronic verification of Medi-Cal eligibility information.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language.

7. Health Care Reform Financial Reporting Resources

Budget Issue. DHCS requests expenditure authority of $1,959,000 ($980,000 General Fund and $979,000 federal funds) for 2015-16 and $1,797,000 ($899,000 General Fund and $898,000 federal funds) on-going for 18 three-year limited term positions. The resources will address the increases in federal Centers for Medicare and Medicaid Services (CMS) mandated reporting requirements.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

8. Hospital Quality Assurance Fee Resources

Budget Issue. DHCS requests extending 9.5 limited-term positions and expenditure authority, set to expire on December 31, 2015, to December 31, 2018. DHCS also requests $350,000 in additional limited-term expenditure authority for two contracts to calculate and actuarially certify increased capitation rates as well as for high level counsel and assistance for federal submissions associated with the Hospital Quality Assurance Fee (HQAF) program.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

9. Martin Luther King Jr. Hospital Resources

Budget Issue. DHCS requests two full-time permanent positions and $745,000 ($373,000 Federal Fund and $372,000 Reimbursement) including annual contract funding of $500,000. This request is needed to meet the department's workload requirements related to Welfare and Institutions Code (WIC) Section 14165.50 to facilitate the financial viability of a new private nonprofit hospital that will serve the population of South Los Angeles. This population was formerly served by the Los Angeles County Martin Luther King, Jr. – Harbor Hospital.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

10. MEDS and Securing Medi-Cal Eligibility Information Resources

Budget Issue. DHCS requests the conversion of ten limited-term positions to permanent and a two-year extension of one limited-term position. The expenditure authority requested for the 11 positions is $1,497,000 ($714,000 General Fund and $783,000 federal funds). The resources are necessary to perform 1) the ongoing workload of managing, protecting, and securing confidential Medi-Cal eligibility information, 2) ensuring compliance with requirements of the federal Social Security Administration (SSA), and 3) monitoring access to the Medi-Cal Eligibility Data System (MEDS). The 11.0 limited-term positions are scheduled to expire on June 30, 2015.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

11. Intergovernmental Transfer Program Resources

Budget Issue. DHCS requests two new permanent positions, the conversion of three limited-term positions to permanent, and $467,000 expenditure authority ($120,000 federal funds and $347,000 reimbursements). The requested staffing resources would address the additional and ongoing workloads from Medi-Cal managed care expansion and mandated statutory requirements to implement SB 208 (Steinberg) Chapter 714, Statutes of 2010. The three limited-term positions are set to expire on October 31, 2015. Starting in 2016-17, and on-going, the requested expenditure authority would be $540,000 ($164,000 federal funds and $376,000 reimbursements).

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

12. Drug Medi-Cal Provider Enrollment

Budget Issue. DHCS' Provider Enrollment Division requests to extend 11 limited term positions that expire June 30, 2015 for one more year for work associated with certifying and recertifying Drug Medi-Cal (DMC) providers. According to DHCS, these requested positions are essential to address provider fraud, waste, and abuse in the DMC program by certifying only providers meeting standards of participation in Medi-Cal, and decertifying fraudulent providers by conducting a thorough screening including collecting disclosure statements, performing monitoring checks, and making referrals to the DHCS Audits and Investigations Division for onsite reviews.

This issue was heard at the April 9th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

13. Drug Medi-Cal Provider Monitoring

Budget Issue. DHCS requests 10 positions in its Substance Use Disorder Prevention, Treatment, and Recovery Services Division for workload associated with monitoring Drug Medi-Cal (DMC) providers.

According to DHCS, these positions would be used to increase program integrity within the program and mitigate the risk of fraud, waste, and abuse. For example, these positions would review the on-site operations of every DMC provider at least once every five years (approximately 133 sites annually) and be responsible for follow-up with DMC providers on all corrective action plans to ensure any deficiencies DHCS identifies are rectified by the DMC providers.

This issue was heard at the April 9th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

14. Substance Abuse – Recovery and Treatment Services (AB 2374, 2014)

Budget Issue. DHCS requests to establish two permanent, full-time positions at a cost of $246,000 (General Fund) due to the enactment of AB 2374 (Mansoor), Chapter 815, Statutes of 2014.

This issue was heard at the April 9th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

15. Performance Outcomes System for EPSDT Medi-Cal Specialty Mental Health Services

Budget Issue. DHCS requests three full-time permanent positions at a cost of $377,000 ($189,000 General Fund and $188,000 Federal Trust Fund) to support the program management, coordination with

counties and other partners, data collection and interpretation and research needs of the Performance Outcomes System project as required by SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012 and AB 82 (Committee on Budget), Chapter 34, Statutes of 2013.

This issue was heard at the April 9th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

16. Family Health Programs Adjustments (DOF Issue 505, 505-MR, 506-MR)

Budget Issue. The May Revision requests adjustments to the California Children's Services (CCS), Child Health and Disability Prevention Program (CHDP), the Genetically Handicapped Person's Program (GHPP), and the Every Woman Counts (EWC) program. See tables below for details.

Table: Family Health Estimate May Revision Summary

Program	Budget Act 2014-15	Projected 2014-15	January Budget Proposed 2015-16	May Revision Proposed 2015-16
CCS	$95,781,000	$92,995,000	$91,291,000	$87,182,000
CHDP	1,713,000	1,662,000	1,677,000	1,359,000
GHPP	128,739,000	130,915,000	136,337,000	121,519,000
EWC	58,583,000	54,311,000	42,356,000	53,312,000
TOTAL	**$284,816,000**	**$279,883,000**	**$271,661,000**	**$264,055,000**

Additionally, the May Revision indicates that the Administration finds that the CCS, CHDP, GHPP, and EWC program caseloads will experience a decline due to the implementation of the federal Affordable Care Act, which allowed individuals to qualify for Medi-Cal or subsidized coverage through the Exchange. Consequently, the caseloads for these programs in 2015-16 are estimated to be at the same level as 2014-15.

Subcommittee Staff Recommendation—Approve.

17. Modify Major Risk Medical Insurance Program

Budget Issue. DHCS proposes trailer bill language to modify the Major Risk Medical Insurance Program (MRMIP) and the Guaranteed Issue Pilot (GIP) Program, effective January 1, 2016.

This issue was heard at the April 23rd Subcommittee hearing.

Subcommittee Staff Comment and Recommendation--Reject proposed trailer bill language. As previously discussed, the proposal gives DHCS broad authority to redesign MRMIP without any input from stakeholders and it eliminates a safety-net option whereby individuals could purchase health coverage throughout the year if they missed the open enrollment period for commercial coverage or do not qualify for Medi-Cal. For these reasons, it is recommended to reject this proposal.

4265 Department of Public Health

1. Genetic Disease Screening Program Update & AB 1559 (2014) (DOF ISSUE 010-MR)

Budget Issue. The May Revision proposes a decrease of $776,000 compared to the January budget, for total funding of $118.6 million (Genetic Disease Testing Fund) for the Genetic Disease Screening Program (GDSP).

Included in the GDSP budget estimate is the following proposal:

- **Expanding California's Newborn Screening Program** – DPH requests one permanent position and $1.975 million from the Genetic Disease Testing Fund in 2015-16 of which $1.825 is one-time funding and $150,000 is requested to be appropriated annually thereafter to implement with AB 1559 (Pan), Chapter 565, Statute of 2014, which expands the statewide Newborn Screening Program to include screening for adrenoleukodystrophy (ALD) as soon as ALD is added to the federal Recommended Uniform Screening Panel (RUSP).

  This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve Genetic Disease Screening Program Estimate and Budget Change Proposal.

