AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, APRIL 30, 2018

2:30 P.M. - STATE CAPITOL, ROOM 437

(Please note room change)

ITEMS TO BE HEARD

LIST OF PANELISTS IN ORDER OF PRESENTATION

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEMBER & STAKEHOLDER PROPOSAL FOR FUNDING FOR PECK HEALTH CENTER

PANELISTS

- **Assemblymember Blanca Rubio**
- **Sergio Bautista**, Chief Deputy Director, ChapCare

ISSUE 2: MEMBERS' & STAKEHOLDER PROPOSAL ON LONG-TERM SERVICES & SUPPORTS DATA COLLECTION

PANELISTS

- **Assemblymember Ash Kalra**
- **H. Stephen Kaye, Ph.D.,**
  - Professor, Institute for Health & Aging, Department of Social and Behavioral Sciences, University of California, San Francisco
  - Director and Principal Investigator Community Living Policy Center

ISSUE 3: MEMBER & STAKEHOLDER PROPOSAL ON MEDI-CAL COVERAGE OF CONTINUOUS GLUCOSE MONITORS

PANELISTS

- **Assemblymember Adam Gray**

- **Matthew J. Levine, M.D., F.A.C.E.**
  - Vice President, California Chapter of American Association of Clinical Endocrinologists
  - Scripps Clinic, Division of Diabetes/Endocrinology
  - Endocrinology Fellowship Director, Scripps Clinic/Scripps Green Hospital
  - Voluntary Assistant Clinical Professor of Medicine
  - U.C. San Diego School of Medicine

- **Alexis Ericksen y Garza**
  - Sacramento Teen USA 2018
  - CCS Patient with Type 1 Diabetes

ISSUE 4: STAKEHOLDER PROPOSAL ON MEDICAL INTERPRETERS

PANELISTS

- **Assemblymember Rob Bonta**
- **Brian Allison**, AFSCME

ISSUE 5: MEMBERS' PROPOSAL ON WHOLE GENOME SEQUENCING

PANELISTS

- **Assemblymember Rob Bonta**
- **Assemblymember Brian Maienschein**

ISSUE 6: MEMBERS' & STAKEHOLDER PROPOSAL ON CAREGIVER RESOURCE CENTERS

PANELISTS

- **Assemblymember Dante Acosta**

ISSUE 7: STAKEHOLDER PROPOSAL ON ALS COMMUNITY TREATMENT FUNDING

PANELISTS

- **Fred Fisher**, President and CEO, Golden West Chapter, ALS Association

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 8: DENTI-CAL AND ORAL HEALTH OVERSIGHT

PANELISTS

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Jayanth Kumar**, DDS, State Dental Director, Department of Public Health
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal and Policy Analyst, Legislative Analyst's Office
- **Sonja Petek,** Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 9: STAKEHOLDER PROPOSAL ON STATE ORAL HEALTH PLAN ROLLOVER AUTHORITY

PANELISTS

- **Michelle Gibbons**, Executive Director, County Health Executives Association of California

ISSUE 10: STAKEHOLDER PROPOSAL ON MEDI-CAL COVERAGE OF SILVER DIAMINE FLUORIDE

PANELISTS

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

ISSUE 11: STAKEHOLDER PROPOSAL ON INCREASED MEDI-CAL RATES FOR DENTAL SERVICES FOR HARD-TO-TREAT PATIENTS

PANELISTS

- **Paul Glassman DDS**, MA, MBA Professor and Director, Community Oral Health University of the Pacific, Arthur A. Dugoni School of Dentistry

ISSUE 12: STAKEHOLDER PROPOSAL FOR A HEALTH PLAN OF SAN MATEO MEDICAL DENTAL INTEGRATION PILOT PROGRAM

PANELISTS

- **Trent Smith**, Advocate, Health Plan of San Mateo

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 13: STAKEHOLDER PROPOSAL ON MEDI-CAL RATE INCREASE FOR NON-EMERGENCY MEDICAL TRANSPORTATION

PANELISTS

Steve Horne, California Medical Transportation Association

ISSUE 14: STAKEHOLDER PROPOSAL ON ASTHMA PREVENTION SERVICES

PANELISTS

- **Joel Ervice**, Associate Director, Regional Asthma Management and Prevention

ISSUE 15: STAKEHOLDER PROPOSAL ON DEMOGRAPHIC DATA COLLECTION

PANELISTS

- **Kimberly Chen**, Government Affairs Manager, California Pan-Ethnic Health Network

ISSUE 16: 340B DRUG PRICING PROGRAM TRAILER BILL

PANELISTS

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Amber Ott**, Vice President, Strategic Financing Initiatives, California Hospital Association
- **Britta Guerrero**, Chief Executive Officer, Sacramento Native American Health Center, Inc.
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 17: GENETICALLY HANDICAPPED PERSONS PROGRAM ESTIMATE

PANELISTS

- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office

ISSUE 18: STAKEHOLDER PROPOSAL ON BLOOD CLOTTING FACTOR REIMBURSEMENT

PANELISTS

- **Linda Hurst,** Pharm. D., Vice President, Herndon Pharmacy, Fresno

ISSUE 19: CHILD HEALTH AND DISABILITY STATE-ONLY PROGRAM

PANELISTS

- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office

ISSUE 20: EVERY WOMAN COUNTS PROGRAM ESTIMATE

PANELISTS

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office

ISSUE 21: CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM ESTIMATE

PANELISTS

- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office

ISSUE 22: HOSPITAL QUALITY ASSURANCE FEE BUDGET CHANGE PROPOSAL & TRAILER BILL

PANELISTS

- **Linda Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey,** Senior Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 23: GRADUATE MEDICAL EDUCATION PROGRAM OVERSIGHT & MONITORING BUDGET CHANGE PROPOSAL

PANELISTS

- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 24: FEDERAL MANAGED CARE REGULATIONS IMPLEMENTATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 25: MEDI-CAL PROGRAM INTEGRITY DATA ANALYTICS SPRING FINANCE LETTER

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 26: OMBUDSMAN CUSTOMER RELATIONS MANAGEMENT SYSTEM SPRING FINANCE LETTER

PANELISTS

- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal and Policy Analyst, Legislative Analyst's Office

ISSUE 27: FREE-STANDING NON-HOSPITAL CLINICS SUPPLEMENTAL REIMBURSEMENT PROGRAM AND COMMUNITY TREATMENT FACILITIES PROGRAM TECHNICAL ADJUSTMENT TRAILER BILL

PANELISTS

- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal and Policy Analyst, Legislative Analyst's Office

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEMBER & STAKEHOLDER PROPOSAL FOR FUNDING FOR PECK HEALTH CENTER

PANELISTS

- **Assemblymember Blanca Rubio**
- **Sergio Bautista**, Chief Deputy Director, ChapCare

Public Comment

PROPOSAL

Community Health Alliance of Pasadena (ChapCare) requests $549,802 one-time to support general operations of Peck Health Center in the City of El Monte.

BACKGROUND

ChapCare provided the following background information:

Established in 1995, ChapCare is a 501 (c) (3) non-profit, Federally Qualified Health Center (FQHC), with a mission to provide excellent, comprehensive, and innovative healthcare that is accessible to the residents of the San Gabriel Valley. Since 1998, ChapCare has provided medical services to many low-income, uninsured residents in the area. ChapCare began providing dental services in 2001 and behavioral health services in 2010. The organization now operates 8 health centers in the San Gabriel Valley (including 3 in El Monte/South El Monte). ChapCare provides a "one-stop" shop where patients across all lifecycles can access comprehensive primary healthcare services, including medical and dental care, behavioral health counseling, nutrition and health education, specialty services (optometry and podiatry), pharmacy, and prevention programs. In 2016, ChapCare provided 47,100 medical visits, 9,893 dental visits, and 3,910 behavioral health encounters to 15,145 unduplicated patients.

The primary service area for the proposed project is the eastern portion of El Monte in zip code 91732, the northeast portion of South El Monte in zip code 91733, and Baldwin Park in zip code 91706, located in Los Angeles County Service Planning Area (SPA) 3 – the San Gabriel Valley.

The target population is primarily low-income, Latino, and monolingual Spanish-speaking. In the service area, there are significant barriers to primary healthcare services: poverty (56% live below 200% of the Federal Poverty Level, which is 17% higher than the County and 21% more than the State), lack of insurance (28% of the population are uninsured, which is also higher than the County and State), a lack of

primary care providers (the service area has been designated a Medically Underserved Population (00243 and 00362) and Health Professional Shortage Area (10699906BV)), lack of transportation (SPA 3 has the greatest number of adult residents who have transportation problems keeping them from obtaining medical care), and language barriers.

ChapCare's $549,802 request will support general operations of its state-of-the-art Peck Health Center in the City of El Monte. Requested funds will play a critical role in supporting the expansion of services provided to the historically under- and un-insured residents of El Monte/South El Monte and Baldwin Park. Specifically, general operating support funds will allow ChapCare to expand services at this site to include family planning, pre-natal, and post-natal care, x-ray services, and behavioral health counseling, as well as additional family medicine and dental capacity, and the number of visits provided at our Peck health center in Fiscal Year (FY) 2018-19. Our goal is to provide the following at the site over a 1-year period:

- 6,775 primary care medical visits (i.e. Family Medicine (including Family Planning) and Pediatrics)
- 2,208 specialist medical visits (i.e. Pre-natal and Post-natal care)
- 3,480 dental visits
- 1,205 behavioral health visits

TOTAL PROJECTED VISITS: 13,668

The projected 13,668 visits represent a 478% increase over the 2,363 visits conducted at the Peck site in fiscal year 16-17. This projection of patient growth for Peck is based, in part, on rates of growth in patient visits at the Lime Health Center in Monrovia, which opened in fiscal year 15-16 and has 9 exam rooms as compared to Peck's 11. The projected expansion of visits at Peck in fiscal year 18-19 requires hiring a total of 9.5 new clinical staff member as follows: 1 General Practitioner, 1 OB/GYN, 1 Registered Nurse, 2 Licensed Vocational Nurses, 2 Certified Medical Assistants, 1 X-Ray Technician, and 1 Licensed Clinical Social Worker (to establish Behavioral Health services at the site). Also, the current Care Coordinator, who is a part-time employee, will become full-time.

Peck is projecting to receive $2,432,207 in revenue, which will come from patient fee-for-service reimbursements, as well as government, foundation, and individual donor sources. Expenses at Peck are projected to total $2,982,008, which leaves a funding gap of $549,802. Approximately 64% of these expenses are for personnel, and will be incurred (largely) by the above-listed personnel additions, which must be initiated in order to meet expansion goals and an increase in related fee-for-service reimbursements.

ChapCare hopes to increase the number of patient visits, thus increasing revenue, however this will likely not come to full fruition until the end of fiscal year 2018-19. For this reason, requested funds will play a vital role in bridging the funding gap to increase the number of patients being served at the Peck Health Center.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Rubio and Sergio Bautista present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 2: MEMBERS' & STAKEHOLDER PROPOSAL ON LONG-TERM SERVICES & SUPPORTS DATA COLLECTION

PANELISTS

- **Assemblymember Ash Kalra**
- **H. Stephen Kaye, Ph.D.,**
  - Professor, Institute for Health & Aging, Department of Social and Behavioral Sciences, University of California, San Francisco
  - Director and Principal Investigator Community Living Policy Center

Public Comment

PROPOSAL

Assemblymember Kalra, with the support of many Assemblymembers, and a large coalition of advocacy and labor organizations, request a General Fund allocation of $3 million to fund the collection and analysis of data on long-term services and supports (LTSS) in California.

They propose that the State use these funds to contract with the University of California, Los Angeles to incorporate specific questions on access to, and need for, LTSS in the California Health Interview Survey (CHIS) in the 2019-20 and 2023-24 survey cycles. A portion of the costs of developing and analyzing the data can be matched with federal funds as an allowable Medicaid administrative cost.

BACKGROUND

The Coalition making this request provided the following background information:

The Department of Finance estimates there are 8 million older adults and people with disabilities in California. This population is expected to grow significantly over the next decade. This is due primarily to the aging of the population but is also a result of the growing number of persons with developmental disabilities who are aging out of their systems of care and of persons with traumatic injuries who are surviving their injuries due to advances in medical care.

Accordingly, the number of Californians with self-care difficulties who live in the community in California is projected to double by 2030. Concurrent with this will be a growing need for long-term services and supports, which assist individuals with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping).

California does not collect data to accurately track and plan for these growing needs or the heterogeneous population groups that will experience them. While national surveys collect data on the prevalence of disabilities and cognitive and functional impairments,

these surveys do not provide state and county level estimates of the population needs and uses of LTSS. Additionally, the surveys do not assess the needs for LTSS by income level, age, type of disability, geographic region, or racial or ethnic group.

Without data to identify populations and areas of the state that experience barriers to LTSS access, the state is unable to develop targeted interventions that can improve health status and reduce state expenditures. Studies show that lack of access to LTSS contributes to higher health care needs and increased utilization of health care services. For example, significant percentages of Medi-Cal beneficiaries who have unmet LTSS needs indicate they have limited mobility, making it difficult to get to medical appointments and do household chores. Studies also show that most Medi-Cal beneficiaries experience high rates of utilization of health services before they begin accessing LTSS, which diminish after they begin receiving appropriate levels of LTSS. For this reason, this request will enable the State to better plan for the LTSS needs of its growing population of older adults and people with disabilities of all ages.

The coalition making this proposal includes, but is not limited to:

- UDW
- SEIU
- AARP
- CalPACE
- Disability Rights California
- Alzheimer's Association
- The Arc of California
- California Domestic Workers Coalition
- California Long-Term Care Ombudsman Association

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Kalra and Dr. Stephen Kaye to present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 3: MEMBER & STAKEHOLDER PROPOSAL ON MEDI-CAL COVERAGE OF CONTINUOUS GLUCOSE MONITORS

PANELISTS

- **Assemblymember Adam Gray**

- **Matthew J. Levine, M.D., F.A.C.E.**
  - Vice President, California Chapter of American Association of Clinical Endocrinologists
  - Scripps Clinic, Division of Diabetes/Endocrinology
  - Endocrinology Fellowship Director, Scripps Clinic/Scripps Green Hospital
  - Voluntary Assistant Clinical Professor of Medicine
  - U.C. San Diego School of Medicine

- **Alexis Ericksen y Garza**
  - Sacramento Teen USA 2018
  - CCS Patient with Type 1 Diabetes

Public Comment

PROPOSAL

Assemblymember Gray and a coalition of Endocrinologists (CA-AACE), Diabetic Educators (AADE), diabetes patients and caregivers (DPAC) and the American Diabetes Association (ADA) proposes to add continuous glucose monitors for the treatment of diabetes to the schedule of covered benefits in the Medi-Cal program.

BACKGROUND

The coalition described above provided the following background information:

Assemblymember Gray and the coalition request trailer bill language to amend Section 14132 of the Welfare and Institutions Code, to the extent that federal financial participation is available, and any necessary federal approvals have been obtained, to add continuous glucose monitors and related supplies to the schedule of benefits under the Medi-Cal program for the treatment of diabetes when medically necessary, subject to utilization controls. The trailer bill language would also authorize the Department of Health Care Services to require the manufacturer of continuous glucose monitors to enter into a rebate agreement with the department. In addition, the coalition requests any necessary funding to implement the proposed trailer bill language.

This coalition was formed after Governor Brown's veto of AB 447 by Assembly Member Gray, which was widely supported and passed the California Legislature unanimously in 2017. AB 447 would have amended Section 14132 of the Welfare and Institutions Code, to add continuous glucose monitors and related supplies required for use with those monitors, to the schedule of benefits under the Medi-Cal program for the treatment of

diabetes when medically necessary, subject to utilization controls. In addition, AB 447 would have allowed the Department of Health Care Services to require manufacturers of continuous glucose monitors to enter into a rebate agreement with the department.

Real-time continuous glucose monitoring systems continuously monitor blood glucose levels and use alarms and alerts to inform patients when levels are exceeding or falling below specified thresholds. Continuous glucose monitoring technology can be administered as a stand-alone device or integrated with insulin pump therapy. Continuous glucose monitoring provides information about the direction and magnitude of blood glucose levels, and as a result, facilitates the making of optimal treatment decisions by and for the diabetic patient.

According to a Department of Health Care Services 2015 report Understanding Medi-Cal's High Cost Populations, spending in the Medi-Cal program associated with adult individuals treated for diabetes totaled $3.6 billion, which is approximately 14% of total spending on non-dual eligibles. The report notes that during calendar year 2011, 303,560 Medi-Cal-only individuals were treated for diabetes. The greatest spending was associated with individuals in Medi-Cal Fee-For-Service (FFS), at $1.9 billion in spending. In the FFS population, the most-costly 1%, just 1,006 individuals, generated approximately 13% of total spending or $248 million. The most-costly 5% of the population generated roughly 36% of all spending, while the most-costly 10% generated over 50% of total spending. These high-risk patients would benefit the most from continuous glucose monitors.

The American Diabetes Association (ADA) supports making continuous glucose monitors a Medi-Cal covered benefit because the alarm function of these monitors alerts diabetes patients when their blood levels go dangerously high or dangerously low in a way that traditional, finger stick measurement cannot. Traditional finger stick measurement only shows a snapshot of blood glucose at that moment but does not warn of rapidly rising or falling levels, which is necessary for the patient to make informed, effective decisions in managing their disease. Diabetes patients who use insulin experience disproportionately high rates of emergency room use, instances of hospitalization and mortality. The Centers for Disease Control and Prevention report that in 2014, there were 245,000 emergency room visits for adults experiencing hypoglycemia and 207,000 visits for hyperglycemic crisis. A study published in the American Journal of Managed Care found the mean costs for hypoglycemia visits were $17,564 for an inpatient admission, $1,387 for an emergency department visit, and $394 for an outpatient visit. Continuous glucose monitors can reduce short-term costs to the Medi-Cal program by reducing severe hypoglycemic events in high-risk populations. Most states' Medicaid programs cover continuous glucose monitors because they improve diabetes control and help prevent greater costs associated with hospitalizations and treatment complications.

The California Chapter for the American Association of Clinical Endocrinologists (CA-AACE) is a professional community of physicians specializing in endocrinology, diabetes, and metabolism, committed to enhancing the ability of its members to provide the highest quality of patient care. CA-AACE supports making continuous glucose monitors a Medi-Cal covered benefit because the technology is medically necessary to

treat certain patients with diabetes. Continuous glucose monitors have been shown in medical literature to improve blood glucose control and limit time spent with low blood sugars in adult patients with Type 1 diabetes. A common obstacle faced by people treated for diabetes is hypoglycemia, which occurs when blood sugar levels fall below a threshold. If not treated immediately, hypoglycemia can necessitate emergency medical treatment. Among diabetic patients receiving insulin, approximately 31% of severe hypoglycemic events require emergency services in the form of ambulance transport, emergency department visits, and hospitalizations.

The coalition is concerned that without access to this technology, Medi-Cal patients are denied access to a standard of care available to Californians in virtually all commercial health plans. Moreover, continuity of care is jeopardized for patients with diabetes in the California Children's' Services (CCS) program. CCS covers continuous glucose monitors. Diabetes patients who are well managed and in control will lose access once they transition to Medi-Cal as adults, leading to poorer outcomes and higher costs. The coalition believes that continuous glucose monitors could help lower costs associated with adults treated for diabetes in the Medi-Cal program by aiding patients and their caregivers in making optimal treatment decisions for the diabetic patient.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Gray and Dr. Levine present this proposal, and requests Alexis Ericksen y Garza share her experiences and recommendations.

The Subcommittee also requests DHCS respond to the following:

1. Please clarify whether or CGMs are a covered benefit under Medi-Cal.

2. If the CCS program covers CGMs, while Medi-Cal does not, what happens when a child ages out of CCS and moves into adult Medi-Cal? Will that individual lose coverage of the CGM?

3. Has DHCS looked into how they could better manage diabetes patients who have high hospitalizations rates?

4. Currently, how does a patient obtain a CGM? Are there Medi-Cal guidelines? If so, please describe the guidelines.

5. How many patients to date have been approved for CGM thru Medi-Cal?

6. If Medi-Cal currently covers CGM on a case by case basis, has DHCS observed any discrimination in the awarding or denial of CGM based on racial, geographic, or other characteristics?

Staff Recommendation: No action is recommended at this time.

ISSUE 4: STAKEHOLDER PROPOSAL ON MEDICAL INTERPRETERS

PANELISTS

- **Assemblymember Rob Bonta**
- **Brian Allison**, AFSCME

Public Comment

PROPOSAL

The California Latino Legislative Caucus and AFSCME request trailer bill and budget bill language to modify the medical interpreters program in Medi-Cal, by:

1) Reappropriating the $3 million General Fund that was provided through the 2017 Budget Act; and

2) Clarifying the statute to indicate that DHCS may establish a pilot project *prior to* completion of the required study.

BACKGROUND

AFSCME provided the following background information:

Language barriers in the health care setting can lead to problems including denial or delay of services, complications with medication management and underutilization of preventive services. Communication challenges can also limit clinicians' ability to understand the patient's condition and effectively provide treatment. AFSCME states that the quality of communication between patients and providers is strongly associated with providers' ability to deliver better and safer care for limited-English-proficient (LEP) patients.

- An estimated 6 million Medi-Cal patients need access to an interpreter in order to understand their healthcare providers;

- 26 percent of Californians speak Spanish;

- 6 percent of physicians speak Spanish; and

- Nearly half of all Medi-Cal patients speak a language other than English.

Research done by Interpreting for California documents hundreds of examples of people who have been harmed by language barriers in California hospitals and clinics, including at least five deaths, which they state may have been prevented with better communication between the patients and healthcare providers. Specifically, patients

described how they were unable to provide consent to medical procedures, family members and even children were relied upon for medical interpretation but unable to fully understand the concepts and treatment, how procedures were delayed due to a lack of access to interpreters, and how they were unable to follow treatment plans because they were not communicated clearly.

DHCS states that federal Medicaid law requires interpretation services to be available to all Medi-Cal patients, and that the Medi-Cal program already is meeting the language access needs of beneficiaries. However, these interpretation services typically are not provided in-person by professional interpreters.

AFSCME highlights the availability of enhanced federal matching funds for interpretation services, however DHCS states that this enhanced match is not available through managed care, in which approximately 80 percent of Medi-Cal patients receive care, and that the federal reporting requirements associated with this enhanced federal funding are extremely complex.

The 2016 Budget Act included the following provisional language:

> 4260-101-0001
> 14. Of the funds appropriated in Schedule (3), $3,000,000 is for the support of activities related to a medical interpreters pilot project, study, or both. Expenditure or encumbrance of these funds is contingent upon the chaptering of future legislation authorizing the medical interpreters pilot project, study, or both, and upon approval by the Department of Finance.

Subsequent to the 2016 Budget Act being signed into law, AB 635 (Atkins, Chapter 600, Statutes of 2016) was also signed into law. AB 635 requires DHCS to work with identified stakeholders to conduct a study to identify current requirements for medical interpretation services as well as education, training, and licensure requirements, analyze other state Medicaid programs, and make recommendations on strategies that may be employed regarding the provision of medical interpretation services for Medi-Cal beneficiaries who are limited English proficient (LEP), in compliance with applicable state and federal requirements. Specifically, this bill:

1) Requires the study to assess and make recommendations on pilot projects that would further the objectives of this bill, including funding for those activities and the allowable use of federal funding.

2) Requires DHCS to work with identified stakeholders to establish a pilot project in up to four separate sites to evaluate a mechanism to provide and improve medical interpretation services for LEP Medi-Cal beneficiaries, as specified. Requires DHCS to take into account both the need for those services, and the recommendations from the study.

3) Authorizes DHCS to use or contract with an external vendor or other subject matter experts to implement this bill. Requires DHCS to consult with identified

stakeholders regarding the draft initial scope of work that will be used to seek and evaluate proposals.

4) Requires DHCS, commencing in 2017, during the annual state budget process, to provide an update to the Legislature regarding this bill's implementation.

5) Authorizes DHCS to expend up to $3,000,000 under the Budget Act of 2016, for the support of activities related to a medical interpreters pilot project, study, or both.

6) Authorizes DHCS to seek any available federal funding for support of this bill.

7) Makes the expenditure or encumbrance of the funds under this bill contingent on approval by the Department of Finance.

8) Sunsets this bill on July 1, 2020 and repeals its provisions on January 1, 2021.

This proposal would amend the statute created by AB 635 in order to ensure the timely implementation of the pilot project, and reappropriate the $3 million in order to expend these funds beyond the current encumbrance timeframe.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Bonta and Brian Allison to present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 5: MEMBERS' PROPOSAL ON WHOLE GENOME SEQUENCING

PANELISTS

- **Assemblymember Rob Bonta**
- **Assemblymember Brian Maienschein**

Public Comment

PROPOSAL

Assemblymembers Gloria, Bonta and Maienschein requests $2 million one-time to support a clinical Whole Genome Sequencing (eWGS) pilot project within the Medi-Cal program.

BACKGROUND

Assemblymember Gloria provided the following background information:

The objective of this funding would be to establish a California Clinical pilot project to test 100 Medi-Cal neonatal and other pediatric patients with undiagnosed disease that have remained undiagnosed, or had multiple incorrect diagnoses, over an extended period of time using eWGS as a first line diagnostic test. Ideally this pilot project would be required to report test results quarterly, and include related diagnosis revisions and treatment pathway alterations. This project is expected to demonstrate the value of eWGS in Medi-Cal (both clinically and financially) compared to current standards of newborn and pediatric healthcare assessments.

Enrollment in Medi-Cal surged in the wake of the enactment of the Affordable Care Act. Since 2011, Medi-Cal annually pays for approximately 50 percent of all births in California and insures one-third of the total state population. Racial and ethnic minorities comprise a disproportionate share of Medi-Cal enrollment. Within the population of over 6 million enrollees ages 0 -18, projections indicate there are likely over 150,000 rare, undiagnosed, genetic diseases potentially afflicting Medi-Cal pediatric patients.

The sponsors of this proposal believe that this pilot project will demonstrate a financial and clinical benefit from improved and accelerated accessibility and cost-effectiveness. In short, that genomic sequencing is not "experimental" anymore, and the state should take full advantage of the advances in this sector created by California's own innovators.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Members Bonta and Maienschein present this proposal.

Staff Recommendation: No action is recommended at this time

ISSUE 6: MEMBERS' & STAKEHOLDER PROPOSAL ON CAREGIVER RESOURCE CENTERS

PANELISTS

- **Assemblymember Dante Acosta**

Public Comment

PROPOSAL

Assemblymembers Acosta and Eduardo Garcia request $5,000,000 General Fund for the Department of Health Care Services (DHCS) to create a workforce pilot program to incentivize youth (young adults) to work in respite care for the elderly. The funds would be directed through the Caregiver Resource Centers and will go towards providing a stipend and educational benefits for the participants, as well as administrative costs. It is anticipated that state funds would be leveraged with outside funding.

BACKGROUND

Assemblymembers Acosta and Garcia and stakeholders provided the following background information:

For 40 years, the 11 community-based nonprofit Caregiver Resource Centers have been working to help address the needs of our state's family caregivers of adults affected by chronic health conditions & cognitive impairment, including dementias like Alzheimer's Disease. Each Caregiver Resource Center offers a complement to care provided by families including family counseling, respite care, support groups, legal/financial consultation & caregiver education.

California has been a trailblazer in creating policy to benefit those in need. Currently, approximately 11.6% of California's population includes an unpaid family caregiver, and with 40% of caregivers diagnosed with depression, there is a dire need for respite services to alleviate their burden. Moreover, costs for assisted living facilities and nursing homes reflect 69.7% and 161% of the median annual income of Californians, which is something that most middle and low-income families cannot afford. Incentivizing young adults to provide necessary in-home care and go into health care fields with such a high demand is of paramount importance.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Acosta present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 7: STAKEHOLDER PROPOSAL ON ALS COMMUNITY TREATMENT FUNDING

PANELISTS

- **Fred Fisher**, President and CEO, Golden West Chapter, ALS Association

Public Comment

PROPOSAL

The ALS Association requests $3 million to help support the critical System of Care, both clinic- and community-based, for ALS patients and their caregivers.

BACKGROUND

The ALS Association provided the following background information:

Amyotrophic lateral sclerosis (ALS), often referred to as Lou Gehrig's disease, is a progressive and fatal neuro-degenerative disease. When motor neurons die, the ability of the brain to initiate and control muscle movement is lost. The result is that people with ALS lose the ability to move, speak, swallow and breathe. The life expectancy of a person diagnosed with ALS is 2-5 years, and there is no effective treatment or cure.

There are only two drugs approved by the FDA for ALS, neither are proven to extend life by more than 2-4 months. The only way to meaningfully extend the length and quality of life for people diagnosed with ALS is to provide them with access to The ALS Association's evidence-based model of care. This model of care involves the seamless integration of community and clinic based multidisciplinary services. This "wraparound" model of care is proven to help people diagnosed with ALS to live significantly longer and better than the only FDA approved drugs.

As a result of the passage of SB 1503 (Steinberg, Chapter 409, Statutes of 2008), which was signed into law by the Governor in 2009, this model of care was added to Chapter 7.5 (commencing with Section 104323) to Part 1 of Division 103 of the Health and Safety Code, relating to ALS. The result was the establishment of a System of Care for ALS Patients in California.

Need for State Funding:
California's System of Care is being over-burdened by the growing numbers of people diagnosed with ALS within the State. The ALS Association, in collaboration with its Certified Treatment Centers (ALS specialty care centers as defined in SB 1503) has built the program infrastructure necessary to execute California's System of Care for ALS Patients.

The System of Care is currently funded by only two sources, third-party insurance reimbursement and philanthropy. These sources alone are insufficient to cover the costs of executing the System of Care. Filling this gap in funding is the basis for this request for state funding.

Only some of the costs associated with operating an ALS specialty care center are reimbursable through insurance (Medicare/Medi-Cal/private). Billing codes do not exist to adequately cover reimbursement for all of the multidisciplinary team's activities, nor does it provide funding to cover the role of the nurse coordinator who plays a key role in the execution of the clinic day.

The ALS Association provides funding for the community and clinic-based components of this multidisciplinary model of care. The ALS Association receives no funding from third-party payers. As a result, the Association relies upon philanthropic sources of funding to pay for the services required. Charitable contributions in support of ALS services come largely from people connected to someone with ALS. Thus, the ALS community significantly underwrites the cost of the only model of care that can meaningfully improve and extend their lives.

California is home to more people with ALS than any other state. With a lifetime risk of being diagnosed with ALS at 1:400, and with military veterans being diagnosed at twice the rate of the general population, most California families will know someone affected by ALS. The California Legislature has a track record of addressing the needs of the ALS community, first by establishing the California's System of Care for ALS Patients, and by supporting Proposition 71 to create the California Institute for Regenerative Medicine (CIRM).

California has become home to technology and biotech giants, and now represents the sixth largest economy in the world, largely because of its investment and support for innovation, incubation, and data driven investment. California has the largest ALS specific scientific and healthcare infrastructure in the country. The ALS Association states that funding for California's System of Care for people with ALS will ensure that the state's dedication to science and technology will be matched with the healthcare infrastructure to execute clinical trials while supporting the constituents who depend on new discovery to treat their disease. In addition to all that The ALS Association and its Certified Treatment Center of Excellence partners provide for individuals living with ALS, this partnership also creates the exclusive space where scientific research and the people living with the disease interact in real time to prove the efficacy of potential therapies.

The unique nature of ALS makes clinical trials particularly challenging. California is a leader in drug discovery, innovation, infrastructure, and forward thinkers. Supporters believe that state funding for California's System of Care for people with ALS will enable great strides towards finding a cure while continuing to improve the lives of those living with ALS.

A "Wraparound" Model of Care for the ALS Community:

In alignment with the Standard of Care for ALS as outlined in SB 1503, the ALS Association's evidence-based multidisciplinary wraparound model of care combines medical, community and home-based services and support to help people with ALS live better and longer with the disease. This program is designed to address the medical, social, emotional and financial challenges of living with ALS by providing a continuum of care that emphasizes coordination and collaboration among expert care managers, social workers, and health care providers in clinical, community and home-based settings. This continuum of care also includes opportunities to advance ALS clinical research. Central to the needs of the ALS community is The ALS Association's Chapter's professional Care Management Program, offered in collaboration with ALS specialty clinics.