2. Office of AIDS: ADAP Client Eligibility Verification Resources

Budget Issue. DPH requests $536,000 in expenditure authority from the AIDS Drug Assistance Program Rebate Fund and five positions to manage the increase in client eligibility verification workload within the AIDS Drug Assistance Program (ADAP). These positions are needed to ensure program integrity and to comply with federal Health Resources and Services Administration client eligibility verification requirements**.**

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

3. ADAP Modernization

Issue. The Subcommittee is in receipt of proposals to expand eligibility for the AIDS Drug Assistance Program (ADAP) medication program and the ADAP insurance assistance programs--the OA-Health Insurance Premium Payment (HIPP) program. These proposals, which may result in program savings in out years because of the current drug rebate return, and include:

a. Update Family Size - Financial eligibility for OA-HIPP and ADAP are the same. Currently the programs serve individuals with incomes up to $50,000 annually based on federal adjusted gross income (FAGI) with no regard for family size. The result is that a single individual is treated the same as a person with dependents. Historically, ADAP served primarily single men with no dependents. Changes in the epidemic, changes in marriage and

family rights for the LBGT community as well as new insurance coverage opportunities through the Affordable Care Act (ACA) make it important to consider the programs' eligibility standards regarding family size.

b. Increase Income Limit - Another issue for consideration is increasing the income limit of $50,000 for these programs, which is estimated to be 447 percent federal poverty level (FPL) to 500 percent FPL or $58,350 for a single individual and $98,950 for a three-person household. Currently five other high income states operate programs with this income eligibility, including Maine, Maryland, Massachusetts, New Jersey and the District of Columbia.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt placeholder trailer bill language to modernize ADAP as specified above.

4. May Revision Estimate Updates (DOF ISSUE 400-MR, 009-MR, 010-MR, 400-MR)

Budget Issue. The May Revision proposes the following estimate updates:

- **Women, Infants, and Children (WIC) –** A decrease of $8.5 million in federal funds and $4.8 million in WIC Manufacturer Rebate Special Funds for 2015-16, for a total of $1.2 billion for the WIC program.

- **Proposition 99** - A decrease of $3.6 million in the Health Education Account and decrease of $675,000 in the Research Account in local assistance; and a $2.3 million decrease in the Health Education Account in state operations.

Subcommittee Staff Recommendation—Approve.

ITEMS FOR DISCUSSION

4260 Department of Health Care Services

1. 2011 Realignment Behavioral Health Growth Account Allocation

Oversight Issue. At the April 9th Subcommittee hearing, the Administration indicated that it plans to follow the same allocation formula for the $60.1 million in 2013-14 Behavioral Health Growth Account funds as was used last year. That is, first priority of the Behavioral Health Growth Account funding would be given to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health Early Periodic Screening, Diagnosis and Treatment (EPSDT) and Drug Medi-Cal. Specifically, this allocation provided additional funding to counties in which the approved claims for EPSDT and Drug Medi-Cal services in the fiscal year were greater than the funding they received from the base account. The remaining balance of this growth account was then distributed using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount.

However, it has recently come to the Subcommittee's attention that the DHCS is considering changing this allocation to distribute this growth funding using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount. With this change, counties who spent more than their allocation to provide entitlement services would not necessarily be made whole.

Background. SB 1020 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2012, created the permanent structure for 2011 Realignment. SB 1020 codified the Behavioral Health Subaccount which funds Medi-Cal Specialty Mental Health Services (for children and adults), Drug Medi-Cal, residential perinatal drug services and treatment, drug court operations, and other non-Drug Medi-Cal programs. Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs and counties have a responsibility to provide for these entitlement programs.

Government Code Section 30026.5(k) specifies that Medi-Cal Specialty Mental Health Services shall be funded from the Behavioral Health Subaccount, the Behavioral Health Growth Special Account, the Mental Health Subaccount (1991 Realignment), the Mental Health Account (1991 Realignment), and to the extent permissible under the Mental Health Services Act, the Mental Health Services Fund. Government Code Section 30026.5(g) requires counties to exhaust both 2011 and 1991 Realignment funds before county General Fund is used for entitlements. A county board of supervisors also has the ability to establish a reserve using five percent of the yearly allocation to the Behavioral Health Subaccount that can be used in the same manner as their yearly Behavioral Health allocation, pursuant Government Code Section 30025(f).

Consistent with practices established in 1991 Realignment, up to 10 percent of the amount deposited in the fund from the immediately preceding fiscal year can be shifted between subaccounts in the Support Services Account with notice to the Board of Supervisors, pursuant to Government Code Section 30025(f). This shift can be done on a one-time basis and does not change base funding. In addition, there is not a restriction for the shifting of funds within a subaccount, but any elimination of a program, or reduction of 10 percent in one year or 25 percent over three years, must be duly noticed in an open session as an action item by the Board of Supervisors, pursuant to Government Code Section 30026.5(f).

Government Code Section 30026.5(e) also requires 2011 Realignment funds to be used in a manner to maintain eligibility for federal matching funds.

DHCS issued Mental Health Services Division Information Notice 13-01 on January 30, 2013, to inform counties that 2011 Realignment did not abrogate or diminish the responsibility that, "they must provide, or arrange for the provision of, Medi-Cal specialty mental health services, including specialty mental health services under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit." As noted above, Government Code Section 30026.5(k) specifies fund sources for Medi-Cal Specialty Mental Health Services. The Administration continues to work with the California State Association of Counties and the California Behavioral Health Directors Association to ensure all counties are aware of these entitlement programs and clients cannot be denied services.

On May 19, 2014, DHCS issued Mental Health and Substance Use Disorder Services Information Notice 14-017 indicating that first priority of the Behavioral Health Growth Account funding would be given to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health EPSDT and Drug Medi-Cal. Specifically, this allocation provided additional funding to eight counties in which the approved claims for EPSDT and Drug Medi-Cal services in 2012-13 were greater than the funding they received in 2012-13 from the Behavioral Health Subaccount. The remaining balance of this growth account would then be distributed using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount.

Subcommittee Staff Comment and Recommendation—Hold Open. DHCS's potential change in methodology to distribute these growth funds undermines the state's direction that counties must provide for the provision of Medi-Cal specialty mental health services, including specialty mental health services under EPSDT, and Drug Medi-Cal, as these are entitlement programs. Additionally, it provides no assurance to counties that if they follow-through with the requirements to provide these services that they would be compensated for the increase in utilization. Although DHCS notes that this is "county" money, Government Code Section 30029.07 requires these funds to be allocated based on a schedule created in consultation with the appropriate state agencies and counties. DHCS should assume a leadership position in the allocation of these funds in a manner that would promote statewide objectives to improve and increase utilization of these services and not allocate these funds without any regard to county performance.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide an overview of this issue.
2. When does DHCS plan to formulate the methodology to distribute the $60 million in 2013-14 growth funds?
3. How has DHCS worked with non-county stakeholders in the development of this methodology?
4. What is DHCS's view on how this growth account funding could be used to incentivize counties to increase utilization of specialty mental health and Drug Medi-Cal services?

2. Drug Medi-Cal Waiver Implementation (DOF ISSUE 001-MR)

Budget Issues. The May Revision requests the authority to establish 13 permanent full-time positions, additional training funds, and limited-term contract funding for an External Quality Review Organization (EQRO) to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS). Details on the proposed funding for this request are displayed in the chart below.

Table: Summary of Proposed Request

Proposed	FY2015-16	FY2016-17	FY2017-18	FY2018-19	FY2019-20	Total
Personal Services:						
13.0 Perm Positions	$ 1,290,000	$ 1,290,000	$ 1,290,000	$ 1,290,000	$ 1,290,000	$ 6,450,000
Operating Expenses and Equipment (OE&E):						
Staff OE&E	$ 366,000	$ 249,000	$ 249,000	$ 249,000	$ 249,000	$ 1,362,000
EQRO Contract	$ 500,000	$ 2,300,250	$ 2,300,250	$ 2,300,250	$ 2,300,250	$ 9,701,000
Technical Assistant Training (Contract)	$ 1,000,000	$ 1,000,000	$ 500,000	$ 500,000	$ 500,000	$ 3,500,000
Total per FY	$ 3,156,000	$ 4,839,250	$ 4,339,250	$ 4,339,250	$ 4,339,250	$21,013,000

In addition, the May Revision proposes the following budget bill language:

> Add the following provision to Item 4260-001-0001:
>
> X. Of the appropriation in Schedule (1), $1,578,000 may not be expended until the Centers for Medicare and Medicaid Services approval is received for the Drug Medi-Cal Organized Delivery System 1115 Demonstration Waiver.
>
> Add the following provision to Item 4260-001-0890:
>
> X. Of the appropriation in Schedule (1), $1,578,000 may not be expended until the Centers for Medicare and Medicaid Services approval is received for the Drug Medi-Cal Organized Delivery System 1115 Demonstration Waiver.