Key Program Components:

- Each individual with ALS and their family members and caregivers are assigned to one of The ALS Association's experienced and skilled Regional Care Managers to help them address the relentless progression of the disease, including the loss of the ability to move, swallow, speak and breathe.

- Regional Care Managers connect individuals and families to essential information, community resources, educational opportunities, other people with ALS and their families, and access to free loans of durable medical equipment (power wheelchairs, etc.) and technology (augmentative communication devices, speech generating devices, adaptive switches, etc.) necessary to live with ALS.

- Chapter Care Managers also participate as members of multidisciplinary ALS clinic teams throughout the state. As members of the Wraparound team, Care Managers serve as a bridge from the home and community to the broad array of professionals who make up specialty ALS multidisciplinary clinic teams (including neurologists, pulmonologists, speech language pathologists, physical and occupational therapists, etc.), all of whom are essential to the proactive treatment of ALS.

- Through in-home, email, and phone consultations, as well as at clinic visits, ALS Association Regional Care Managers make assessments, troubleshoot, inform and coordinate a treatment plan that is continually updated to respond to the specific and unique needs of every person with ALS with medical partner input.

- Regional Care Managers also advocate with insurance companies and government agencies on behalf of people with ALS and assist with referrals to medical, legal, financial, transportation, in-home health care and counseling services.

- ALS clinics and Centers for ALS care and research combine multidisciplinary medical treatment as well as clinical research opportunities to identify the causes, potential treatments and ultimately, a cure for ALS. During a single clinic visit, a person with ALS is examined by a number of specialists, including a neurologist, nutritionist, respiratory therapist, speech therapist, physical and/or occupational

therapist, social worker and others essential to the care team. A Regional Care Manager is integrated into each affiliated multidisciplinary clinic team to ensure the effective coordination of the clinic visit, treatment plan and follow-up appointments.

- People with ALS are encouraged to visit an affiliated clinic at least every three months to monitor progression of the disease and address medical issues.

- In order to assist people with ALS to remain safe, comfortable, mobile and in communication as the disease progresses, The ALS Association maintains equipment loan libraries that provide essential medical, adaptive and assistive equipment to people with ALS at no charge. This equipment includes costly hospital beds, wheelchairs, Hoyer lifts, respiratory equipment and high-tech communication devices as well as low tech canes, walkers, adaptive switches and alphabet boards. This loan equipment is essential for people with ALS who lack adequate insurance coverage or who experience long waiting periods while customized equipment is assembled and delivered. The equipment loan program features devices that help decrease isolation and maintain lifestyle, independence and quality of life as muscle function deteriorates.

- ALS Association support groups are crucial learning forums focused on promoting strategies for meeting the challenges of living with ALS. More than 20 monthly support groups throughout CA feature both educational speakers and small group discussions. Support groups are open to all people with ALS, caregivers, family members and friends at no charge.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Fred Fisher present this proposal.

Staff Recommendation: No action is recommended at this time.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 8: DENTI-CAL AND ORAL HEALTH OVERSIGHT

PANELISTS

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Jayanth Kumar**, DDS, State Dental Director, Department of Public Health
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal and Policy Analyst, Legislative Analyst's Office
- **Sonja Petek,** Fiscal and Policy Analyst, Legislative Analyst's Office

- **Katie Andrew**, Senior Policy Associate, Oral Health, Children Now
- **Brianna Pittman-Spencer**, Legislative Director, California Dental Association
- **Kimberly Chen**, Government Affairs Manager, California Pan-Ethnic Health Network

Public Comment

ISSUE

This issue provides an overview of Medi-Cal dental services and oral health programs at the Department of Public Health. It also includes a discussion of the use of Proposition 56 funds, specifically for dental providers, and stakeholder input on this issue.

Denti-Cal Budget:
The budget includes $1.2 billion ($434.9 million General Fund and $797.8 million federal funds) in 2017-18 and $1.4 billion ($485.1 million General Fund and $879.4 million federal funds) in 2018-19 for base fee-for-service expenditures for dental services in the Medi-Cal Dental Program, known as Denti-Cal.

The budget also includes $118.2 million ($40.8 million General Fund and $77.4 million federal funds) in 2017-18 and $104.2 million ($37 million General Fund and $67.2 million federal funds) in 2018-19 for base dental services provided through dental managed care (DMC) plans.

Dental Services Funding Summary			
Fiscal Year:	**2017-18**	**2018-19**	**BY to CY**
Denti-Cal Fee-for-Service			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$434,901,050	$485,090,200	$50,189,150
0890 – Federal Trust Fund	$797,756,950	$879,373,800	$81,616,850
Total Expenditures	**$1,232,658,000**	**$1,364,464,200**	**$131,806,200**
Dental Managed Care (DMC)			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$40,822,620	$37,020,060	($3,802,560)
0890 – Federal Trust Fund	$77,374,380	$67,155,940	($10,218,440)
Total Expenditures	**$118,197,000**	**$104,176,000**	**($14,021,000)**

BACKGROUND

Denti-Cal (Department of Health Care Services)

Dental care is provided on a fee-for-service basis in all counties (except Sacramento), with Sacramento and Los Angeles Counties also offering services through managed care plans. Covered dental services include 24-hour emergency care for severe dental problems, urgent care (within 72-hours), non-urgent appointments (offered within 36-days), and preventive dental care appointments (offered within 40-days). Federal regulations mandate that California's state plan meet the requirements for providing early and periodic screening, diagnostic, and treatment (EPSDT) services for beneficiaries under the age of 21 years. EPSDT services include dental screening services furnished by direct referral to a dentist for children beginning at 1 year of age and dental care, at as early an age as necessary, to relieve pain and infections, restore teeth, and maintain dental health.

Dental Program Administration

Under the fee-for-service model, providers are reimbursed according to a rate schedule set by DHCS. The Medi-Cal Dental Managed Care Program contracts with three Geographic Managed Care (GMC) Plans and five Prepaid Health Plans (PHP) that provide dental services to enrolled beneficiaries. Each dental plan receives a negotiated monthly per capita rate from the state for every recipient enrolled in their plan.

Medi-Cal beneficiaries residing in Los Angeles County can access dental care either through the fee-for-service delivery system or through prepaid health plans, while Medi-Cal beneficiaries residing in Sacramento County are - with the exception of specific populations – mandatorily enrolled in prepaid health plans for dental care. If Sacramento County beneficiaries are unable to secure services through their prepaid health plan in accordance with the applicable contractual time frames and the Knox-Keen Act, they can qualify for the beneficiary dental exemption, which allows them to move into the fee-for-service delivery system.

Dental Transformation Initiative (DTI)

A major component of the new Medi-Cal 2020 (1115 Waiver) is the DTI which will provide up to $750 million to dental services. The DTI has four "Domains" as follows:

1) *Increase Preventive Services Utilization (Domain 1):* Increase the statewide utilization of preventive services by at least ten percentage point over the five year Waiver 2020 period for Medi-Cal beneficiaries ages 1 through 20. This is to be accomplished with semi-annual incentive payments to providers who meet or exceed a predetermined increase in preventive services to additional Medi-Cal beneficiaries.

2) *Caries Risk Assessment and Disease Management Pilot (Domain 2):* Assess caries risk and manage the disease of caries using preventive services and non-invasive treatment approaches instead of more invasive and costly restorative procedures. This project is limited to children age 6 and younger and providers in select pilot counties are eligible to opt-in. Providers opting-in must complete the approved training, and submit claims data to the dental fiscal intermediary. The pilot counties were selected by DHCS through an analysis that identified counties with high percentage of restorative services, a low percentage of preventive services, and an indication of likely participation by providers. The pilot counties include: Glenn, Humboldt, Inyo, Kings, Lassen, Mendocino, Plumas, Sacramento, Sierra, Tulare, and Yuba.

3) *Continuity of Care (Domain 3):* Increase dental continuity of care for children enrolled in the Medi-Cal program who receive annual dental exams from a dentist at the same service office location year after year. This will begin as a pilot program in 17 counties and will be used to evaluate if incentive payments are effective in promoting continuity of care. The selection of the pilot counties was based on claims data collected and analyzed at statewide and county levels with continuity of care levels *below, equal to, or above* the statewide continuity of care baseline (and other factors) as follows:

    a. Below: Del Norte, El Dorado, Marin, Nevada, Shasta
    b. Equal To: Alameda, Fresno, Kern, Modoc, Riverside, Stanislaus, Yolo
    c. Above: Madera, Placer, San Luis Obispo, Santa Cruz, Sonoma

4) *Local Dental Pilot Programs (Domain 4):* Increase dental prevention; caries risk assessment and disease management, and continuity of care among Medi-Cal children by Local Dental Pilot Programs (LDPP) innovative pilot projects through alternative programs, using strategies focused on urban or rural areas, care models, delivery systems, workforce, local case management initiatives and/or education. A maximum of 15 LDPPs may be approved for participation, and they may be a county, a city and county, a consortium of counties serving a region, a Tribe, an Indian Health Services program, the University of California or the California State University.

Extensive detail on the DTI can be accessed through the DHCS website through the following link:

http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx

Utilization Data

In April 2015, DHCS worked collaboratively with stakeholders to establish measures for assessing beneficiary utilization, as recommended by the California State Auditor (CSA). The final measures are reported by DHCS and made publicly available through the Denti-Cal website on a quarterly basis. The measures are stratified by county, age and ethnicity to provide insight into utilization across regions and demographics. The measures are based on 90 day continuous eligibility within the FFS delivery system, with the exception of the Usual Source of Care measure which requires two years of continuous enrollment. DHCS provided the following dental utilization data for both fee-for-service and managed care:

Utilization by Delivery System Among Medi-Cal Beneficiaries
Annual Dental Visit (ADV)*

Year*	Age Group	FFS(1)	GMC(2)	PHP(3)
2013	Age 0-20	54.6%	42.1%	41.6%
	Age 21-64	13.0%	10.9%	8.5%
	Age 65+	9.2%	7.6%	5.2%
2014	Age 0-20	54.3%	42.2%	41.9%
	Age 21-64	25.0%	19.6%	19.3%
	Age 65+	19.2%	15.4%	14.5%
2015	Age 0-20	52.0%	41.3%	42.1%
	Age 21-64	26.6%	22.3%	23.2%
	Age 65+	25.6%	20.6%	18.6%
2016	Age 0-20	50.9%	40.2%	40.8%
	Age 21-64	24.3%	16.9%	13.7%
	Age 65+	23.7%	15.5%	12.3%

*12 month period ending in September of indicated year
(1) Fee-for-Service Dental Delivery System
(2) Dental Managed Care in Sacramento County is known as Geographic Managed Care (GMC)
(3) Dental Managed Care in Los Angeles County is known as Prepaid Health Plan (PHP)

Proposition 56 Payments

For 2018-19, the Governor's budget proposes an increase of approximately $232 million in Proposition 56 funding for supplemental payments for dental and physician services, and maintains the supplemental payment or rate increases for all other affected

providers (ICF-DD, HIV/AIDS Waiver and Women's Health Services). The total 2018-19 Proposition 56 funding for these providers, including the increase for doctors and dentists, is $649.9 million. DHCS estimates the total funding (both federal and Proposition 56) in 2017-18 for these payments is $1,147 million and in 2018-19 is $2,025 million. Several stakeholders have provided either proposals or general feedback on potential uses for the proposed increase in Proposition 56 funding, as follows:

Children Now

Children Now proposes to use a portion of Proposition 56 funds for targeted supplemental payment rate increases in fluoride varnish application and pediatric preventive dental services as follows:

Service	CPT/CDT Billing Codes	Medi-Cal FFS Reimbursement[iii]
Fluoride varnish administration (by physician)	99188	$18.00
For individuals over the age of 21 who have transitioned out of the foster care system, allow for the removal of orthodontic appliances, construction, and retainer placement for those former foster youth that have incomplete but approved treatment authorizations.	D8680	$244.00
Topical application of fluoride to help prevent dental decay	D1206 / D1208	$8.00 or $18.00 (for children under 6)
Topical fluoride varnish, therapeutic application for moderate to high caries risk patients	D1206	$8.00 or $18.00 (for children under 6)
Dental Sealant to prevent the progression of dental decay	D1351	$22.00

California Dental Association

The CDA provided the following statement regarding the use of Proposition 56 funds in dental care:

> "Prevention is at the core of effectively managing dental disease and reducing the cost burden of severe health conditions. Supporting prevention for children and adults should always be a high priority within the healthcare system. Dental disease is highly preventable, yet California has some of the highest dental disease rates in the nation. We must do more to prevent disease onset and apply chronic disease management principles to control its progression and severity across the lifespan – a goal that is clearly articulated in California's recently released state oral health plan. Providers and advocates have stressed a significant need to incentivize prevention in the state.
>
> In addition, periodontal services are essential to improving the general health of the adult population, and may reduce state expenditures on medical services, especially for beneficiaries with chronic diseases affected by systemic inflammation, like diabetes and heart disease. Periodontal services were part of

last year's full restoration of adult benefits but were excluded from the supplemental payments and are being paid at the pre- elimination 2009 rates. Because of the elimination, there is currently a backlog of untreated disease for many adults and that often includes the need for periodontal services. When the prop 56 SPA was submitted last year, adult benefits were not yet fully restored, and utilization rates beginning January 2018 were not yet known. Since that time, initial data should be available to project the state costs to include supplemental rate increases for periodontal services in the next SPA.

The reimbursement rates for all dental services need to be reasonable to ensure improved access to care. Given the importance of preventive and periodontal care, the potential long-¬term cost savings to the state, and the significant additional resources proposed by the Governor's budget for this program, the Department is urged to include preventive procedures (CDT Codes D1000 – D1999) and periodontal procedures (D4000 – D4999) in the 2018-19 Prop 56 SPA."

California Pan Ethnic Health Network (CPEHN)

CPEHN, as part of a coalition of stakeholders including Health Access, Western Center on Law and Poverty, Justice in Aging, and the National Health Law Program, submitted the following comments to the Subcommittee specific to Proposition 56 funds in dental care:

"Evaluation

We must ensure that California's investments in Denti-Cal services produces relevant data to measure the effectiveness of the supplemental payments in increasing access to providers and services. It is unclear if DHCS has developed evaluation standards of supplemental payments from Proposition 56. We urge DHCS to define and disseminate clear standards of evaluation of the supplemental payments from Proposition 56.

Transparency and Accountability

There is no clear account of DHCS's process to select codes for supplemental payments from Proposition 56. California voters have made significant investments in Denti-Cal services. We recommend DHCS share the process of choosing the specific codes eligible for supplemental payments. Additionally, we suggest DHCS develop a Stakeholder Advisory Board for the planning and evaluation of Proposition 56's supplemental payments. The evaluation should include analysis of utilization by age, geographic region and service as well as provider capacity, including full-time equivalent and newly enrolled Denti-Cal providers. The undersigned organizations supports sufficient resource allocation to DHCS for the purpose of increasing access to Denti-Cal. We urge DHCS to work closely with the Legislature and stakeholders to ensure robust implementation of supplemental payments from Proposition 56.

Supplemental Payment Codes to Include in FY 2018-19
In July 2017, we along with other health consumer advocates asked DHCS to include preventative services, periodontal treatment, and special needs patients among the services that would qualify for supplemental rates. We reiterate this request moving forward.

Prevention
We recommend that basic preventive services be eligible for supplemental payments as these services are essential for good oral health care. Maintaining an individual's teeth is always preferable to having to restore teeth and function after loss due to decay and disease, which will also save the Medi-Cal program money in the long-run.

We appreciate the recent efforts to increase the use of preventive services for children on Medi-Cal through DTI, but adults are excluded from this goal despite the clear need. For example, prophylaxis for adults (D1110) and topical application of varnish (D1208) are among the top ten utilized dental procedures among Denti-Cal patients but are currently not designated for supplemental payments. Working in alignment with DTI, we recommend supplemental payments are applied to preventive services, including D1110. We recommend DHCS plan for the sustainability of the DTI and ensure there be ongoing opportunities to increase access to Denti-Cal providers for children.