Proposed Drug Medi-Cal Waiver. As previously discussed by the Subcommittee, DHCS is pursuing a DMC Organized Delivery System Waiver as an amendment to the current Section 1115 Bridge to Reform Demonstration Waiver. DHCS proposes this wavier amendment to demonstrate how an organized system of care for substance use disorder care would increase successful outcomes for DMC beneficiaries. The state's proposal is currently under federal CMS review. According to DHCS, CMS

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to only approve six of the 13 requested positions as the workload justification for these positions appears exaggerated. For example, DHCS proposes that it would take 25 days (200 hours) to prepare for each quarterly Waiver Advisory Group meetings. DHCS has also used the assumption that all 53 counties that have expressed interest will apply and fails to account for its own phased-in approach. Additionally, many of the proposed workload activities are one-time in nature, such as the review and approval of county

implementation plans, which would only occur once. It is recommended to approve the proposed budget bill language.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide an overview of this request.
2. When does DHCS plan to release the updated terms and conditions of this proposed waiver?
3. When does DHCS anticipate federal action on the proposed waiver?

3. Drug Medi-Cal Residential Treatment Services

Budget Issue. The May Revision includes $47 million ($14.8 million General Fund) for the provision of residential treatment services in Drug Medi-Cal. This estimate assumes the approval of the Drug Medi-Cal Waiver by June 30, 2015 and that 22 counties will begin providing residential treatment services in the budget year, with 11 counties starting in September.

Background. As part of the Drug Medi-Cal waiver proposal, DHCS has indicated that it has received informal approval from CMS that under this waiver proposal, the Institutions for Mental Disease (IMD) payment exclusion would not apply for counties that opt-into this demonstration. Consequently, federal funds would be available to provide residential treatment services to all eligible adults and inpatient voluntary detox in chemical dependency treatment facilities and freestanding psychiatric facilities.

Additionally, DHCS has indicated that residential treatment providers would not have their Medi-Cal provider enrollment applications processed until the federal Centers for Medicare and Medicaid Services (CMS) has approved the Drug Medi-Cal Waiver.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open. Given past Subcommittee discussions about how long it takes for the Provider Enrollment Division to process provider applications, it is unclear how providers in 11 counties would be able to begin providing residential treatment services. Additionally, even if CMS approves the waiver before the end of June, counties must first complete their implementation plans and DHCS must approve these plans. Consequently, it is highly unlikely that these services would commence in September and at the level projected in the budget year.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide an overview of this request.
2. Please explain why DHCS is confident that residential treatment services will be provided in 11 counties starting in September.

4. Medi-Cal: Caseload Update

Budget Issue. The May Revision projects total Medi-Cal expenditures in 2015-16 to be $91.3 billion ($18.2 billion General Fund) which is an increase of $9.6 billion ($650.3 million General Fund) as compared to the Governor's January budget. It is projected that 12.1 million individuals will be enrolled in Medi-Cal in 2014-15 and 12.4 million in 2015-16. See tables below for funding details.

Table: January to May Revision Comparison

	January	**May Revision**	
	2015-16	**2015-16**	**Difference**
Benefits	$91,331,800,000	$87,040,600,000	-$4,291,200,000
County Administration	$3,617,300,000	$3,789,600,000	$172,300,000
Fiscal Intermediaries	$463,300,000	$475,300,000	$12,000,000
Total	**$95,412,400,000**	**$91,305,400,000**	**-$4,107,000,000**
General Fund	$18,610,500,000	$18,171,800,000	-$438,700,000
Federal Funds	$61,637,100,000	$59,111,800,000	-$2,525,400,000
Other Funds	$15,164,700,000	$14,021,800,000	-$1,142,900,000

Key adjustments to the Governor's January budget included in the May Revision are:

- **Children's Health Insurance Program (CHIP) Enhanced Federal Matching Rate.** The May Revision reflects a $381.1 million General Fund offset due to the enhanced federal matching rate for the Children's Health Insurance Program (CHIP) from 65 percent to 88 percent starting October 1, 2015 (through September 2017). The full year estimate of this offset is $650 million. According to DHCS, the $381.1 million reflects that this enhanced rate is in effect for only part of 2015-16 and considers lags based on date of service and date of payment.

- **Managed Care Rate Adjustment.** An increase of $125 million General Fund related to increases in managed care rates.

LAO Findings on Caseload. The LAO raises concerns regarding the Medi-Cal caseload estimate, but does not recommend any adjustments at this time. The LAO's concerns include that DHCS does not account for how the improving economy would impact caseload (fewer people become or remain eligible for Medi-Cal).

LAO Findings on CHIP Funding. The LAO finds that the Administration's full year estimate of CHIP savings ($650 million) is reasonable. It notes that the budget year estimate ($381 million) is more difficult to assess as the method the Administration used to determine the lags between date of service and date of payment is not transparent. Additionally, the LAO points out that the Administration did not use the enhanced CHIP matching rate for administrative costs associated with CHIP. DHCS indicates it

is awaiting federal guidance regarding this question. If the state is able to claim the enhanced CHIP rate for administrative expenses, the General Fund savings would likely be in the low millions to tens of millions dollars higher.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the May Revision caseload estimate, with any changes to conform as appropriate to other actions taken by the Subcommittee.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide an overview of the May Revision adjustments to the Medi-Cal caseload and budget.
2. Please explain how DHCS considered payment lags in regard to the CHIP budget year savings.

5. Medi-Cal: County Administration Augmentation (DOF ISSUE 515-MR)

Budget Issue. The May Revision proposes to increase Medi-Cal county administration funding by $150 million ($48.8 million General Fund) due to ongoing implementation issues related to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) information technology system built to implement the federal Affordable Care Act (ACA). This augmentation would fund county administration at the current year level for ACA-related workload at $390 million ($195 million General Fund).

Background. Beginning with the 2013-14 budget and each year since, counties have received supplemental funding related for eligibility determination workload related to the ACA. SB 28 (Hernandez) Chapter 442, Statues of 2013, directs DHCS in consultation with the counties and County Welfare Directors Association (CWDA) to design and implement a new budgeting methodology for county administrative costs that reflects the impact of the ACA on county administrative work and present that methodology to the Legislature no later than March 2015. The new county budget methodology is intended to be an improved process that will include specific reviews of annual time studies, claimed expenditures, and other data metrics. This new methodology has not yet been developed given the issues with CalHEERS and the process workarounds necessary to determine eligibility. DHCS indicates it has begun collecting data to develop this methodology.

Subcommittee Staff Comment and Recommendation—Hold Open. Counties have raised concerns that the proposed level of funding will not enable counties to perform the eligibility-related workload necessary to ensure program integrity and delivery quality customer service. Additionally, counties are requesting the development of the new methodology, pursuant to SB 28, to be used in for the 2016-17 budget. It is recommended to hold this item open as discussions continue on this topic.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide a review of this proposal. What is the basis for the $150 million augmentation?

2. How did DHCS work with counties on developing this estimate?

3. What is DHCS's proposed timeline to implement a new budgeting methodology?

6. Medi-Cal: Impact of President's Executive Order (DOF ISSUE 521-MR)

Budget Issue. The May Revision includes $33.1 million ($27.8 million General Fund) to reflect the costs of providing Medi-Cal to newly qualified individuals as a result of the President's Executive Order on immigration. However, this number has been revised by the Administration and the estimated cost for this proposal is $41.5 million ($33.2 million General Fund) in 2015-16 and $206 million ($165.2 million General Fund) on an ongoing basis. These numbers were revised to include dental and managed care carve-outs in the per member per month rate (revised from $242.09 to $274.54).