In addition, we recommend that other preventive services for both adults and children, including D1206 (topical application of fluoride varnish), D1208 (topical application of fluoride), D1351 (sealant), and D1352 (preventive resin restoration in a moderate to high caries risk patient) be eligible for supplemental payments. To prevent multiple supplemental payments for the same service, we recommend limiting supplemental payments to services where additional supplemental payments have not already been provided, including services for Medi-Cal beneficiaries above the age of 20.

Periodontal/Gum Treatment
We appreciate the Legislature's and Governor's leadership in fully restoring adult dental benefits, including partial dentures, gum treatment, and root canals on back teeth, and we are pleased that partial dentures and root canals on back teeth are eligible for supplemental payments as this will help ensure individuals are able to find Denti-Cal providers willing to provide these services. To ensure that the restoration of gum treatment services are actually utilized, we recommend periodontal services be eligible for supplemental payments. There is strong and growing evidence of the relationship between poor gum health and medical problems, including diabetes, heart disease, and increased risk for aspiration pneumonia. Thus, gum treatment is essential not just to oral health, but overall health.

Special Needs Patients
We support the Gary and Mary West Senior Dental Center recommendation to compensate providers for cases that require additional medical screening before treatment can be undertaken to help ensure access for these complex patients."

Department of Public Health

The OHP was established in July 2014. Prior to 2014, the OHP was known as the Oral Health Unit and the Office of Oral Health. The program's mission is to improve the oral health of all Californians through prevention, education, and organized community efforts. To achieve these goals, the OHP is providing strategic advice and leadership to oral health stakeholders throughout the state, building oral health workforce capacity and infrastructure, and implementing and evaluating evidence-based best practices in oral disease prevention. Initial steps to build capacity and address the burden of oral disease are to develop a state burden report, a state oral health plan, and an oral health surveillance plan. The state plan will serve as a roadmap to identify priorities, short term, intermediate, and long term goals and objectives along with recommendations to address the burden of disease, increase access to oral health services for high risk populations, and to increase the oral health status of all Californians. Funding for the OHP is provided by the State General Fund, the Preventive Health and Health Services Block Grant, and the Health Resources and Services Administration.

The mission of the OHP is to promote oral health by reducing the prevalence of dental decay and tooth loss, periodontal disease, and other chronic diseases through prevention, education, and organized community efforts. As of 2006, 54 percent of kindergarten children and 71 percent of third graders in the state had tooth decay. Tooth decay is the most common chronic health condition in children. In addition, low-income and minority children suffer disproportionately from dental caries, also known as tooth decay. In 2012, only 67 percent of adults age 18 and over had visited a dentist or dental clinic in the previous year. A three-year aggregate comparison of Medicaid reimbursement for in-patient emergency department treatment ($6,498) versus preventive treatment ($660) revealed that, on average, the cost to manage symptoms related to dental caries on an in-patient basis is approximately 10 times more than the cost to provide dental care for these same patients in a dental office. Medical studies have also shown that the smoking of cigarettes and use of other tobacco products affects oral health by causing dental disease, including gum disease and bone loss, cancers of the mouth and throat, and severe tooth wear.

The Budget Act of 2014 established a state OHP (in CDPH's Chronic Disease Control Branch), as well as a State Dental Director and a State Oral Health Epidemiologist to build the infrastructure for a robust statewide oral health program. Health & Safety Code (HSC) sections 104750-104765 and 104770-104825 establish authority for CDPH to maintain a dental program that includes: 1) a Dental Director, 2) development of comprehensive dental health plans; 2) consultation to coordinate national, state, and local agency dental health programs; 3) program evaluation related to preventive services; 4) consultation and provision of program information to health professionals and their associated educational institutions, and volunteer agencies; and, 6) authority

to receive funds to implement a State dental program.

An Oral Disease Burden Report and a California State Oral Health Plan are currently in development and will provide a roadmap for the next 10 years of oral health priorities for the State. Current OHP dental health initiatives include: 1) the Community Water Fluoridation Implementation Project funded by the federal Preventive Health and Health Services Block Grant; 2) the Oral Health Workforce Expansion Program, funded by the federal Health Resources and Services Administration (HRSA); 3) the Perinatal Infant Oral Health Quality Improvement Project also funded by HRSA; and 4) the California Children's Dental Disease Prevention Program. The infrastructure in this proposal is based on recommendations from the Association of State and Territorial Dental Directors regarding "Building Infrastructure & Capacity in State and Territorial Oral Health Programs" and modeling infrastructure on the CDPH experience with implementation of similar statewide public health programs to address priorities as outlined in the State Oral Health Plan.

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

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

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

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

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

California State Oral Health Plan
Beginning April 1, 2017, the 2016 Tobacco Tax Act increases the excise tax on cigarettes by $2.00 per pack (based on a pack of 20 cigarettes) and imposes an equivalent excise tax on other tobacco products. A portion of the 2016 Tobacco Tax Act revenues will be transferred into three newly created funds: the State Dental Program Account (Fund 3307), the Tobacco Law Enforcement Account (Fund 3308), and the Tobacco Prevention and Control Programs Account (Fund 3309). The Proposition specifies allocations to various entities, including $30 million annually for Public Health's state dental program.

These resources will expand the OHP, resulting in increased capacity for CDPH and local jurisdictions to implement the California State Oral Health Plan. The OHP will determine the projected outcomes through input from stakeholders including local jurisdictions and Denti-Cal, with an emphasis on the goals, objectives, strategies and activities included in the State Oral Health Plan, Healthy People 2020 Oral Health Objectives, Denti-Cal and Maternal and Child Health Services Block Grant performance measures, and the California Wellness Plan.

Surveillance and tracking of program outcomes will be based on the guidelines established by the Association of State and Territorial Dental Directors. The impact will be tracked by conducting and/or analyzing periodic surveys and performance reports, such as: 1) oral health survey of kindergarten and 3rd grade children; 2) utilization of Medicaid dental services based on the annual Medi-Cal/Denti-Cal performance report; 3) Maternal and Infant Health Assessment; 4) Behavioral Risk Factor Surveillance System; 5) Youth Risk Behavior Surveillance System; 6) California Health Interview Survey; 7) National Survey of Children's Health; 8) California Cancer Registry; and, 9) survey of dental practitioners.

In February 2018, DPH provided the following updates on the content and implementation of the State Oral Health Plan:

- The Plan identifies five major objectives and 25 different strategies for achieving the objectives;

- DPH will fund the 61 Local Health Jurisdictions (LHJs) to implement the Plan; DPH had received 58 applications and granted 3 extensions;

- DPH will establish a technical assistance (TA) center at the UCSF School of Dentistry to provide TA to the LHJs;

- The first year of the grants is for planning, while years 2-5 will be for implementation of activities that help meet the objectives of the Plan;

- Each LHJ has funding for one new project coordinator, a base grant of $140,000 plan an additional amount calculated based on population and poverty levels; Los Angeles County will receive $2.7 million annually;

- DPH will review LHJ plans and provide TA, including through webinars;

- DPH is establishing a surveillance system to track progress, using the following data sources: kindergarten records; surveys of 3rd grade students; Behavioral Health Survey; and adding questions to the California Health Information Survey (CHIS);

- DPH will issue periodic reports on the program; and

- DPH expected all of the grants to be issued by the end of March.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of the challenges and progress in addressing those challenges and achievements in the Denti-Cal Program, and respond to the following:

1. How does the Department plan to determine which codes are eligible for supplemental payments moving forward?

2. Please provide an estimate for how much it would cost to apply 40% supplemental payments to covered preventive services? Covered periodontal services?

3. Is it possible for the Department to apply supplement to preventive services for adults not covered by the DTI? (Can DHCS differentiate between children and adults? Or would the SPA need to be age-independent?)

4. Please discuss utilization of newly restored adult benefits so far in 2018?

The Subcommittee requests DPH provide an overview of the Oral Health Program and of the California State Oral Health Plan and its implementation.

The Subcommittee requests the stakeholder panelists to present their proposals and comments related to Proposition 56 funding.

Staff Recommendation: No action is recommended at this time.

ISSUE 9: STAKEHOLDER PROPOSAL ON STATE ORAL HEALTH PLAN ROLLOVER AUTHORITY

PANELISTS

- **Michelle Gibbons**, Executive Director, County Health Executives Association of California

Public Comment

PROPOSAL

Oral health stakeholders in California, including the California Dental Association, California Health+ Advocates, California Pan-Ethnic Health Network, Children Now, The Children's Partnership, and the County Health Executives Association of California, requests trailer bill to grant the California Department of Public Health (CDPH) optimal authority over the distribution of Oral Health Program funds, including the authority to rollover unexpended Oral Health Program funds over three years. In particular, the proposed statutory language grants CDPH the flexibility to distribute funds in a timely manner and ensure the availability of these funds over a three-year period.

BACKGROUND

Oral health stakeholders, identified above, provided the following background information:

The successful passage of Proposition 56 in 2016, which increased the tobacco tax by $2 per pack, helped to secure funding for implementing CDPH's State Oral Health Plan developed by the State Dental Director in collaboration with these organizations. Proposition 56 allocates $30 million annually to the State Oral Health Program for preventing and treating dental disease, including conditions caused by tobacco products. CDPH and key stakeholders have participated in the Oral Health Program's Advisory Partnership Committee meetings throughout the past year, where challenges around expending funding have been identified and the inability to move funding to subsequent years has been raised as a primary concern.

Stakeholders have identified the funding distribution practices in other CDPH programs, such as the California Tobacco Control Program, as particularly effective, and believe that the State Oral Health Program should be allowed to utilize similar practices with local health jurisdictions for distributing Proposition 56 dollars. Without the flexibility to distribute funds in a timely manner and access to these dollars in subsequent fiscal years, stakeholders are concerned that the Oral Health Program, CDPH and potentially local health jurisdictions will be dictated by restrictive policies and timelines instead of strategic disbursements, creating delays and missed opportunities to fully realize the benefit of the funding voters intended to improve the oral health of all Californians.

Stakeholders are proposing the following trailer bill:

Health and Safety Code- New section within Article 2 of Chapter 3, of Part 3, of Division 103. State Oral Health Program (Sections 104750-104765)

(a) Notwithstanding any other provision of law, the Department may allocate the funds appropriated from the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund, pursuant to subdivision (d) of section 303130.57 of the Revenue and Tax Code for the purposes of maintaining an oral health program, to a county, city, consortium of counties, or another entity, by a process and in an amount as determined by the Dental Director, provided that these funds shall not be used to supplant existing state or local General Funds for these same purposes

(b) Notwithstanding any other provision of law, commencing with the appropriation for the 2017-18 fiscal year, and for each fiscal year thereafter, any amount appropriated to the department to implement the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 State Dental Program shall be available for encumbrance and expenditure for three fiscal years beyond the date of the appropriation.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Michelle Gibbons present this proposal and requests the administration provide reactions and technical assistance on this issue/proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 10: STAKEHOLDER PROPOSAL ON MEDI-CAL COVERAGE OF SILVER DIAMINE FLUORIDE

PANELISTS

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

Public Comment

PROPOSAL

The California Dental Association (CDA) proposes the addition of silver diamine fluoride as a covered benefit under Denti-Cal.

BACKGROUND

The CDA provided the following background information:

Dental caries remains the most common—yet preventable—chronic disease of children. Application of silver diamine fluoride is one of the most promising approaches in dental care to arrest dental caries. Silver diamine fluoride is being used in a very limited fashion in California's Dental Transformation Initiative but is not a benefit covered by Denti-Cal. It is a painless topical medication that can provide enormous benefit and eliminate the need for more extensive restorative procedures. Modernizing the benefits offered under Denti-Cal provides vulnerable patients with expanded quality of care as part of an overall comprehensive dental treatment plan and has the potential to reduce state costs.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Brianna Pittman-Spencer present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 11: STAKEHOLDER PROPOSAL ON INCREASED MEDI-CAL RATES FOR DENTAL SERVICES FOR HARD-TO-TREAT PATIENTS

PANELISTS

- **Paul Glassman DDS**, MA, MBA Professor and Director, Community Oral Health University of the Pacific, Arthur A. Dugoni School of Dentistry

Public Comment

PROPOSAL

Gary and Mary West Health Institute (West Health) proposes Medi-Cal rate increases for dental services for hard-to-treat patients.

BACKGROUND

West Health provided the following background information:

Denti-Cal's standardized policies and payments are based on a healthy population and do not acknowledge the additional costs of caring for people with special needs. Individuals living with chronic medical, mental, behavioral or developmental disabilities currently face greater challenges accessing appropriate dental care than healthier people.

Appropriately caring for patients with special needs often requires additional time, multiple visits and other modifications compared to healthier patient treatments. Many cannot tolerate being in a dental chair long enough to have the necessary services provided due to their disabilities and others require additional medical screenings at every appointment before treatments can be performed. These factors contribute to additional costs, which are not currently reimbursed under Denti-Cal, limiting the amount of dental practices willing to provide oral care for these beneficiaries.

Denti-Cal eligible patients often have difficulty finding access to care because of low reimbursement rates and burdensome administrative requirements. This barrier to care can be even more significant for patients with special needs such as those with chronic conditions and disabilities which require more than routine delivery of care. In addition, patients with special needs often are at high risk for developing oral diseases. These patients often forego care, resulting in later stage complications.

West Health believes that additional reimbursements will give vital financial support to Denti-Cal providers currently serving these patients and may incentivize others to deliver this necessary care. West Health also believes that a budget that appropriately reimburses for the additional costs for caring for this vulnerable population is the first step in the pursuit of a Denti-Cal system that ensures all patients have access to high-quality and appropriate dental care.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Dr. Glassman present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 12: STAKEHOLDER PROPOSAL FOR A HEALTH PLAN OF SAN MATEO MEDICAL DENTAL INTEGRATION PILOT PROGRAM

PANELISTS

- **Trent Smith**, Advocate, Health Plan of San Mateo

Public Comment

PROPOSAL

The Health Plan of San Mateo (HPSM) is requesting trailer bill to authorize a medical/dental integration pilot program, the cost of which will be covered by HPSM, as described here:

Under a five-year pilot project, HPSM would partner with dental providers to deliver an integrated care approach to enrolled Medi-Cal members and establish objectives for improving access to oral health care, including access to dental prevention services and pediatric dentistry, and test innovative payment models to build broad dental provider participation. As the single entity responsible for both medical and oral health care, HPSM will explore best ways to establish formal collaboration among healthcare systems, medical practices and dental practices within the local region. Additionally, HPSM would evaluate the cost impact of integrating dental care, such as reductions in preventable emergency room visits due to dental pain and dental procedures performed in a hospital setting. This pilot would add no additional costs to the state as any costs would be covered by HPSM.

BACKGROUND

HPSM provided the following background information:

Strong public health evidence supports the notion that improved oral health leads to better health outcomes in general, which in turn reduces costs to the healthcare system. HPSM believes that it has an opportunity to test this concept through a five-year pilot to integrate medical and dental care, with the goals to improve access to dental care, reduce avoidable medical costs, and improve health outcomes for Medi-Cal members. This budget proposal would authorize HPSM to arrange for the provision of dental services to Denti-Cal beneficiaries in San Mateo County, each of whom receives medical services through HPSM already.

The Problem:
A growing body of evidence shows that investing in the maintenance of a person's oral health has benefits for their overall health and well-being:

- Gum disease has been associated with adverse pregnancy outcomes, respiratory disease, cardiovascular disease, and diabetes.

- Poor oral health is associated with chronic pain, lost school days, and inappropriate use of the emergency department.

For diabetics, oral health and properly controlled blood sugar go hand-in-hand. People with diabetes are twice as likely to develop gum disease, and in return, infected gums make it harder to control blood sugar. Infections can cause gums to bleed, feel swollen and tender, and can lead to tooth loss. Nearly 14% of Californians have been diagnosed with diabetes, and the numbers are rising rapidly. Diabetes costs in this state exceed $24 billion each year.

Despite the link between dental health and overall health, dental and medical services have traditionally been delivered by separate systems. As HPSM describes, the Medi-Cal program reflects this, with beneficiaries enrolled in a commercial or local health plan such as HPSM for medical benefits and the fee-for-service (FFS) Denti-Cal system for their dental care. In the FFS Denti-Cal system, patients access dental care on their own and no supporting infrastructure exists to allow the medical and dental systems to make connections when needed for a patient's overall health needs. HPSM believes that this fragmented model makes it impossible to coordinate care to improve patient health or measure outcomes and cost-savings. Further, data from DHCS indicates that in San Mateo County only 40% of eligible kids and 17% of eligible adults received any dental service in 2015-16, which is lower than the statewide Denti-Cal average.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Trent Smith present this proposal.