The Administration assumes that beginning October 1, 2015, individuals that qualify under the President's order will begin enrolling in Medi-Cal and that it would take 12 months to reach full enrollment. The following assumptions are then used:

Total Eligible for Anticipated DACA/DAPA in California less total Eligible for DACA/DAPA in DHCS existing undocumented population.	1,221,283
Based on past experience with DACA, estimate that 55% of those immediately eligible will apply for DACA.	55.00%
Total Applicants for Anticipated DACA/DAPA.	671,706
Based on past experience with DACA, estimate that approximately 80% of those who apply will be approved.	80.80%
Total Approved Applicants for Anticipated DACA/DAPA (parents/guardians and expanded children).	542,792
Estimated approved DACA/DAPA population with incomes less than 138% FPL.5	43.80%
Universe of those under 138% FPL, who are eligible for Medi-Cal.	**237,635**
A 10 percent take-up rate for this population is assumed.	**23,763**
Estimated FY 2015-16 Average Monthly Undocumented Population6	701,433
Percentage of undocumented Californian's eligible for DAPA/DACA. 10	50%
Total Eligible for DACA/DAPA.	350,717
Based on past experience with DACA, estimate that 55% of those immediately eligible will apply for DACA.	55.00%
Total Applicants for Anticipated DACA/DAPA.	192,894
Based on past experience with DACA, estimate that approximately 80% of those who apply will be approved.	80.80%
Estimated Undocumented population currently on Medi-Cal that would be approved for DACA/DAPA.	**155,874**
A 50 percent take-up rate for this population is assumed.	**77,937**
TOTAL	**101,700**

Background. The President's executive actions expand the Deferred Action for Childhood Arrivals (DACA) program and create the Deferred Action for Parents of Accountability (DAPA) program (also known as the Deferred Action for Parents of Americans and Lawful Permanent Residents program) as follows:

- ***Expands DACA Program.*** Previously, undocumented individuals who were younger than 31 years of age as of June 2012, had entered the United States prior to the age of 16, and had lived in the United States continuously since January 1, 2010, were eligible for DACA. The President's executive actions expand the population eligible for DACA to include people of any age who entered the United States before the age of 16 and meet the other DACA requirements. The President's executive actions also extend the period of DACA eligibility and work authorization from two years to three years.

- ***Creates DAPA Program.*** The President's executive actions also create the DAPA program, which allows undocumented immigrants who have lived in the United States continuously since January 1, 2010 and are parents of United States citizens or lawful permanent residents to request deferred action and work authorization for three years.

A lawsuit was filed in February by officials of 26 states who contend the President's executive actions violated the United States Constitution as an overreach of executive powers. The suit seeks an order blocking the immigration changes from taking effect. Initial arguments in the suit were heard by a United States district judge on January 15, 2015, where the states asked the judge to block the executive actions until they have been able to challenge the actions in court. The judge has halted implementation of the President's actions. Officials from 12 states, including California, and the District of Columbia recently filed an amicus or "friend of the court" brief supporting the President's executive actions.

LAO Findings. The LAO notes that there are significant uncertainties with regard to the executive actions in that it is unclear when and if the President's actions may be implemented, many eligible for this program may not enroll, and individuals would have to proactively enroll into Medi-Cal. Additionally, the LAO finds that the Administration's estimated expenditures for this proposal are likely overstated because the enrollment phase-in is likely to take longer than estimated by the Administration.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide a review of this proposal and the assumptions used to develop this estimate.

7. Coordinated Care Initiative: Multipurpose Senior Services Program Transition Timeline

Budget Issue. Current statute authorizing the Coordinated Care Initiative (CCI) states that the Multipurpose Senior Services Program (MSSP) will transition from a federal waiver to a managed care benefit after 19 months of MSSP beneficiary enrollment into managed care. This proposal will extend the transition deadline to December 31, 2017, but would allow an earlier transition in a county or region when the MSSP sites and managed care plans mutually agree they are ready to transition and want to transition early; in addition both the MSSP sites and managed care plans would have to demonstrate that they have met readiness criteria that is developed by DHCS, California Department of Aging (CDA), MSSP providers, managed care plans and stakeholders.

Background. MSSP beneficiary managed care enrollment was staggered with CCI counties; however, a majority of the CCI counties plan to integrate MSSP as a managed care benefit beginning May 1, 2017. During MSSP integration, there have been operational issues that slowed the transition of the MSSP benefit into managed care. After the MSSP transition, MSSP will no longer operate as a federal 1915(c) waiver in CCI counties for eligible Medi-Cal beneficiaries enrolled in Medi-Cal managed care but will be a managed care benefit authorized and managed by Medi-Cal managed care plans. Other Medi-Cal beneficiaries ineligible to enroll in Medi-Cal managed care, and non-CCI counties, may receive MSSP through Fee-For-Service under the 1915(c) waiver.

Concerns have been raised that the transition timeline is too short due to insufficient time to resolve outstanding operational issues between the managed care plans and the MSSP providers. According to DHCS, it is their intent to transition MSSP only upon managed care plans' and MSSP providers' mutual agreement that both entities demonstrate readiness to fully integrate the MSSP benefit. The proposed language also requires DHCS to notify the appropriate fiscal and policy committees of the Legislature 30 days in advance of the MSSP services transition to a managed care plan benefit in CCI counties.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide a review of this proposal.

8. Medi-Cal: Behavioral Health Treatment (DOF ISSUE 524-MR)

Budget Issue. The May Revision proposes expenditures of $27.1 million ($13.6 million General Fund) in 2014-15 and $201.6 million ($100.8 million General Fund) in 2015-16 for the provision of behavioral health therapy (BHT) series to eligible Medi-Cal children with autism spectrum disorder (ASD). The projected number of Medi-Cal children receiving BHT in 2014-15 is 1,500 and 7,000 in 2015-16. This does not include children who may transition from receiving BHT through the regional centers. The department anticipates finalizing the rate for BHT services in Medi-Cal managed care in June.

Additionally, DHCS requests the following language to transfer funds from the Department of Developmental Services to DHCS as children transition from receiving BHT through regional centers to receiving these services through Medi-Cal:

> Add the following provision to Item 4260-101-0001 (similar language is proposed for item 4300-101-0001):
>
> X. The Department of Finance may authorize the transfer of expenditure authority from Item 4300-101-0001 Schedule (2) 4140019 Purchase of Services to this item to support the transition of current Medi-Cal eligible regional center clients receiving Behavioral Health Treatment services upon completion of the statewide transition plan.
>
> The Director of Finance shall provide notification to the Joint Legislative Budget Committee of any transfer of expenditure authority approved under this provision not less than 30 days prior to the effective date of the approval. The 30-day notification shall include a description of the transfer, including the number of children affected and assumptions used in calculating the amount of expenditure authority to be transferred.

Transition Plan. DHCS and DDS are in the processing of developing a transition plan that will describe how children receiving BHT services at regional centers will transition to receiving these benefits through Medi-Cal. DHCS plans to release a draft version of this transition plan on May 22nd at its next BHT Stakeholder Workgroup meeting.

Number of Children by County Currently Receiving BHT in Medi-Cal. At its April 23rd Subcommittee hearing, the Subcommittee requested information on the number of children receiving BHT through Medi-Cal since implementation of this as managed care benefit on September 15, 2014. Below is a chart from DHCS reflecting this information as of May 5, 2015.

Table: Number of Children Receiving BHT in Medi-Cal, as of May 5, 2015

County	# of Beneficiaries Receiving BHT Services
Alameda	73
Alpine	0
Amador	0
Butte	0
Calaveras	<11

County	# of Beneficiaries Receiving BHT Services
Colusa	0
Contra Costa	15
Del Norte	0
El Dorado	<11
Fresno	16
Glenn	0
Humboldt	0
Imperial	0
Inyo	0
Kern	<11
Kings	0
Lake	0
Lassen	0
Los Angeles	89
Madera	<11
Marin	<11
Mariposa	0
Mendocino	0
Merced	16
Modoc	0
Mono	0
Monterey	22
Napa	0
Nevada	0
Orange	330
Placer	15
Plumas	0
Riverside	75
Sacramento	87
San Benito	0
San Bernardino	62
San Diego	12
San Francisco	<11
San Joaquin	31
San Luis Obispo	<11
San Mateo	<11
Santa Barbara	15
Santa Clara	48

County	# of Beneficiaries Receiving BHT Services
Santa Cruz	<11
Shasta	<11
Sierra	0
Siskiyou	<11
Solano	37
Sonoma	<11
Stanislaus	<11
Sutter	<11
Tehama	0
Trinity	0
Tulare	<11
Tuolumne	0
Ventura	<11
Yolo	<11
Yuba	<11

Subcommittee Staff Comment and Recommendation—Approve Budget Bill Language (BBL). It is recommended to approve the revised cost estimates related to providing BHT in Medi-Cal. Additionally, it is recommended to modify the proposed BBL to require the departments to provide more information about the transfer amount. The modified BBL is noted below:

Add the following provision to Item 4260-101-0001:

X. The Department of Finance may authorize the transfer of expenditure authority from Item 4300-101-0001 Schedule (2) 4140019 Purchase of Services to this item to support the transition of current Medi-Cal eligible regional center clients receiving Behavioral Health Treatment services upon completion of the statewide transition plan.

The Director of Finance shall provide notification to the Joint Legislative Budget Committee of any transfer of expenditure authority approved under this provision not less than 30 days prior to the effective date of the approval. The 30-day notification shall include a description of the transfer, including the number of children **per regional center** affected, the **cost difference per regional center client compared to the cost per Medi-Cal enrollee,** and assumptions used in calculating the amount of expenditure authority to be transferred.

Item 4300-101-0001

X. The Department of Finance may authorize the transfer of expenditure authority from Schedule (2) 4140019-Purchase of Services to Item 4260-101-0001 to support the transition of current Medi-Cal eligible regional center clients receiving Behavioral Health Treatment services upon completion of the statewide transition plan.

The Director of Finance shall provide notification to the Joint Legislative Budget Committee of any transfer of expenditure authority approved under this provision not less than 30 days prior to the effective date of the approval. The 30-day notification shall include a description of the transfer, including the number of children **per regional center** affected, the **cost difference per regional center client compared to the cost per Medi-Cal enrollee,** and assumptions used in calculating the amount of expenditure authority to be transferred.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide a review of this proposal and the assumptions used to develop this estimate.

2. Please provide an update on the transition planning.

9. Medi-Cal: Enrollment Application Assistance Payments

Budget Issue. The May Revision proposes trailer bill language to:

- Reallocate any remaining funds for Medi-Cal application assistance payments, for eligible applications submitted through June 30, 2015, to county outreach and enrollment grants.

- Extend the date by which county outreach and enrollment grant funds can be spent from June 30, 2016 to June 30, 2018.

Section 70 of AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, authorized in-person enrollment application assistance payments of $58 per approved Medi-Cal application. This provision sunsets on June 30, 2015. Once all in-person enrollment assistance payments have been made for the approved Medi-Cal applications received through June 30, 2015, this proposal would reallocate any remaining funds to the county outreach and enrollment grants authorized under Section 71 of SB 101 (Committee on Budget and Fiscal Review),Chapter 361, Statutes of 2013. This proposal would also extend the date by which these county grant funds could be allocated to June 30, 2018.

Of the $23.5 million dedicated to county outreach and enrollment grants, as of April 2015, approximately $3.8 million has been distributed to counties. Under current law, these funds must be fully expended by June 30, 2016.

Background. Section 70 of AB 82 authorized DHCS to accept contributions by private foundations, specifically The California Endowment (TCE), in the amount of $14 million. These funds were matched with federal funds and provided a total of $28 million for in-person enrollment application assistance. Section 71 of SB 101 authorized DHCS to accept private contributions by private foundations, specifically TCE, in the amount of $12.5 million. These funds were also matched with federal funds and provided a total of $25 million for county outreach and enrollment grants.

Covered California (CC) currently administers payments to Certified Enrollment Entities (CEEs) for in-person enrollment assistance for individuals who apply for insurance affordability programs, are found eligible, and enroll in either Medi-Cal or a CC Qualified Health Plan. In addition, CC pays Certified Insurance agents (agents) for applications that result in a Medi-Cal eligibility determination. Agents receive compensation from health plans for Qualified Health Plan enrollment. CC currently holds contracts with more than 900 CEEs and nearly 15,000 agents. CC has an Interagency Agreement with DHCS, which provides funding for the $58 payments made to agents and CEEs and also provides reimbursement for a portion of CC's cost to administer the application assistance program.

Beginning July 1, 2015, CC is implementing a new payment model for Qualified Health Plan enrollment assistance work under the Navigator Grant Program. The Navigator Program is required pursuant to federal Exchange regulations, but does not provide compensation for applications with Medi-Cal eligible individuals. CC will no longer be providing application assistance payments to CEEs and agents for applications with Medi-Cal eligible individuals received after June 30, 2015. CC confirmed that it will make the payments to assisters for valid Medi-Cal applications received through June 30, 2015.

Of the $28 million dedicated to agents and CEEs for Medi-Cal applications, as of April 2015, $18.2 million has been identified for applications submitted October 2013 through December 2014. Based on current enrollment trends, DHCS estimates CC will pay out an additional $7.3 million through June 30, 2015. This would leave approximately $2.5 million in remaining funding for Medi-Cal assistor payments unspent.

Of the $23.5 million dedicated to county outreach and enrollment grants, as of April 2015, approximately $3.8 million has been distributed to counties. Under current law, these funds must be fully expended by June 30, 2016.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt the proposed placeholder trailer bill language.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide an overview of this request.
2. Is there a backlog in Medi-Cal application assistance payments? If so, what is it? How does DHCS plan to address this backlog?

10. Medi-Cal: Ground Emergency Medical Transportation Supplemental Reimbursement Program – Trailer Bill Language

Budget Issue. The May Revision proposes trailer bill language (TBL) to modify the existing ground emergency medical transportation (GEMT) Supplemental Reimbursement Program in order to maximize federal financial participation for public GEMT provider's services, subject to federal approval. This new mechanism would have no impact to the General Fund.

Background. Welfare and Institutions (W&I) Code §14105.94, as enacted on October 2, 2011, authorized the GEMT supplemental reimbursement program. This voluntary Certified Public Expenditure (CPE) based program provides additional funding to eligible governmental entities that provide GEMT services to Medi-Cal beneficiaries. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 09-024 on September 4, 2013, authorizing the federal share of the supplemental reimbursement payments based on uncompensated costs for Medi-Cal fee-for-service (FFS) transports, effective January 30, 2010.

Since its inception, the GEMT supplemental reimbursement program has provided approximately $45.6 million (federal funds) in additional reimbursements to GEMT providers for their uncompensated care costs.

AB 2577 (Cooley) from the 2014 legislative session would have required DHCS to develop an intergovernmental transfer (IGT) funded program to increase capitation rates to health plans for GEMT services. AB 2577 was vetoed by the Governor; in the veto message the Governor directed DHCS to continue to work on options that would maximize funding for GEMT services in a manner that was operationally possible.

As directed by the Governor's veto message for AB 2577, DHCS indicates it continued to work on potential options for increasing federal funding to public GEMT providers. DHCS determined that the program construct of AB 2577 was not possible to implement and instead is proposing to develop a modified GEMT program in FFS, in collaboration with the GEMT stakeholders.

Under the current GEMT methodology, funded through CPEs, participating providers are limited to supplemental reimbursement up to Medi-Cal allowable costs. These costs may not reflect the GEMT provider's full cost of providing the transport to a Medi-Cal beneficiary. Modifying the existing GEMT supplemental payment methodology to utilize IGTs will allow the providers to receive supplemental reimbursement up to the maximum allowed under federal Medicaid rules, which is generally comparable to the rates they receive from commercial payers, likely higher than the Medi-Cal allowable costs, thus providing additional federal funds to GEMT providers.