Staff Recommendation: No action is recommended at this time.

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ISSUE 13: STAKEHOLDER PROPOSAL ON MEDI-CAL RATE INCREASE FOR NON-EMERGENCY MEDICAL TRANSPORTATION

PANELISTS

Steve Horne, California Medical Transportation Association

Public Comment

PROPOSAL

The California Medical Transportation Association requests funding to restore the 10 percent rate cut implemented through AB 97 (2011 budget trailer bill) for non-emergency medical transportation in Medi-Cal.

BACKGROUND

The California Medical Transportation Association provided the following background information:

- The 2011 rate cut has almost eliminated access to NEMT (Fee-For-Service, FFS) wheelchair/litter van services (Medi-Cal patients who cannot ride in a regular vehicle – private or public due to medical conditions).
- Medi-Cal rates do not cover NEMT provider costs for trips beyond short distances (10 miles each way) posing severe access problems in rural areas.
- Most NEMT services have been transferred to Managed Care Plans (MCPs), but Fee-For-Service (FFS) rates are used by many MCPs as a benchmark or baseline.
- Where a few MCPs pay NEMT at rates higher than FFS, (Kaiser, Partnership Health Plan) patients churning between MCP eligibility and FFS cannot access NEMT while they're on FFS.
- Most NEMT users are dialysis patients dependent on NEMT to obtain their life-sustaining dialysis treatment.
- Failure to receive timely dialysis care causes complications that require extremely expensive emergency care and hospitalization, or death.
- Only patients determined by a physician as too sick, frail or disabled to ride in a bus or car qualify for NEMT.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Steve Horne present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 14: STAKEHOLDER PROPOSAL ON ASTHMA PREVENTION SERVICES

PANELISTS

- **Joel Ervice**, Associate Director, Regional Asthma Management and Prevention

Public Comment

PROPOSAL

California Pan-Ethnic Health Network (CPEHN), Children Now, and Regional Asthma Management and Prevention (RAMP) request DHCS ensure access to medically necessary asthma education and home environmental trigger assessments for Medi-Cal beneficiaries with poorly controlled asthma by adopting trailer bill that clarifies that these are already covered benefits including when provided by non-licensed providers under the supervision of licensed providers. Specifically, it is proposed that DHCS, in accordance with existing state and federal law, ensure qualified professionals that fall outside of the state's clinical licensure system may provide these services as long as a licensed practitioner has initially recommended the services.

BACKGROUND

The organizations listed above provided the following background information:

Asthma is a significant public health problem and driver of health care costs. Over 5.6 million Californians have been diagnosed with asthma -- about 1 in 7 state residents. Asthma is of particular concern for low-income Californians enrolled in Medi-Cal. Low-income populations, like the over two million Medi-Cal beneficiaries who have been diagnosed with asthma at some point in their lives, have higher asthma severity, poorer asthma control, and higher rates of asthma emergency department visits and hospitalizations. Among the nearly 1.5 million Medi-Cal beneficiaries with current asthma, 15% (223,000) have poorly controlled asthma (using recent visit to an emergency department or urgent care clinic as a proxy for poor control). In 2016, Medi-Cal beneficiaries represented 50% of asthma emergency department/urgent care clinic visits, even though beneficiaries represented only 33% of Californians.

Ample research indicates asthma education, including home environmental assessments, frequently provides a return on investment (ROI) due to decreased utilization of more costly health care services such as emergency department visits and hospitalizations. To take just two examples, one education program targeting high risk children demonstrated a ROI of $11.22 for every $1 spent, while another program targeting children demonstrated a ROI of $7.69-$11.67 for every $1 spent.

Increasing access to asthma education and home environmental asthma trigger assessments will help fulfill California's Quadruple Aim of strengthening the quality of care, improving health outcomes, reducing health care costs and advancing health equity.

STAFF COMMENTS/QUESTIONS

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

1. Does DHCS currently have the administrative authority to permit and encourage plans and providers to use supervised, non-licensed professionals in the delivery of asthma education in clinical settings?

    a) If yes, why isn't the delivery of this service being used widely amongst all plans and providers? Are there financial restraints?

    b) If no, what does DHCS need from the legislature to make sure that asthma education in clinical settings is delivered by supervised, non-licensed professionals across all plans and providers?

2. If any of the services are currently authorized, are the costs already factored into managed care rates? If any of the services are not currently authorized, what are the anticipated costs of doing so?

3. What was the Department of Finance's final cost estimate of these services for the enrolled version of AB 391 (Chui, 2017)?

4. In the current Medicaid State Plan, what authority exists to use non-licensed providers to provide preventive services allowed under the 2013 "preventive services rule"? Has DHCS considered using this specific federal flexibility in the context of delivery asthma preventive services through qualified asthma providers?

Staff Recommendation: No action is recommended at this time.

ISSUE 15: STAKEHOLDER PROPOSAL ON DEMOGRAPHIC DATA COLLECTION

PANELISTS

- **Kimberly Chen**, Government Affairs Manager, California Pan-Ethnic Health Network

Public Comment

PROPOSAL

The California Asian Pacific Islander Legislative Caucus and the California Pan-Ethnic Health Network (CPEHN) request $1.4 million one-time for DHCS to expand disaggregated demographic data collection of Asian Pacific Islander ethnicities for enrollees in Medi-Cal and other health programs through SAWS, CalHEERS and MEDS.

BACKGROUND

CPEHN provided the following background information:

CPEHN believes that the first step in being able to identify and reduce health disparities is the accurate collection and reporting of racial and ethnic data of those enrolling in health coverage. California is home to the nation's largest Asian American and second largest Native Hawaiian and Pacific Islander populations. Since 2013, Medi-Cal has more than doubled the number of enrollees from the Asian American, Native Hawaiians and Pacific Islander (AANHPI) communities. However, without granular, disaggregated data for many subgroups within the AANHPI population, distinct health disparities remain unaddressed and subpopulations remain unaccounted for.

With the passage of AB 1726 (Bonta, Chapter 607, Statutes of 2016), Accounting for Health in AANHPI Demographics, in September 2016, through the Department of Public Health, the State took the steps toward better collecting and releasing disaggregated demographic data for specific underrepresented AANHPI communities. To build on this effort, CPEHN requests the Legislature invest $1.4 million so that DHCS may expand disaggregated demographic data collection of Asian Pacific Islander ethnicities for enrollees in Medi-Cal and other health programs through SAWS, CalHEERS and MEDS.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Kimberly Chen present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 16: 340B DRUG PRICING PROGRAM TRAILER BILL

PANELISTS

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Amber Ott**, Vice President, Strategic Financing Initiatives, California Hospital Association
- **Britta Guerrero**, Chief Executive Officer, Sacramento Native American Health Center, Inc.
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS requests trailer bill language to restrict the scope of the use of the 340B Program within the Medi-Cal program to comply with existing federal requirements. According to DHCS, these restrictions would help protect program integrity, prevent unnecessary overpayments, result in additional drug rebate savings, as well as serve to mitigate the amount of time and resources expended to resolve drug rebate disputes related to 340B claims.

BACKGROUND

The federal Veterans Health Care Act of 1992 established the 340B Drug Pricing Program (340B Program), which requires drug manufacturers that participate in Medicaid to offer significantly reduced prices to certain safety net health care providers, known as covered entities. According to the federal Health Resources and Services Agency (HRSA), which oversees the 340B Program, these discounts enable covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Health care organizations eligible to be covered entities are defined in federal statute and include HRSA-supported health centers and look-alikes (e.g. federally qualified health centers), Ryan White clinics and state AIDS Drug Assistance programs, Medicare/Medicaid Disproportionate Share Hospitals, children's hospitals, and other safety net providers.

Prescription Drug Rebates in Medi-Cal

The federal Omnibus Budget Reconciliation Act of 1990 established the Medicaid Drug Rebate Program, which requires drug manufacturers to pay rebates to state Medicaid programs for drugs dispensed to Medicaid beneficiaries. These rebates are shared between states and the federal government according to the relevant federal matching rate for the beneficiaries to whom the drugs were dispensed. In addition to the federal rebate program, California law requires DHCS to enter into contracts with drug manufacturers to provide supplemental rebates for drugs dispensed to Medi-Cal

beneficiaries in the fee-for-service delivery system or enrolled in county organized health systems (COHS). These rebates are in addition to those received through the federal rebate program. In 2010, the federal Affordable Care Act further extended eligibility for the federal rebate program to drugs dispensed to beneficiaries enrolled in non-COHS Medi-Cal managed care plans. The budget includes General Fund savings from drug rebates of approximately $1.4 billion in 2017-18 and $1.5 billion in 2018-19 through the federal rebate program, state supplemental rebate program, from managed care beneficiaries, and beneficiaries in the Family Planning Access, Care, and Treatment (Family PACT) program and Breast and Cervical Cancer Treatment Program (BCCTP).

In general, federal law prohibits states from receiving federal drug rebates for Medicaid beneficiaries if the drugs dispensed were already discounted as part of the 340B Program. Rebates inappropriately claimed under both programs are known as "duplicate discounts." HRSA provides guidance to 340B covered entities and states to prevent duplicate discounts, including the Medicaid Exclusion File (MEF), a provider level data source that compiles the National Provider Identification (NPI) Number or Medicaid Provider Number of covered entities which dispense 340B discounted drugs to Medicaid beneficiaries. The MEF is available for preventing duplicate discounts in fee-for-service. However, HRSA has encouraged covered entities to work with states to develop strategies to prevent duplicate discounts for drugs dispensed to managed care beneficiaries.

Contract Pharmacies
HRSA permits covered entities to dispense drugs purchased in the 340B Program through off-site contract pharmacies, often commercial retail pharmacies. These arrangements are permitted only if the covered entity, the contract pharmacy, and the State Medicaid agency have established an arrangement to prevent duplicate discounts. The covered entity must report any such arrangement to HRSA. The HRSA guidance establishing this requirement did not apply to drugs dispensed to managed care beneficiaries. However, federal regulations on Medicaid managed care organizations released in May 2016 required states to include managed care contract provisions requiring plans to establish procedures for excluding 340B claims from utilization data provided to states for rebate collection.

Trailer Bill Language Proposal Discontinues 340B Reimbursement in Medi-Cal
According to DHCS, legislation is needed to provide DHCS the authority to restrict the scope of the use of the 340B Program within the Medi-Cal program in order to comply with existing federal statutory requirements. Such restrictions would help protect program integrity, prevent unnecessary overpayments, result in additional drug rebate savings, as well as serve to mitigate the amount of time and resources expended to resolve drug rebate disputes related to 340B claims.

The proposed trailer bill language would:

1. Repeal state law requiring 340B covered entities to dispense only 340B inventory to Medi-Cal beneficiaries and bill at average acquisition cost for those drugs.

2. Require DHCS to seek federal approval to prohibit covered entities from dispensing or administering a 340B drug to a Medi-Cal beneficiary.

3. Require DHCS, in the event federal approval is not obtained to prohibit dispensing or administering a 340B drug to a Medi-Cal beneficiary, to seek federal approval to limit the use of contract pharmacies by a covered entity; and/or, to prohibit or limit which covered entities, and which specified drugs, can be dispensed or administered to a Medi-Cal beneficiary.

4. Allow DHCS to apply those prohibitions and limitations to the entirety of the Medi-Cal program, or a segment thereof, including but not limited to the Medi-Cal fee-for-service and managed care delivery systems, and any other program eligible for federal drug rebates.

5. Require a covered entity subject to the limitations proposed to bill DHCS or a managed care plan their usual and customary charge.

6. Require that covered entities bill the Medi-Cal program at their acquisition cost, plus the appropriate dispensing fee for the applicable delivery system (fee-for-service or managed care) in which they operate.

7. Allow that, if a covered entity required to use 340B drugs is unable to purchase a specific 340B drug, the covered entity may dispense a drug purchased at regular drug wholesale rates to a Medi-Cal beneficiary. The covered entity is required to maintain documentation of their inability to obtain the 340B drug, in the form and manner specified by DHCS.

8. Require a covered entity to identify a 340B drug on the claim submitted to the Medi-Cal program or to a managed care plan for reimbursement.

9. Require DHCS, upon federal approval, to implement these changes on a prospective basis at least 90 days from the date federal approval is obtained, but no sooner than January 1, 2019.

10. Allow DHCS to implement changes without taking regulatory action, but commits DHCS to adopting regulations within five years.

According to DHCS, the budget includes no additional General Fund savings as a result of this proposal. However, the Administration indicates it expects General Fund savings beginning in 2019-20 after federal approvals are received and the program is implemented.

Previous Administration 340B Proposal Not Approved

DHCS submitted a trailer bill language proposal accompanying the 2017 May Revision to correct problems regarding the use of contract pharmacies in the 340B Program. According to DHCS, some 340B covered entities do not directly dispense medications, but instead contract with a different, non-340B pharmacy that receives a higher, non-340B price billed to the department under fee-for-service or to a Medi-Cal managed

care plan. The proposed trailer bill language prohibited the use of contract pharmacies in the 340B program in Medi-Cal, consistent with recent concerns raised by federal agencies and a federal audit. The proposal was intended to avoid inappropriate duplicate discounts by claiming federal drug rebates on already discounted drugs and prevent unnecessary overpayment in Medi-Cal. Due to the likelihood that the proposed language would have imposed significant changes on current operations for many 340B entities, as well as the lack of sufficient time for proper legislative consideration of the impacts of the proposal on essential Medi-Cal providers, the Legislature did not adopt this proposal.

The current trailer bill language proposal includes provisions that allow DHCS, should it not receive federal approval to prohibit dispensing of 340B drugs to Medi-Cal beneficiaries, to subsequently submit a proposal for federal approval to prohibit or limit the use of contract pharmacies to dispense 340B drugs to Medi-Cal beneficiaries. This subsequent proposal provided for by the current trailer bill language is substantially similar to the department's 2017 proposal that was not approved.