SB 534 (Pan), set for hearing in the Senate Appropriations Committee on May 18 requires the DHCS to design and implement an intergovernmental transfer program for public Medi-Cal managed care ground emergency medical transport services in order to increase Medi-Cal capitation payments to Medi-Cal managed care plans for the purpose of increasing Medi-Cal reimbursement to public ground emergency medical transport services providers; permits DHCS to provide supplemental Medicaid reimbursement

for the cost of paramedic services at a rate of payment equal to cost through the use of certified public expenditures. SB 534 is also intended to address the issues raised in the Governor's veto message.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide an overview of this request.

11. Major Risk Medical Insurance Program Reconciliation Process

Issue. As discussed at the April 23rd Subcommittee hearing, DHCS is in the process of reconciling Major Risk Medical Insurance Program (MRMIP) and Guaranteed Issue Pilot (GIP) actual plan expenditures and claims with what the state already paid these plans. There is currently a four-year backlog in the reconciliation process. Consequently, it is unknown how much the state may owe plans or how much plans may owe the state. The Administration estimates that on the net of both programs' reconciliations, the state would receive an increase in funding.

Subcommittee staff requested technical assistance from the Administration on methods to facilitate and expedite the reconciliation process. It is important to expedite this process, so that the state has an understanding of the true balance of the Managed Risk Medical Insurance Fund (MRMIF).

In order to expedite this process, the Subcommittee may want to consider trailer bill language that would:

- Specify that DHCS and the plans consult on the reconciliations.
- If DHCS and a plan do not reach an agreement, DHCS has the authority to provide notification to the plan of the final determined amount.
- The plan has 60 days to repay DHCS.
- If the plan does not repay in 60 days:
    - Interest begins to accrue
    - DHCS can offset the repayment amount from other payments to the plan.
    - DHCS can enter into a repayment agreement with the plan and can choose to waive interest.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide a review of the technical assistance provided to the Subcommittee.

12. Health Home Program (DOF ISSUE 522-MR)

Budget Issue. The May Revision proposes trailer bill language (TBL) to provide DHCS with the authority to establish a Health Home Program (HHP) Account in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds, to be expended upon appropriation by the Legislature, for the purposes of implementing the HHP pursuant to AB 361 (Mitchell), Chapter 642, Statutes of 2013.

Background. The Medicaid Health Home State Plan Option is afforded to states under the federal Affordable Care Act (ACA) allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS), and other community-based services needed by beneficiaries with chronic conditions.

AB 361 authorizes DHCS, subject to federal approval, to create an ACA HHP for beneficiaries with chronic conditions. The HHP will serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. Health Homes provide six core services: comprehensive care management; care coordination (physical health, behavioral health, and community-based LTSS); health promotion; comprehensive transitional care; individual and family support; and referral to community and social support services. AB 361 provides that its requirement shall not be implemented unless federal financial participation is available and that the program is cost neutral regarding state General Funds. AB 361 also requires that if DHCS implements the program, DHCS must ensure that an evaluation of the program is completed and that DHCS submits a report to the appropriate policy and fiscal committees of the Legislature two years after implementation of the program.

Federal matching funds at 90 percent would be available for eight quarters. Federal matching funds would be available for staffing and contractor services at 50 percent. Foundation funding would be available to provide the non-federal share during the first eight quarters of HHP. Any unexpended funds within the HHP Account, within the Special Deposit Fund from a local government, foundation or other organization will be returned to the entity.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt this placeholder trailer bill language to ensure DHCS has the ability to receive foundation funding to support this program.

Questions. The Subcommittee has requested DHCS to respond to the following:

1. Please provide a review of this proposal, including a description of the targeted population, the total funding and how it will be allocated.

2. Has DHCS secured non-General Fund funding for this program?

3. Please provide a review of the proposed timeline and implementation of the Health Home Program?

4. Please describe the stakeholder process used in the development of this program.

0530 California Health and Human Services Agency

4260 Department of Health Care Services

4265 Department of Public Health

1. High Cost Drug Proposal (DOF ISSUE 521-MR and 400)

Budget Issue. The May Revision proposes to allocate funding for the treatment of Hepatitis C (HCV) to various state departments as noted in the table below. The May Revision also proposes to eliminate the $300 million General Fund reserve that was proposed in the January budget for HCV treatment and eliminate Budget Bill Control Section 8.75 that provided for this reserve.

Tables: Summary of Hepatitis C Treatment Costs in Various State Departments

2015-16 Budget Year			
Departments	General Fund @ GB	General Fund @ MR	Difference
Health Care Services	65.3	126.0	60.7
Corrections & Rehabilitation	10.0	70.6	60.6
State Hospitals	0.0	6.3	6.3
Public Health (ADAP)	0.0	0.0	0.0
CS 8.75/Org 5209	200.0	0.0	-200.0
Total	275.3	202.9	-72.4

2014-15 Current Year			
Departments	General Fund @ GB	General Fund @ MR	Difference
Health Care Services	65.3	113.7	48.4
Corrections & Rehabilitation	10.0	61.7	51.7
State Hospitals	0.0	0.0	0.0
Public Health (ADAP)	0.0	0.0	0.0
CS 8.75/Org 5209	100.0	0.0	-100.0
Total	175.3	175.4	0.1

Additionally, the May Revision indicates that the agency will convene two workgroups with state departments and local entities to discuss clinical and procurement issues with the goal of developing a proposal for inclusion in the 2016-17 budget.

Department of Health Care Services (DHCS) – Revised HCVC Clinical Guidelines. The May Revision indicates that DHCS plans to update its HCV policy to include newly FDA-approved drugs and include people with less advanced stages of the disease (including State 2). The new policy will include HCV patients, regardless of stage, who also have diabetes, HIV, Hepatitis B, debilitating fatigue,

a desire to become pregnant, and other co-morbid conditions. The May Revision includes $13.4 million ($6.7 million General Fund) for the increased costs to account for this expansion of clinical guidelines.

Department of Public Health – Revised HCV Clinical Guidelines. The Office of AIDS (OA) proposes to expand access to HCV medications to include all HCV co-infected ADAP clients, regardless of liver disease stage. According to DPH, this policy is in alignment with the federal Health and Human Services guidelines for treating HCV co-infection among HIV-infected persons and the revised Department of Veteran Affairs' HCV clinical guidelines, which recommend that all HIV/HCV co-infected patients be treated. HIV co-infection accelerates liver disease progression among HCV-infected persons.

For the January budget, OA estimated that 12 percent of ADAP clients are co-infected with HCV, 32.4 percent of the co-infected clients have F3 or F4 liver disease, and 10 percent of ADAP's co-infected sub-population with F3 or F4 disease would be treated for HCV each FY. However, due to low utilization of the new HCV drugs in 2014-15 to date, this revised estimate is based on actual utilization data pro-rated for the remainder of the current year. Therefore, the 2014-15 estimate is based on providing treatment to clients with F3 or F4 disease only, since OA expects that the transition to providing treatment for all co-infected clients will require a ramp-up time period beginning 2015-16. The updated estimate for 2015-16 is based on the earlier methodology, except that the restriction on treating only patients with F3 or F4 disease was removed, and OA estimates that only five percent of ADAP's co-infected sub-population will be treated for HCV each fiscal year; all HCV co-infected ADAP clients were considered eligible for treatment. Additionally, OA expects to implement preferential utilization of lower cost treatment regimens (e.g., Viekira Pak™) among eligible patients when such regimens are equally effective and no medical contraindications to their use exist; this was included in the estimate calculations.

- 2014-15: OA estimates that 13 clients with F3 or F4 disease will be treated for HCV during FY 2014-15, with an estimated $1.4 million in program expenditures and $107,402 in rebate revenue. The estimated net cost is $1.3 million.

- 2015-16: OA estimates that access to HCV treatment for all ADAP clients will result in 199 clients being treated with $9.9 million in program expenditures and $3.4 million in rebate revenue, for a net cost of $6.5 million.

Subcommittee Staff Recommendation—Approve. It is recommended to approve the adjustments to the Department of Health Care Services and Department of Public Health's budgets reflected above and delete Budget Bill Control Section 8.75.

Questions. The Subcommittee has requested the departments to respond to the following:

1. Please provide a review of this proposal.

2. DHCS: Have you released the updated clinical guidelines to the public? If not, when will these guidelines be released? Will stakeholders have an opportunity to comment on these guidelines?