Opposition To This Proposal
The Subcommittee has received a substantial number of letters from stakeholders in opposition to this proposal. In general, hospitals and clinics are strongly opposed as they are at risk of losing substantial resources should this proposal be approved. Moreover, opposition contends that there are ways to eliminate duplicate discounts and generally address the problems with this program without eliminating the program in managed care, as proposed by the administration. A large coalition of health care providers, labor organizations, patient advocates and hospital and clinic representatives provided the following information:

> "Savings from the 340B drug discount program help safety-net hospitals and clinics preserve vital health care programs and services. The discounts providers receive from the pharmaceutical industry through the 340B program support providers' efforts to improve care for all patients, including offering specialized programs for some of our most vulnerable Medi-Cal populations who rely on safety-net providers. These services include:
>
> - Extended hours of operation for community clinics and health centers
> - HIV clinics that include a full range of health and mental health services for patients
> - Hepatitis C clinics, which are safety-net centers of excellence that provide lifesaving, curative treatments for Medi-Cal patients
> - Post-operative services, including "meds to beds" programs that allow patients to be discharged from major operations, such as cardiac surgeries or organ transplants, with critical medications needed for proper recovery and ensure that patients receive necessary follow-up with pharmacists
> - Specialized treatments at infusion clinics, such as those provided to patients with congestive heart failure, hemophilia, multiple sclerosis and cancer
> - Case workers for individuals experiencing homelessness and additional support staff to address complicated care needs

- Increased access to specialty care through expanded transportation services to patients without reliable transportation
- Expanded pharmacy access for Medi-Cal and uninsured patients so that pharmacies are available throughout local communities"

"If program changes are pursued, millions of Californians receiving care at the following institutions, all of whom are federally defined 340B covered entities, will be impacted:

- Cancer Hospitals
- Children's Hospitals
- Critical Access Hospitals
- Disproportionate Share Hospitals
- Public Health Care Systems
- District Hospitals
- Federally Qualified Health Centers
- Hemophilia Diagnostic Treatment Centers
- Ryan White HIV/AIDS Programs
- Sole Community Hospitals
- Sexually Transmitted Disease Clinics
- Title X Family Planning Clinics
- Tribal/Urban Indian Health Centers
- Tuberculosis Clinics"

The following organizations (and others) have sent letters of opposition to the Subcommittee:

- Adult and Pediatric Hemophilia Treatment Center, UCSF
- Adventist Health
- AIDS Healthcare Foundation
- Alameda Health Systems
- Alliance of Catholic Health Care
- APLA Health
- Arrowhead Regional Medical Center
- Association of California Healthcare Districts
- California Association of Public Hospitals and Health Systems
- California Chamber of Commerce
- California Children's Hospital Association
- California HIV Alliance
- California Hospital Association
- California Pharmacists Association
- California Psychiatric Association
- California Rural Indian Health Board
- California State Association of Counties
- California Health+ Advocates
- California Consortium for Urban Indian Health
- Center for Inherited Blood Disorders

- Children's Specialty Care Coalition
- Contra Costa Health Services
- County Behavioral Health Directors Association
- County Health Executives Association of California
- City and County of San Francisco
- County of Contra Costa
- County of Monterrey
- County of Ventura
- County of Riverside
- County of San Bernardino
- County of Santa Clara
- District Hospital Leadership Forum
- Essential Access Health
- Harm Reduction Coalition
- Hemophilia Council of California
- Local Health Plans of California
- Loma Linda University Health
- Los Angeles LGBT Center
- Mental Health America of California
- Providence St. Joseph Health
- San Francisco AIDS Foundation
- SEIU California
- Shasta Health Assessment and Redesign Collaborative
- The Hemophilia Alliance
- University of California
- Urban Counties of California
- Western States Region IX Comprehensive Hemophilia Diagnostic and Treatment Centers

Legislative Analyst

The LAO completed a detailed, thorough analysis of the Governor's 340B proposal, which can be accessed here:

http://www.lao.ca.gov/Publications/Detail/3790

The following is the LAO's Assessment, included in their analysis:

> "Recognize the Administrative Challenges Caused by the 340B Program. We recognize that the complexity of utilizing the 340B Program in Medi‑Cal has grown in recent years, largely due to the ACA's expansion of Medicaid prescription drug rebates to managed care, as well as due to the increasing use of contract pharmacy arrangements. These relatively recent developments have made the task of appropriately avoiding duplicate discounts more challenging for DHCS.

Proposal Would Likely Bring the Benefit of State Medi-Cal Savings . . . We agree with the administration's assessment that the elimination of the use of the 340B Program in Medi-Cal would likely ultimately result in overall state savings. These savings would largely come in the form of higher Medi-Cal managed care prescription drug rebates. However, these savings would be partially offset by higher Medi-Cal costs elsewhere, such as potentially higher prescription drug costs in managed care since no 340B savings would be passed along to MCPs. The state would ultimately have to compensate MCPs for their higher prescription drug costs. We would note that total Medicaid drug rebate amounts are shared between the federal and state governments, with the state currently receiving about one-third of the total rebate revenue.

. . . While Eliminating a Portion of Covered Entities' 340B Savings. State savings generated by eliminating the use of the 340B Program in Medi-Cal would be in place of the 340B savings currently enjoyed by covered entities for prescription drugs dispensed to Medi-Cal enrollees. Covered entities would still be able to benefit from 340B savings for the 340B prescription drugs they dispense to non-Medi-Cal enrollees. While it is highly uncertain, it is our understanding that total state and federal Medi-Cal savings resulting from the proposal might be very roughly comparable in magnitude with the 340B savings currently enjoyed by covered entities for drugs dispensed to Medi-Cal enrollees. However, the state would likely only receive about one-third of these savings since the remaining portion would have to be shared with the federal government.

Potential Impacts on Covered Entities and Their Partners. Under the Governor's proposal, covered entities and their partners—such as contract pharmacies—would no longer be able to benefit from savings under the 340B Program for prescription drugs paid for through Medi-Cal. According to certain covered entities' association groups, the elimination of the use of the 340B Program in Medi-Cal could result in some covered entities ceasing to participate in the 340B Program altogether if the program ceases to be financially worthwhile. For example, some covered entities that serve high proportions of Medi-Cal enrollees might no longer find it worthwhile to continue to operate under the 340B Program given the reduced patient population for which 340B discounts would be available. In such cases, for example, the administrative burden of complying with the 340B Program might outweigh the financial benefit to the covered entity. We would note that certain covered entities, such as FQHCs, are reimbursed by Medi-Cal at the cost of providing care to Medi-Cal enrollees. Therefore, FQHCs' loss of savings through eliminating the use of the 340B Program in Medi-Cal could, in certain situations, be made up for through other, higher Medi-Cal reimbursements that compensate FQHCs at their higher non-340B prescription drug costs.

Governor's Proposal Merits Serious Consideration. We find that the Governor's proposed elimination of the use of the 340B Program in Medi-Cal deserves serious consideration by the Legislature since it would (1) likely ultimately result

in state savings, (2) eliminate the administrative challenges associated with overseeing the use of the 340B Program in Medi-Cal, and (3) prevent duplicate discounts from occurring in Medi-Cal and therefore ensure compliance with federal rules. The potential savings generated by the Governor's proposal would increase the amount of General Fund resources available for appropriation by the Legislature. Since the associated savings would benefit the state General Fund rather than covered entities, the availability of these greater resources would give the Legislature additional flexibility to pursue its priorities and maximize legislative oversight over how savings resulting from prescription drug discounts are targeted. While the state General Fund savings are likely less than the reduction in 340B savings for covered entities since Medicaid drug rebates have to be shared with the federal government, spending the additional savings on Medi-Cal or another state program in which the federal government shares in the cost would increase the total benefit to the state beyond what it would otherwise be. Finally, the Legislature could choose to allocate the additional savings to covered entities to, for example, attempt to hold them harmless for the change while at the same time providing input into how this allocated funding is spent by covered entities. (As previously highlighted, there are no restrictions under the 340B Program on how covered entities may use savings resulting from 340B prescription drug discounts.)

Before Reaching a Decision on the Governor's Proposal, the Legislature Should Ask for Additional Key Information From DHCS. Certain key pieces of information that could inform the Legislature's decision on the Governor's 340B proposal have not yet been made available to the Legislature. We recommend that the Legislature request that DHCS gather the following key pieces of information for submittal to the Legislature before making a decision on the Governor's 340B proposal:

Medi-Cal Savings Estimate. The administration has not released an estimate of the amount of state savings its 340B proposal would generate for the Medi-Cal program if enacted. This information is critical for understanding the state fiscal impact of eliminating the use of the 340B Program in Medi-Cal.

Fiscal Impact of Proposal on Covered Entities. The impact of the Governor's proposal on covered entities' 340B savings and the overall benefit they receive from the program is currently unknown. Because the information needed to develop an estimate of this fiscal impact is likely not readily available to the administration, we recommend that the Legislature request for DHCS to collect this information from covered entities operating in the state.

Analysis of Alternative Policy Approaches. The Governor's proposal to prohibit the dispensing of 340B prescription drugs to Medi-Cal enrollees comes with advantages to the state—such as generating state savings and likely simplifying the administration of the Medi-Cal prescription drug benefit—as well as trade-offs—such as reducing the fiscal benefit covered entities' receive through the 340B Program. Alternative policy approaches that would be designed to ensure

compliance with the federal rules on duplicate discounts and protect Medi-Cal program integrity exist, but these would feature different trade-offs when compared to the Governor's approach. Below, we offer a preliminary analysis of several alternative policy approaches to address the challenges associated with the use of the 340B Program in Medi-Cal. We recommend that the Legislature request additional information from the administration on the trade-offs associated with alternative policy approaches. Such alternative policy approaches include, but are not limited to:

Prohibit or Limit the Dispensing of 340B Drugs to Medi-Cal Enrollees at Contract Pharmacies. As proposed under the Governor's proposal in case the federal government rejects the full elimination of the use of the 340B Program in Medi-Cal, an alternative policy approach would be to prohibit or limit the dispensing of 340B prescription drugs to Medi-Cal enrollees at contract pharmacies. (These pharmacies would continue to be allowed to dispense prescription drugs to Medi-Cal enrollees, just not under the 340B Program.) A potential benefit of this approach is that it would target an area of the 340B Program in Medi-Cal that is challenging to oversee from a state perspective. It would likely generate some state savings, though the savings would be less than under the Governor's proposed full elimination of the use of the 340B Program in Medi-Cal. Covered entities would still be able to retain some savings through the 340B prescription drugs dispensed to Medi-Cal enrollees—though the amount of savings would likely be less than under current state policy. Contract pharmacies, on the other hand, would no longer be able to benefit from savings under the 340B Program. All in all, this approach could help to ameliorate the problem of duplicate discounts.

Prohibit or Limit Certain Covered Entities From Dispensing Certain or All 340B Prescription Drugs to Medi-Cal Enrollees. As proposed under the Governor's proposal in case the federal government rejects the full elimination of the use of the 340B Program in Medi-Cal, an alternative policy approach would be to prohibit or limit certain types of covered entities from dispensing certain or all 340B prescription drugs to Medi-Cal enrollees. The Governor's proposal does not specify which types of covered entities could be prohibited or limited from using the 340B Program in Medi-Cal (or which prescription drugs could be targeted for exclusion). Potential policies the administration could pursue under this approach include, for example, prohibiting the use of 340B prescription drugs in Medi-Cal managed care. Alternatively, the administration could prohibit most covered entities from dispensing 340B prescription drugs to Medi-Cal enrollees but exempt certain covered entities that are needed to ensure access to care from this prohibition. A potential benefit of this approach is that DHCS could specifically target those covered entities or prescription drugs for which the interaction between the 340B Program and the Medicaid rebate program proves most administratively complex and challenging. However, short of the full elimination of the use of the 340B Program in Medi-Cal, some degree of administrative complexity as related to the Medi-Cal prescription drug benefit

would remain. In addition, the Governor's alternative approach would delegate to the administration significant authority to craft state policy concerning the use of the 340B Program in Medi-Cal, and thereby potentially serve to limit the Legislature's role in determining the state's policy approach. While this approach would likely result in some state savings, the amount of savings would likely be less than under the Governor's proposed full elimination of the use of the 340B Program in Medi-Cal. All in all, this approach could, depending on how it was ultimately implemented by DHCS, help to address the problem of duplicate discounts.

Pay for 340B Prescription Drugs at Cost in Managed Care. Requiring MCPs to pay covered entities for 340B prescription drugs at covered entities' actual acquisition costs plus a professional dispensing fee, as currently required in Medi-Cal FFS, would be yet another alternative policy approach. A potential benefit of this approach is that it would allow the state (rather than covered entities and their partners) to benefit from the savings generated by the 340B Program within the Medi-Cal managed care delivery system and harmonize the reimbursement levels that the state pays for 340B drugs across FFS and managed care. State savings generated under this approach could potentially be comparable to those generated under the Governor's proposed full elimination of the use of the 340B Program in Medi-Cal. However, given the need under this approach to still make efforts to prevent duplicate discounts, this approach would likely be relatively more administratively burdensome than the Governor's proposal and could require additional state resources.

The Implications of the Status Quo. Finally, we note that the Legislature could elect to maintain existing state policy related to the use of the 340B Program in Medi-Cal. This approach would not generate state savings as under the Governor's proposal or certain alternative approaches we discuss above and instead allow covered entities to continue to retain savings through the use of the 340B Program in Medi-Cal. Taking no action could place strain on DHCS given the challenges under existing state policy of preventing duplicate discounts, ensuring program integrity in Medi-Cal, and obtaining the maximum amount of potential state savings available through the federal Medicaid drug rebate program."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal, and requests the additional panelists to provide their perspectives and positions on this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 17: GENETICALLY HANDICAPPED PERSONS PROGRAM ESTIMATE

PANELISTS

- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The proposed 2018-19 Genetically Handicapped Persons Program (GHPP) budget includes total funds of $132.8 million ($118.3 million General Fund), compared to the 2017-18 estimate of $117.2 million ($98.7 million General Fund). The $19.6 million General Fund increase from 2017-18 to 2018-19 is due to the following:

- $8 million for year-over-year natural growth in costs for treatment/services including a slight increase (0.6%) in caseload;

- $8 million due to the high-cost drug Orkambi for cystic fibrosis; while current year utilization is down compared to Budget Act, the estimate assumes an increase in utilization costs for this drug in 2018-19; and

- $4 million increased General Fund costs due to lower offsets from blood factor drug rebates; data shows GHPP clients shifting away from blood factor products in favor of using long-lasting, lower-cost drugs, thereby reducing the available blood factor rebates and thereby increasing the need for General Fund to backfill.

Genetically Handicapped Persons Program State-Only Estimate			
	2017-18 Estimate	**2018-19 Proposed**	**CY to BY Change**
General Fund	$98,717,500	$118,326,500	$19,609,000 (20%)
Federal Funds	$0	$0	$0
Enrollment Fees	$434,700	$434,700	$0
Rebates Special Fund	$18,000,000	$14,088,000	($3,912,000) (-22%)
TOTAL FUNDS	**$117,152,200**	**$132,849,200**	**$15,697,000 (13%)**

BACKGROUND

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

medical condition covered by the GHPP and legislation over the years have added other medical conditions including Cystic Fibrosis, Sickle Cell Disease, Phenylketonuria, and Huntington's disease. The last genetic condition added to the GHPP was Von Hippel-Lindau Disease.

Unlike other programs, GHPP covers services even when they are not directly related to the treatment of the GHPP eligible medical condition; the approval of these services is subject to individual review based on medical need. There is no income limit for GHPP, however, GHPP clients may be required to pay an annual enrollment fee based on the client's adjusted gross income.

The mission of GHPP is to promote high quality, coordinated medical care through case management services through:

- Centralized program administration;
- Case management services;
- Coordination of treatment services with managed care plans;
- Early identification and enrollment into the GHPP for persons with eligible conditions;
- Prevention and treatment services from highly-skilled Special Care Center teams; and,
- Ongoing care in the home community provided by qualified physicians and other health team members.

Caseload

As shown in the table below, the administration anticipates a very slight increase in caseload in state-only GHPP.

GHPP State-Only Average Monthly Caseload			
	2017-18	2018-19	CY to BY Change
GHPP Caseload	655	659	4 (0.6%)

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the GHPP estimate and describe what is going on related to changes to the pharmacy reimbursement rate for blood clotting factors.

Staff Recommendation: No action is recommended at this time.

ISSUE 18: STAKEHOLDER PROPOSAL ON BLOOD CLOTTING FACTOR REIMBURSEMENT

PANELISTS

- **Linda Hurst,** Pharm. D., Vice President, Herndon Pharmacy, Fresno

Public Comment

PROPOSAL

The Advocating for Access Specialty Pharmacy Coalition (AfA) requests trailer bill language that would change the current statute to require blood factor reimbursement to be based on Wholesale Acquisition Cost (WAC), not to exceed the current statutory reimbursement rate of 120 percent of the Average Sales Price (ASP).

BACKGROUND

The AfA provided the following background information:

In October 2017, DHCS presented their proposed reimbursement methodology change for blood factors at a stakeholder meeting. DHCS contends that their proposed change to reimbursement for blood clotting factor does not require legislative authority because Welfare and Institutions Code Section 14105.86(b) states that reimbursement for blood factor "shall not exceed 120 percent of the average sales price" and their proposed cuts to reimbursement will not exceed 120 percent of the average sales price. The AfA asserts that the proposed changes to reimbursement for blood clotting factor would result in drastic cuts to specialty pharmacies that serve bleeding disorder patients and threaten patient access, health and safety. Bleeding disorder patients receive life-saving blood clotting factor from local specialty pharmacies.

Hemophilia is an inherited disorder, which is quite rare both nationally and across the globe. According to the National Heart, Lung and Blood Institute, about 18,000 Americans are diagnosed with hemophilia. Individuals with hemophilia have low or non-existent levels of blood clotting proteins, called factor. Hemophilia is characterized by uncontrolled bleeding, caused by trauma or many times spontaneous bleeding episodes into muscles and joints. Joint bleeding will lead to the development of painful, disabling hemophiliac arthropathy. Bleeding disorder patients are always at risk for life-threatening bleeding such as intracranial hemorrhage and internal organ bleeding. Blood clotting factor medications are used for the treatment and prevention of these bleeds and is dispensed by a specialty pharmacy. Specialty pharmacies provide a team-based care approach to managing the patient's care by working closely with the patient, their physician and caregivers.