3. DHCS: How many Medi-Cal individuals will receive HCV treatment under the new clinical guidelines?

4265 Department of Public Health

1. AIDS Drug Assistance Program (DOF ISSUE 007-MR)

Budget Issue. The May Revision proposes a decrease of $5.7 million in federal funds and $20.2 million in ADAP Rebate Fund due to a larger number of ADAP clients transition to Medi-Cal and fewer ADAP clients accessing new Hepatitis C treatment than originally estimated.

Additionally, the May Revision proposes to reallocate $1.5 million Ryan White (RW) base funding to local health jurisdictions and/or community-based organizations to support targeted efforts to re-engage HIV-infected minority clients in medical care and treatment. Both in California and nationwide, minority populations are at a greater risk of not being linked to care and treatment shortly after HIV diagnosis and becoming disengaged from medical care and treatment services. Because HIV-infected persons who have an undetectable viral load due to appropriate treatment have a close to zero risk of transmitting HIV to their partner(s), the greater risk of minority populations being untreated leads to health disparities in HIV viral load suppression, survival, and infection rates. In 2012, only 75 percent of HIV-diagnosed African American Californians in care had a suppressed viral load, as compared with 83 percent of Latinos and 88 percent of non-Hispanic Whites. Linking and re-engaging clients in HIV care and treatment services both improves individual health outcomes and prevents new HIV infections.

Enrollment Workers. Although the addition of health care coverage assistance programs are providing the opportunity for more individuals to obtain health coverage, these programs are complicated and the success of enrollment into these programs is often dependent on enrollment workers who can direct individuals to coverage programs that meet each person's unique needs.

Concerns have been raised that local health jurisdictions and the state Office of AIDS (OA) are not sufficiently funded to ensure enrollment into the various ADAP programs and that the expansion of ADAP programs, such as when the OA-Health Insurance Premium Payment program begins paying medical out-of-pockets costs in 2016, will add to this workload.

Local health jurisdictions (LHJ) are currently allocated $2 million for costs associated with the administration of ADAP enrollment. This funding is allocated based on the number of ADAP clients the LHJ enrolled in the previous year.

Subcommittee Staff Comment and Recommendation. It is recommended to do the following:

- **Approve** the revised ADAP May Revision estimate, including the proposal to reallocate $1.5 million RW base funding to local health jurisdictions and/or community-based organizations to support targeted efforts to re-engage HIV-infected minority clients in medical care and treatment.
- **Augment** the allocation to the local health jurisdictions for ADAP enrollment by $2 million (rebate fund) to be allocated according to the existing formula (the number of ADAP clients enrolled in the previous year).
- **Augment** OA's budget by $1 million (rebate fund) to support efforts to work with enrollment workers, provide technical assistance on improving the ADAP enrollment process, increase

capacity due to the projected changes in the program, and develop quality metrics for the ADAP program.

Questions. The Subcommittee has requested DPH to respond to the following questions:

1. Please provide an overview of the May Revision Proposal.

2. Licensing and Certification Program (DOF ISSUE 201-MR)

Budget Issue. As previously discussed in Subcommittee on March 5th, the Governor proposes:

1. **L&C Workload -** An increase of $19.8 million in 2015-16 for 173 permanent positions and 64 two-year, limited-term positions, for a total of 237 positions (123 positions will become effective July 1, 2015 and 114 positions will begin on April 1, 2016), and an increase in expenditure authority of $30.4 million in 2016-17 from the L&C Special Fund to address the licensing and certification workload. This request attempts to address the L&C's past failures to complete its survery workload and close/complete complaint investigations.

2. **L&C Quality Improvement Projects –** An increase of $2 million in 2015-16 from the Internal Departmental Quality Improvement Account to implement quality improvement projects recommended by Hubbert Systems Consulting for the Licensing and Certification Program.

3. **Los Angeles County Contract -** An increase in expenditure authority of $9.5 million from the L&C Special Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County. This proposal includes $2.6 million to fully fund the current contract positions at current Los Angeles County salary rates, and $6.9 million to fund 32 additional Los Angeles County positions to enable the county to address long-term care facility complaints and entity-reported incidents, and investigate aging long-term care complaints and entity-reported incidents (Tier 1 and Tier 2 federal workload).

4. **Los Angeles County Contract Monitoring –** An increase of $378,000 from the L&C Special Fund and three positions, to provide on-site oversight and perform workload management, training, and quality improvement activities to improve the efficiency and effectiveness of the Los Angeles County contract licensing and certification activities. In order to begin the on-site oversight immediately, the department plans to administratively establish three positions in 2014-15.

May Revision. As part of the May Revision, the Governor proposes to increase the Los Angeles County Contract Proposal (number three above) by $5.3 million to fund (1) a 2-percent salary increase that became effective in October 2014; (2) a 2-percent salary increase that became effective in April 2015; (3) an increase to the fringe benefit rate; (4) an increase to the indirect cost rate; (5) a productive workload adjustment based on 1,760 hours per full-time equivalent position; and (6) consistency with state staff ratios for county field staff. (The total projected contract amount is $36,489,046.) DPH notes that due to the timing of the Governor's budget and ongoing negotiations with Los Angeles County the January budget proposal did not include funding for the above specified purposes.

Subcommittee Staff Comment and Recommendations. The following actions are recommended:

1. **Approve the budget change proposals and make the 64 limited-term positions proposed under "L&C Workload" permanent.** The state makes a significant investment in the training of health facility evaluator nurses (HFENs) and acknowledges that it takes 12 to 14 months for HFEN to complete the training necessary to become proficient and work independently. Consequently, these positions would only be available to actively complete workload for one year, since these positions

are authorized for only two years. Given that L&C's problem is not just closing a backlog of complaints, but also timely investigation and completion of new complaints and surveys and monitoring for compliance with state health facility licensing requirements (which are generally more stringent than the federal requirements), these positions should be permanent. Once the backlog is addressed, these trained and skilled surveyors could be directed to address other workload activities that are not the focus of this Governor's proposal.

2. **Adopt placeholder trailer bill language to establish timeframes to complete complaint investigations at long-term care facilities.** Specifically, this placeholder language would specify that department would be required to:

    a. For A[1] and AA[2] complaints received on or after July 1, 2016, the department shall complete the investigation within 90 days of receipt. This time period may be extend up to an addition 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department shall notify the facility of this extension and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation shall be issued and served within thirty days of the completion of the complaint investigation.

    b. For all other categories of complaints received on or after July 1, 2017, the department shall complete the investigation within 90 days of receipt. This time period may be extend up to an addition 90 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department shall notify the facility of this extension and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation shall be issued and served within thirty days of the completion of the complaint investigation.

    c. Report on an annual basis (in the Licensing and Certification Fee report) data on the department's compliance these new timelines.

3. **Adopt placeholder trailer bill language** allowing for an extension of the 45-day complaint investigation for hospitals due to extenuating circumstances. The department would be required to document the circumstances in its final determination and provide written notice to the facility and complainant of the basis of the extension and the anticipated completion date.

4. **Increase funding (by $1.4 million) to the Long Term Care (LTC) Ombudsman Program at the Department of Aging to facilitate an increase in skilled nursing facility (SNF) complaint investigations and quarterly visits by:**

[1] Class "AA" violations are violations that meet the criteria for a class "A" violation and that the state department determines to have been a direct proximate cause of death of a patient or resident of a long-term health care facility.

[2] Class "A" violations are violations which the state department determines present either (1) imminent danger that death or serious harm to the patients or residents of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom.

a. **Directing $1 million (one-time) from the State Health Facilities Citation Penalties Account to the LTC Ombudsman Program in 2015-16.**

b. **Increasing the licensing and certification fee for skilled nursing facilities to generate $400,000 to support the LTC Ombudsman Program on an ongoing-basis.**

As shown in the table below, since the reduction in funding for the LTC Ombudsman Program in 2008-09, there has been a reduction in the number of SNF complaint investigations and SNF quarterly visits by the LTC Ombudsman Program. As previously discussed by the Subcommittee, it is reasonable to assume that the ombudsman program's presence and advocacy on behalf of SNF residents improves quality of life for these residents and improves a SNF's compliance with state and federal laws. This is because the ombudsman is often able to intervene on behalf of a resident and investigate and resolve complaints before they result in more serious and costly cases of abuse and neglect.