Specialty pharmacies are key drivers in ensuring quality and cost-effective care by optimizing pharmacy management and ensuring patient involvement. Bleeding Disorder patients need access to quality specialty pharmacy providers that meet the National Hemophilia Foundation's Medical and Scientific Advisory Council (MASAC)

Recommendation 188 and meet California AB 389. Bleeding Disorder patients require specialty pharmacist medication adherence, which leads to lower total health care costs. Reductions in hospitalizations, joint replacements and emergency department visits are key drivers of declining health care costs associated with improved clotting factor medication adherence.

Optimizing pharmacy management is crucial to cost management in hemophilia care. The following data describes the specialized and expensive management services specialty pharmacies provide to bleeding disorder patients to reduce the total cost of care:

a. **Preventing avoidable Emergency Department visits**
   i. Proactively preventing access issues-supplies, dosing issues, inventory management
   ii. 24-7-365 Emergency on call coverage
   iii. Providing nursing to prevent ER Visit
   iv. Emergency shipment-same day delivery to prevent ER Visit
b. **Preventing continuing bleeds**
   i. Proactively educating patients on the importance of prompt treatment within 2 hours of bleed onset.
   ii. Educating patients and caregivers on the importance of R.I.C.E.5
c. **Preventing target joint development-Target Joint definition can vary but the most common definition is 4 or more bleeds in the same joint over a 6-month period.**
   i. Proactively educating patient on target joint development and the importance of preventing the development of target joints.
   ii. Monitoring the risk of target joint development
d. **Precision Dispensing-Preventing wastage and reducing cost by dispensing product as close to the dose as possible.**
   i. Managing expensive inventory of clotting factor product in various assay sizes to manage treatment doses as close as possible to the prescription.

The proposed DHCS blood clotting factor reimbursement methodology would drastically cut reimbursement to specialty pharmacies by approximately 75-90 percent, which would threaten patient access, quality of care and patient safety. The proposed reimbursement methodology would require providers to bill at Actual Acquisition Cost (AAC) and Medi-Cal would reimburse providers the billed amount, not to exceed ASP+20%. In addition, the proposed methodology includes a Professional Dispensing Fee of $10.05 or $13.20, as well as an administrative service fee of $474.69 for contracted providers.

AfA is concerned that DCHS's proposed reimbursement methodology would result in a reduction of approximately 75-90% from the current reimbursement rate. In addition, AfA is concerned that the proposed reimbursement methodology of billing for the administrative service fee will require another prior authorization, adding to provider's administrative cost as well as the state's cost of processing this per diem. They are concerned that DHCS will not be able to timely administrate the collection of provider invoices on a quarterly basis because it will be a complicated process to review

invoices, cost changes and calculate that charges were appropriate and below ASP+20%. As a result, there is a real danger that the state will not pay claims promptly under this proposed reimbursement methodology. Most importantly, they are concerned that patients will not have access to clotting factor medications in their homes to treat bleeds promptly, prevent devastating joint damage and prompt treatment of any life-threatening bleed before getting to the ER. Patient quality of care and access to care could revert to the 1980s, when patients had a median of 23.5 bleeds (range 1-107) annually and a median of 20 joint bleeds (range 0-52) annually.

In an effort to reduce costs and preserve patient access and safety, AfA requests trailer bill language that would change the current statute to require blood factor reimbursement to be based on Wholesale Acquisition Cost (WAC), not to exceed the current reimbursement rate of 120 percent of the Average Sales Price (ASP).

The current reimbursement rate for blood factors is contained in Welfare and Institutions Code Section 14105.86(b) which states that reimbursement for blood factors shall be by national drug code and "shall not exceed 120 percent of the average sales price of the last quarter reported." AfA requests trailer bill language which would amend Section 14105.86 (b) to read: "The reimbursement for blood factors shall be by national drug code and shall be the published wholesale acquisition cost of the benchmark National Drug Code, not to exceed 120 percent of the average sales price of the last quarter reported."

AfA recommends a WAC based pricing methodology as other states have utilized. The WAC based methodology would allow for efficient electronic billing and prompt payment and would not require the state to hire additional employees to administrate payment. Further, WAC based prices are often lower than the current DHCS reimbursement rate for blood factors, which is ASP plus 20 percent. AfA believes that a WAC based methodology would save the state more money than the current proposed DHCS reimbursement change, while still preserving patient access to life-saving medications.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Linda Hurst present this proposal.

The Subcommittee requests DHCS respond to the following:

1. Has CMS issued a specific deadline for California to submit a State Plan Amendment to change the reimbursement for blood factors?

2. How many stakeholder meetings has DHCS had on the proposed change to the pharmacy reimbursement?

3. What impact will this change have on patients' access to care and to these products? Will there be fewer specialty pharmacies willing to accept blood factor patients?

4. If yes, will patients need to access care through emergency rooms instead? Do all ERs have all clotting factors in stock to treat patients?

5. Has DHCS done an analysis as to what the increased hospital and ER costs could be if fewer specialty pharmacies accept Medi-Cal patients?

6. Does DHCS have contracts for specialty services with Specialty Pharmacies that dispense blood factors?

7. If yes, do these contracts include Performance Obligations? What are they? Do Specialty Pharmacies meet these performance requirements?

8. Do the performance requirements require specialized services and expertise in hemophilia?

Staff Recommendation: No action is recommended at this time.

ISSUE 19: CHILD HEALTH AND DISABILITY STATE-ONLY PROGRAM

PANELISTS

- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The estimate for the Child Health and Disability Program (CHDP) (non-Medi-Cal, state-only funding) includes $3,000 General Fund for 2018-19, reflecting no change to the estimate from the current year (2017-18) estimate for the program. This reflects no expected change to utilization, which is estimated to be 36 CHDP screens per year.

BACKGROUND

The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment. The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

In July 2003, the CHDP program began using the "CHDP Gateway," an automated pre-enrollment process for non-Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal or formerly the Healthy Families program.

Historically, the CHDP program has provided state funded health assessments and immunizations to low income children and youth. In fiscal year (FY) 2003-04, the CHDP Gateway was implemented which shifted CHDP services costs to Medi-Cal and provided Medi-Cal Administrative funding to local CHDP Programs. The CHDP Gateway is an electronic enrollment system that operates at CHDP provider offices to enable the providers to electronically enroll children and youth in limited duration presumptive eligibility full scope Medi-Cal and encourages families to enroll their children in ongoing Medi-Cal coverage. When the Gateway was implemented, residual state-only CHDP services funding was retained to provide state funded health assessments and immunizations to children and youth with limited scope emergency Medi-Cal (e.g., children and youth with ineligible immigration status).

Caseload and expenditures have been close to eliminated as a result of the expansion of eligibility for full-scope Medi-Cal services to individuals under the age of 19, regardless of immigration status, that began in May 2016, pursuant to the provisions of SB 75 (Committee on Budget and Fiscal Review, Chapter 18, Statutes of 2015). All children who only had emergency Medi-Cal prior to the implementation of SB 75 now have full scope Medi-Cal, including the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. As such, DHCS states that CHDP state-only services are no longer needed as these services are now provided by Medi-Cal under the EPSDT benefit.

Currently, all children and youth under 21 years of age who are full scope Medi-Cal beneficiaries receive well child health assessments and immunizations under the EPSDT benefit. The majority of these beneficiaries are enrolled in Medi-Cal managed care health plans and receive capitated EPSDT services from their plan provider network. The residual CHDP Medi-Cal fee-for-service (FFS) population (e.g., foster care beneficiaries and presumptive eligibility beneficiaries) receive those same well-child health assessments and immunizations through Medi-Cal funded FFS CHDP providers. Prior to the SB 75 expansion of Medi-Cal, CHDP also provided state funded (state-only) health assessments to children/youth under age 19 from families under 200 percent of the federal poverty level (FPL) who had limited scope emergency Medi-Cal.

Caseload

The following table shows the dramatic decrease in utilization (caseload) over the past several years primarily reflecting implementation of the Affordable Care Act and SB 75:

YEAR	TOTAL NUMBER OF CHDP SCREENS
2013-14	22,927
2014-15	15,923
2015-16	5,937
2016-17	494
2017-18	36
2018-19	36

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the CHDP estimate.

Staff Recommendation: No action is recommended at this time.

ISSUE 20: EVERY WOMAN COUNTS PROGRAM ESTIMATE

PANELISTS

- **Rene Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The proposed 2018-19 budget includes $36 million total funds ($9 million General Fund) for EWC, a $3 million (9.2%) increase from the 2017-18 estimate of $32.9 million ($6 million General Fund). As shown below, most of the funding is tobacco tax revenue. The $3 million increase reflects:

- The transition from an accrual to a cash budget, as approved through the 2017 health budget trailer bill; and

- Expenditure data through June 2017 which showed higher expenditures than previously projected, and reprocessing and correction of some claims are anticipated to increase costs.

Every Woman Counts Estimate

Funding	2017-18 Estimate	2018-19 Proposed	CY to BY Change
General Fund	$6,000,000	$8,962,000	$2,962,000 (49%)
Proposition 99	$14,515,000	$14,515,000	$0
Breast Cancer Control Account	$7,912,000	$7,989,000	$77,000 (1%)
Federal (CDC) Funds	$4,509,000	$4,509,000	$0
TOTAL FUNDS	**$32,936,000**	**$35,975,000**	**$3,039,000 (9.2%)**

BACKGROUND

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

treatment. EWC was transferred to DHCS from the Department of Public Health in 2012.

EWC provides breast cancer screening and diagnostic services to California's uninsured and underinsured women age 40 and older whose incomes are at or below 200 percent of the Federal Poverty Level (FPL). Women age 21 and older may receive cervical cancer screening and diagnostic services. EWC also provides outreach and health education services to recruit and improve cancer screening and early cancer detection in underserved populations of African-American, Asian-Pacific Islander, American Indian, older, and rural women. EWC covered benefits and categories of service include office visits, screening, diagnostic mammograms, and diagnostic breast procedures, such as ultrasound, fine needle and core biopsy, pap test and HPV co-testing, colposcopy and other cervical cancer diagnostic procedures and case management.

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

Caseload

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

YEAR	EWC Caseload
2013-14	292,914
2014-15	275,219
2015-16	161,000
2016-17	25,030
2017-18	26,820
2018-19	26,820

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the EWC Program estimate.

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

ISSUE 21: CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM ESTIMATE

PANELISTS

- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Excluding Medi-Cal costs, the proposed 2018-19 CCS budget includes total funds of $88.8 million ($83.4 million General Fund), as compared to the current year (2017-18) estimate of $82.9 million total funds ($77.5 million General Fund). The increase in General Fund primarily reflects the costs of the following new high-cost treatments:

- DEFLAZACORT: A lifetime treatment of Duchenne Muscular Dystrophy (DMD) patients.
- Exondys 51: A lifetime treatment of DMD in patients who have a confirmed mutation in the DMD.
- SPINRAZA: A lifetime treatment program for spinal muscular atrophy (SMA).
- CERLIPONASE ALFA (BRINEURA): A lifetime treatment to slow the progression of infantile ceroid lipofuscinoses, neuronal, type 2 (CLN2).

CCS Budget
(Non-Medi-Cal)

	2017-18 Estimate	2018-19 Proposed	CY to BY Change
General Fund	$77,478,100	$83,371,700	$5,893,600 (7.6%)
Federal Fund	$5,453,000	$5,453,000	$0
TOTAL FUNDS	**$82,931,100**	**$88,824,700**	**$5,893,600 (7.1%)**

BACKGROUND

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

Historically, the CCS program has served children who fit into three categories: 1) children in Medi-Cal; 2) Children in Healthy Families; and 3) "State-only" children who are not eligible for either Healthy Families or Medi-Cal. The Family Health Estimate

includes CCS costs only for children who are not in Medi-Cal. The largest category of children in CCS are in Medi-Cal, however these costs are contained separately, in the Medi-Cal estimate. State-only children, who are not eligible for Medi-Cal, qualify for CCS by being in a family for which their estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

The CCS program is administered as a partnership between county health departments and DHCS. For CCS-eligible children in Medi-Cal, their care is paid for with state-federal matching Medicaid funds. The cost of care for CCS-Only children is funded equally between the State and counties. The cost of care for CCS children who had been in the Healthy Families program was, and continues to be, funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds, despite the fact that these children have transitioned into Medi-Cal.

Whole Child Model

SB 586 (Hernández, Chapter 625, Statutes of 2016) authorizes DHCS to establish a "Whole Child Model" (WCM) for children enrolled in both Medi-Cal and CCS in 21 counties served by four county organized health systems, instead of the existing arrangement in most counties where CCS services are “carved out” from the Medi-Cal managed care plan. The bill continues the CCS carve-out in the remaining 37 counties until January 1, 2022.

The WCM is being implemented in the following 21 counties served by four COHS plans: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo.

This bill contains a number of provisions to ensure the expertise and quality of care in CCS is preserved as part of the transition to the WCM, including requirements for plan readiness, time-limited continuity of care, ensuring CCS benefits are provided according to CCS program standards; requiring Medi-Cal managed care plans to facilitate timely access to services by CCS providers and facilities with clinical expertise in treating the enrollee’s specific CCS condition; requiring DHCS to pay plans participating in the WCM a new actuarially sound rate specifically for CCS children and youth; requiring a “rate floor” for CCS providers; and requiring an independent evaluation that compares CCS services in WCM counties before and after CCS services are carved into the plan, and that compares the WCM counties to other counties where CCS is not carved into the plan.

Caseload

After several years of dramatic decreases with increases in CCS-Medi-Cal reflecting the Medi-Cal expansion to cover all eligible children regardless of immigration status, adopted through SB 75 (2015 budget trailer bill), caseload is expected to be stable in the state-only CCS program, at approximately 15,621 children.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present the CCS state-only program estimate and provide an update on the implementation of SB 586.

Staff Recommendation: No action is recommended at this time.

ISSUE 22: HOSPITAL QUALITY ASSURANCE FEE BUDGET CHANGE PROPOSAL & TRAILER BILL

PANELISTS

- **Linda Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey,** Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Budget Change Proposal:
DHCS requests permanent and three-year limited-term (LT) authority for the Hospital Quality Assurance Fee (HQAF) program. A total of 11.5 permanent positions and expenditure authority: 2.0 new permanent positions effective July 1, 2018 and the conversion of 9.5 existing limited-term (LT) positions to permanent effective January 1, 2019. In addition to the permanent positions, three-year LT resources equivalent to 9.5 positions effective July 1, 2018. The total request is $2,269,000 ($1,135,000 HQAF Fund and $1,134,000 Federal Fund) in FY 2018-19.

In November 2016, the voters of California passed Proposition 52 which permanently extended the HQAF program. The conversion of 9.5 current LT positions and contract funding to permanent are needed for ongoing administration and implementation of the HQAF program. The 2.0 new permanent positions will address new workload demands as a result of Centers of Medicare and Medicaid Services' (CMS) requirements for annual upper payment limit (URL) reviews, program impacts related to the managed care rule, and to further support the continuation of the HQAF program. The three-year LT resources equivalent to 9.5 positions are needed to meet new workload demands arising from the implementation of a new HQAF managed care directed payment model pursuant to federal regulations.

Trailer Bill:
This proposal would authorize DHCS to be reimbursed, no more than $500,000 per fiscal quarter, for staffing or administrative costs for implementing the new directed payment mechanism for the Hospital Quality Assurance Fee (HQAF) program, consistent with the federal rule.

BACKGROUND

Budget Change Proposal:
The HQAF program was established on April 1, 2009, by Assembly Bill (AB) 1383 (Chapter 627, Statutes of 2009), and was subsequently extended by Senate Bill (SB) 90 (Chapter 19, Statutes of 2011), SB 335 (Chapter 286, Statutes of 2011), and SB 239 (Chapter 657, Statutes of 2013). In November 2016, the voters of California passed Proposition 52, which permanently extended the HQAF program. The HQAF program

collects fees from private hospitals and uses these funds, matched with federal funds, to provide supplemental payments to managed care plans in order to enhance reimbursement for hospital services and provide funding for health care coverage for children in the Medi-Cal program. The program provides Medi-Cal managed care supplemental payments of approximately $3-4 billion annually for Medi-Cal hospital services, over $850 million annually in children's health care funding, and supports hospital services for Medi-Cal beneficiaries. In 2015, Budget Change Proposal (BCP) SNFD 15-05 HQAF authorized 9.5 LT positions and contract funding effective from January 1, 2016 to December 31, 2018.