Consequently, in an effort to address L&C problems from another perspective, it is recommended augment funding for the LTC Ombudsman Program in regard to its work at SNFs. While the $1.4 million augmentation does not equal the projected unmet need, the LTC Ombudsman Program also uses volunteers and this infusion of new funding can be used to train and support new volunteers to meet this workload.

Table: Long-Term Care Ombudsman Program Skilled Nursing Facility Workload

	2008-09	2013-14	Difference	Average Hours to Complete	Average Hourly Wage	Cost
SNF Complaints	36,516	24,968	11,548	8	30	$2,425,080
SNF Quarterly Visits	1,280	884	396	7	30	$83,160
						$2,508,240

Questions. The Subcommittee has requested DPH to respond to the following questions:

1. Please provide an overview of the May Revision proposal.

2. Please provide a review of the technical assistance provided to the Subcommittee regarding establishing timelines for complaint investigations and funding for the Long Term Care Ombudsman Program.

3. Genetic Disease Screening Program Prenatal Screening Trailer Bill Language

Budget Issue. The May Revision proposes trailer bill language (TBL) to clarify that private health insurance plans cannot consider the Genetic Disease Screening Program (GDSP) Prenatal Screening Program to be an out-of-network provider. Currently, some private health plans have considered the Prenatal Screening Program to be treated as an out-of-network provider even though it is the sole provider of these services in California. This has resulted in some health plans either denying prenatal services claims or reimbursing only a portion of a total claim, resulting in lower than anticipated collections. GDSP has also been informed by the Department of Managed Care that they cannot balance bill patients.

The GDSP budget reflects a revenue increase of $837,215 in revenue as a result of this proposed TBL.

GDSP is able to collect approximately 98 percent of all fees owed on behalf of Medi-Cal clients (which is approximately 45 percent of the total caseload), and approximately 81 percent of the fees owed by individuals with private insurance. In an effort to increase the collection rate from non-Medi-Cal payers CDPH is introducing the attached Trailer Bill Language (TBL). If this TBL is adopted, GDSP anticipates an increase in the non-Medi-Cal fee collection rate to from 81 percent to 83 percent in 2015-16.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt this proposed trailer bill language to facilitate GDSP's collection of prenatal screening fees from private health plans.

Questions. The Subcommittee has requested DPH to respond to the following questions:

1. Please provide an overview of the May Revision proposal.

4. California Clinical Laboratory Testing

Issue. Stakeholders have raised a concern that changes to the federal Clinical Laboratory Improvement Amendments (CLIA) will no longer allow medical laboratories in California to use the federal quality control option known as the Equivalent Quality Control (EQC). Stakeholders have requested state law be amended to allow for EQC to be used until December 31, 2015. CLIA will prohibit EQC after January 1, 2016.

Background. The Centers for Medicare and Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total, CLIA covers approximately 251,000 laboratory entities. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.

DPH's Laboratory Field Services ensures compliance with state and federal clinical laboratory laws and regulations by performing biannual onsite inspections to ensure accuracy and reliability of laboratory test results and conducting review of laboratory performed proficiency testing results.

Both federal and state laws require laboratories to meet certain quality standards when performing laboratory tests. Among them are standards to ensure the accuracy and reliability of the testing no matter where the testing is performed or what type of testing instrument is used.

Quality control consists of the procedures used to detect errors that occur due to test system failure, adverse environmental conditions and variance in operator performance, as well as the monitoring of the accuracy and precision of the test performance over time.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff has requested technical assistance on this issue. It is recommended to hold this item open as discussions continue on this topic.

Questions. The Subcommittee has requested DPH to respond to the following questions:

1. Please provide an overview of this issue and the technical assistance provided to the Subcommittee.

4800 California Health Benefit Exchange

1. Emergency Regulations and Rulemaking Authority

Budget Issue. The California Health Benefit Exchange (Covered California) proposes trailer bill language in the May Revision to:

a. Extend its current emergency regulations and the exchange board's rulemaking authority for an additional year until January 1, 2017, extends its ability to readopt emergency regulations until January 1, 2020 for emergency regulations adopted prior to the effective date of the Budget Act of 2015, and

b. Provide limited statutory exemptions from the Administrative Procedure Act's (APA) rulemaking requirements for (i) standard plan designs, and (ii) having separate regulations for each procurement.

Background. In 2010, Covered California was granted authority to adopt emergency regulations through January 1, 2016. Emergency regulations must be made permanent within one year, or else they expire. A provision in a 2014-15 budget trailer bill provided a one-year extension of the board's emergency regulations before those regulations needed to be made permanent. However, according to Covered California, changes in federal regulations and marketplace implementation issues continue to require timely adjustments in Covered California's rules and regulations.

Covered California indicates that this proposal will enable Covered California to account for new federal regulations and to continue implementing and updating current policies to respond to market needs. An example of continuing changes in federal regulations is the final federal 2016 Notice of Benefit and Payment Parameters rule, which requires:

- Changes to special enrollment periods and expanded triggering events allowing consumers to select a plan through an exchange during special enrollment periods;
- Changes to termination of coverage provisions, allowing a retroactive termination; and
- Changes to eligibility standards for exemptions.

According to Covered California, failure to extend Covered California's emergency rulemaking authority could lead to inconsistency between federal, state and Covered California regulations, risk litigation, and create uncertainties in eligibility and enrollment for Covered California and Medi-Cal.

Even where federal policy is established, Covered California indicates that it is continuously updating—and in many instances still developing—its implementation policies to account for lessons learned from its first renewal period. With emergency rulemaking authority, Covered California plans to quickly revise its policies to respond to market needs.

Additionally, Covered California is seeking limited statutory exemption from the APA for standard plan designs and from having separate regulations for each procurement.

Covered California is authorized to establish standard benefit plan designs, including copays and deductibles, to allow consumers to compare health care plans on an "apples to apples" basis. To develop its standard plan design, Covered California is required to rely on federal regulations that are updated annually. These updates include changes in the Final Notice of Benefit and Payment Parameters and the Actuarial Value Calculator (AV Calculator). These annual changes result in significant challenges to Covered California's ability to adopt permanent regulations within the necessary timeline. For example, the permanent rulemaking process can take up to a year to complete. However, in 2014, rates for standard plan designs were due May 1, 2014, less than two months after the final AV Calculator was released.

Without an exemption from the permanent rulemaking process, Covered California argues that it would be highly problematic for Covered California to implement policies to standardize insurance products in the individual and small group markets. Therefore, Covered California proposes to remove standard plan designs from the formal rulemaking process. Under this proposal, the standard plan designs would be subject to approval of the board, and must be publicly noticed and discussed during at least two board meetings.

In its enacting legislation, Covered California was granted certain exceptions from the Public Contract Code and from Department of General Services (DGS) oversight in an effort to provide it with flexibility in its contracting and procurements processes. Unlike agencies that are under DGS oversight, Covered California's contracting and procurements processes are not exempt from the rulemaking requirements of the APA.

According to Covered California, one unanticipated consequence of this is that once Covered California's emergency regulation authority ends, it would be required to adopt its competitive solicitations and some of its contracts as permanent regulations before its contracts could be executed. This would create an administrative burden on Covered California because of the excessive amount of time it would take to contract for necessary services.

As an alternative, Covered California proposes a process that would provide it the flexibility of being exempt from the APA's permanent rulemaking requirements, while also promoting transparency in its contracting and procurements processes. Under this proposal, the board would adopt a contracting manual incorporating procurement and contracting policies and procedures that must be followed by Covered California.

Subcommittee Staff Recommendation Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal.

Questions. The Subcommittee has requested Covered California to respond to the following:

1. Please provide a review of this proposal and the need for these extensions.

2. How did Covered California work with stakeholders on this proposal?