On May 6, 2016, CMS issued a final rule that amends and expands the requirements of Title 42, Code of Federal Regulations, Part 438 (42 CFR 438) pertaining to Medicaid managed care. Pursuant to 42 CFR 438.6, HQAF program payments in managed care constitute unallowable direction of payment, and must be discontinued, phased down over a 10-year period, or converted into an allowable directed payment model. To continue providing critical funding for hospital services and minimize risks related to CMS approval of future capitation rates including HQAF program payments, and in consultation with CMS and the private hospital stakeholder community, DHCS is converting the majority of HQAF program payments into an allowable directed payment model. The new private hospital directed payment model will implement a uniform dollar or percentage increase in reimbursement to private hospitals that provide designated services under their contracts with Medi-Cal managed care plans. The payments will be based on actual utilization of inpatient and outpatient hospital services, and structured utilizing a pool approach that caps payments to a maximum amount each year. The maximum amount of the pool will be reevaluated annually. The directed payment model pool amount is anticipated to be approximately $2.1 billion in 2017-18.

Continuation of the HQAF program administration, on an ongoing basis due to passage of Proposition 52 in November 2016, requires a change to the existing staffing levels from LT positions to permanent positions. Permanent positions are necessary to support and maintain infrastructure across multiple divisions: Safety Net Financing Division (SNFD), Third Party Liability and Recovery Division (TPLRD), Capitated Rates Development Division (CRDD), and the Office of Legal Services (QLS). These resources were originally limited-term since the HQAF program had a sunset date. Ongoing legal consultation services are needed to continue supporting the program and build payment rates. The three-year LT resources equivalent to 9.5 positions are needed to perform workload associated with the new HQAF directed payment model. Limited-term resources impact Managed Care Quality and Monitoring Division (MCQMD) and CRDD.

Trailer Bill:
The HQAF program contains a provision providing funding from the fee to pay for DHCS's staffing and administrative costs directly attributable to implementing the program, not to exceed $250,000 per fiscal quarter.

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that amended and expanded the requirements of Title 42, Code of Federal Regulations Part 438 pertaining to Medicaid managed care. The final rule introduced

new requirements, practices, and procedures related to Medicaid capitation rate setting, and fundamentally changed existing requirements. In particular, the final rule prohibits states from directing provider reimbursement through managed care contracts (Title 42 CFR Section 438.6(c-d)), except in the following circumstances:

- Through one of the following allowable directed payment mechanisms:
  - Value-based purchasing models for provider reimbursement, such as pay-for-performance arrangements, bundled payments, or other payment arrangements that recognize value or outcomes over volume of services;
  - Delivery system reform or performance improvement initiatives; and
  - Minimum or maximum fee schedules, or uniform dollar or percentage increases, for network providers that provide designated services under the contract; or
  - Through existing pass-through payments, as defined in Title 42 CFR Section 438.6(a), subject to a 10-year phase-down and annual "base amount" calculation beginning July 1, 2017.

Pursuant to Title 42 CFR Section 438.6, HQAF program payments in managed care constitute an unallowable payment, which must be discontinued, and either phased down over a 10-year period or converted into an allowable directed payment mechanism. To continue providing funding for hospital services and minimize risks related to CMS approval of future capitation rates, including HQAF program payments, and in consultation with CMS and the private hospital community, DHCS is in the process of converting the majority of HQAF program payments into an allowable directed payment. The new directed payment will implement a uniform dollar or percentage increase in reimbursement to private hospitals that provide designated services under their contracts with Medi-Cal managed care plans. The implementation of the directed payment mechanism for the HQAF program represents significant additional workload for DHCS necessitating additional resources that would exceed the allowable $250,000 per quarter.

To bring HQAF program payments in managed care into compliance with the federal Medicaid managed care regulations, DHCS requires additional resources that would exceed the allowable funds available via statute currently. This proposal would authorize DHCS to be reimbursed, no more than $500,000 per quarter, for staffing or administrative costs for implementing the new directed payment for the HQAF program, consistent with the federal rule.

The current cap on funds used for the administration of the HQAF program would not support necessary resources to comply with changes in federal requirements. This would significantly delay or jeopardize the HQAF program that results in $3-4 billion for private hospitals and over $850 million to fund children's health services annually.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 23: GRADUATE MEDICAL EDUCATION PROGRAM OVERSIGHT & MONITORING BUDGET CHANGE PROPOSAL

PANELISTS

- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Safety Net Financing Division (SNFD), requests 2.0 full-time permanent positions and expenditure authority of $244,000 ($122,000 Federal Fund and $122,000 Designated Public Hospital Graduate Medical Education Special Fund). The resources will support fiscal oversight and programmatic monitoring requirements related to 42 Code of Federal Regulations (CFR) § 438.60, that authorizes DHCS to implement the Medicaid Graduate Medical Education (GME) Program.

The 2.0 full-time positions will complete new workload associated with the development, implementation, training and administration of the GME program under which payments will be made to Designated Public Hospitals (DPH) and their affiliated government entities participating in the Medi-Cal managed care program. No General Fund is necessary for these positions, as the DPHs will be required to pay for the non-federal share of the positions.

BACKGROUND

The GME program aims to improve service delivery for Medi-Cal beneficiaries in Medi-Cal managed care settings by providing financial support to train and retain health care professionals in California.

The Medicare enactment of direct and indirect GME identified the importance of paying the extra costs of teaching hospitals to ensure seniors' ability to access the care they require. According to the 1997 Balance Budget Act, Medicare capped the levels of funding for both direct and indirect GME costs when the number of allopathic and osteopathic medical residents exceeded the expected limit. In accordance with 42 C.F.R. § 438.60, DHCS is authorized to make new GME payments to DPH systems. DHCS anticipates making similar goals as Medicare, except with the focus on hospitals providing services to the managed care population.

GME is the post-medical school supervised hands-on training that all physicians complete to become independent and licensed practitioners. The length of this training varies depending on specialty, but generally lasts three to five years. Residents and supervising physicians at teaching hospitals are available around the clock and are

prepared to care for critically ill or injured patients, with hospitals typically absorbing the cost of training.

Hospitals that train new heath care providers incur significant costs beyond those customarily associated with patient care. Currently, these GME expenditures are not included in the Medi-Cal Managed Care capitation rates. DHCS is implementing a new GME program, building from the Medicare program as it uses similar methods, data sources and provides reimbursement for Medi-Cal's share of the providers' GM E costs. This new GME program will provide a combination of direct GME payments, recognizing Medi-Cal's share of the cost of training new health care providers and indirect GME payments, recognizing the additional time and resources a system provides to do that training, and can be viewed as incentive payments that recognize the importance of training a new generation of workforce. This proposal will provide DHCS the necessary staffing to effectively implement a new GME program with the fiscal oversight and programmatic monitoring provisions outlined in 42 C.F.R. §438.60 .

The DHCS, Safety Net Financing Division (SNFD), is responsible for the on-going management, administration, and monitoring of Fee-For-Service (FFS) reimbursement payment systems for general acute care hospitals and supplemental payments for providers that serve the Medi-Cal population. This includes developing policy and related processes, documenting program policy needs, and acting as liaison with all DHCS's divisions for all aspects of FFS reimbursement and supplemental payments. In addition, part of this responsibility is to collaborate with and facilitate regular meetings with hospital stakeholder groups and hospital representatives.

To develop, coordinate, implement, and administer the GME Program, SNFD requests 2.0 permanent positions: 1.0 Associate Governmental Program Analyst (AGPA) and 1.0 Health Program Specialist I (HPS I).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 24: FEDERAL MANAGED CARE REGULATIONS IMPLEMENTATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS requests position and contract funding for the ongoing efforts to implement the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule CMS-2390-F (Final Rule). Previously approved limited-term (LT) resources are set to expire on June 30, 2018. This proposal continues the same level of staff resources, permanently, as follows: 9.0 positions and expenditure authority, expenditure authority equivalent to 4.0 positions, and contractual funding of $1,300,000. Total funding request: $3,094,000 ($1,547,000 GF; $1,547,000 FF) in FY 2018-19 and ongoing.

The Centers for Medicare & Medicaid Services (CMS) issued the Final Rule, which made changes to the Medicaid managed care regulations to reflect the increased utilization of managed care as a delivery system. The resulting regulations align the rules governing Medicaid managed care with those of other major sources of coverage, including Qualified Health Plans (QHPs) and Medicare Advantage (MA) Plans; implement statutory provisions; change actuarial payment provisions; promote quality of care; and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. They also strengthen beneficiary protections and policies related to program integrity. Additionally, this rule requires states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries.

BACKGROUND

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

States design, administer, and oversee their own Medicaid managed care programs within the requirements set forth in federal Medicaid law and further elaborated in regulation. These federal regulations, last updated in 2002, set forth state responsibilities and requirements in areas including enrollee rights and protections, quality assessment and performance improvement (including provider access standards), external quality review, grievances and appeals, program integrity, and sanctions. The 2002 regulations (67 Fed. Reg. 409089, June 14), were a response to the Balanced Budget Act of 1997 (Pub. L. 105-33).

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

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

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

Fundamentally, the Final Rule extends a more rigorous regulatory structure to all forms of capitated managed care, whether they be full-risk MCQs or partially capitated plans. The reforms themselves sweep across a broad landscape.

DHCS previously submitted two Budget Change Proposals (BCP) for the Final Rule:

- FY 2016-17 May Revise Letter - Federal Managed Care Regulations Staffing Resources 4260-402-BCP-BR-2016-MR (38.0 permanent positions and two-year LT funding equivalent to 19.0 resources; all LT resources expire June 30, 2018). $3,000,000 in ongoing contract expenditure authority was included in this proposal for support in data auditing and validation by an EQRO. This is critical for DHCS to have the appropriate resources to evaluate and publicly report MCP health outcomes and utilization factors that Medi-Cal members experience when accessing services in the managed care delivery system. The Encounter Data Validation activity was postponed due to data enhancements that DHCS was working on. The enhancements are now complete, and DHCS is moving forward with this activity in FY 2017-18.

- FY 2017-18 BCP - Federal Managed Care Regulations 4260-018-BCP-2017-GB (15.0 permanent positions and four-year LT funding equivalent to 40.0 resources; all LT resources expire June 30, 2021). External contract authority was included in this proposal to support the Mental Health Services Division and the Director's Office as follows:
  - Mental Health Services Division - $471,000 in FY 2017-18 and $606,000 in FY 2018-19 and ongoing.
    External contract funding for, but not limited to 1) External Quality Review; 2) translation of informational materials to the State's threshold languages and compliance with accessibility requirements for Limited English Proficient Medi-Cal beneficiaries; and 3) technical assistance activities to build infrastructure to implement the Final Rule.

  - Directors Office - $538,000 in FY 2017-18 and $763,000 in FY 2018-19 to FY 2020-21.
    Department-wide external contracts for technical assistance in conjunction with State staff to implement the Final Rule.

The Final Rule provisions have staggered implementation dates, with some beginning immediately, some implementing 60 days following the Final Rule publication date (5/6/16), and some implementing in contract years 7/1/17, 7/1/18, and 7/1/19. Although these previous BCPs included resources related to implementation of the Final Rule, due to the staggered implementation dates and the ongoing monitoring and workload associated with the Final Rule, DHCS is requesting continued staffing and contract resources in this proposal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 25: MEDI-CAL PROGRAM INTEGRITY DATA ANALYTICS SPRING FINANCE LETTER

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Audits and Investigations (A&I), requests limited term expenditure authority of $9,000,000 ($2,250,000 General Fund (GF) and $6,750,000 Federal Fund (FF)) in Fiscal Year (FY) 2018-19 and up to $10,000,000 in FY 2019-20 subject to meeting the requirements of provisional language in the 2018-19 Budget.

The contract allows DHCS A&I staff to access numerous proprietary databases to gain additional information about providers to identify and prioritize its investigations. The contractor will sort approximately 200 million Medi-Cal fee-for-service (FFS) claims, including Mental Health and Substance Use Disorder services claims, through statistical models and intelligent technologies to uncover patterns and relationships in Medi-Cal claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent or erroneous.

BACKGROUND

In 2010, Congress passed the Small Business Act, which required the Centers for Medicare and Medicaid Services (CMS) to implement a Medicare predictive modeling system and other analytic modeling technology. Based upon the success of the Medicare implementation, CMS was then expected to determine the feasibility of implementing the same technology within state Medicaid programs. Not long after the enactment of the Small Business Act, CMS began to encourage Medicaid program integrity units to pursue new data analytics technologies within their respective states. While the initial focus was placed on predictive analytics, the absence of a consistent definition for what predictive analytics entails led to the consensus that states should pursue enhanced data analytics, which may include predictive modeling and link analysis as options.

In addition to the Small Business Act of 2010, the Affordable Care Act (ACA), also enacted in 2010, contained a myriad of new program-integrity requirements to prevent, detect and take strong enforcement action against fraud in the Medicaid program. The thought behind the new requirements was to focus more on fraud prevention and front-end program integrity measures versus the traditional "pay and chase" model where efforts are made to recoup overpayments identified after the payments to providers have already been made. Some of the new requirements included enhanced provider

screening and enrollment expectations, finger-printing of high-risk provider types as a condition of enrollment and payment suspension when a credible allegation of fraud has been established against a provider.

Events in 2013 accelerated DHCS' need to enhance its data analytics capabilities. Rehab Racket, a CNN investigative news story, aired on July 29, 2013, shortly after management and oversight of the Drug Medi-Cal (DMC) program was transferred from the Department of Alcohol and Drug Programs to DHCS, citing widespread fraud in the California program. DHCS proactively and aggressively responded by performing field visits of all DMC providers in the state in an effort to identify unscrupulous activity. Ultimately, DHCS A&I visited 497 facilities, suspended 87 DMC providers from the program representing over $59 million in annual billings, and sent 98 fraud referrals to the California Department of Justice for criminal investigation and prosecution. As of October 2017, criminal charges have been filed against 48 of the suspended DMC providers and 137 affiliated individuals

To complement the DMC investigative field work performed by DHCS A&I staff, enhanced data analytics services were obtained via a short-term limited scope contract. The contractor subsequently ran an independent risk scoring algorithm for all DMC providers in the program and identified as high-risk many of the DMC providers, which DHCS A&I had also identified as suspect via its labor-intensive field visits. The data analytic tool identified many of the same suspect providers in a fraction of the time spent by DHCS A&I to reach the same conclusions. This highlighted the potential for increased efficiencies gained via the use of enhanced data analytics.

The short-term data analytics services yielded two conclusions. First, expanding the universe of data used to identify suspect targets beyond paid claims data has inherently increased the probability of identifying fraud in a more comprehensive fashion. Second, the new data analytics tools are user-friendly tools that can be utilized by all staff disciplines. Being a data scientist or a Statistical Analysis System programmer is no longer a prerequisite to use the tools. DHCS believes the enhanced data analytics tools, coupled with the new multi-disciplinary Special Investigations Unit (SIU) approach to investigations, will allow DHCS to efficiently address fraud and ensure the greatest global impact possible towards ensuring the integrity of the program.

In the 2014-15 Budget, DHCS received limited term expenditure authority of $5,000,000 ($1,250,000 GF; $3,750,000 FF) in 2014-15, $10,000,000 ($2,500,000 GF; $7,500,000 FF) in 2015-16 and 2016-17, and $5.0 million ($1,250,000 GF; $3,750,000 FF) in 2017-18 to secure a data analytics contractor to expand on recent data analytics activities that have enhanced DHCS's Medi-Cal program integrity efforts. Due to procurement challenges, DHCS only utilized some of the appropriation for an interim narrow pilot of high-risk providers using the California Multiple Award Schedules (CMAS) and Software as a License programs. The interim narrow pilot only provided data analytical services of the DMC and Specialty Mental Health Services (Short Doyle) claims. The Stage 2 Alternatives Analysis (S2AA) is currently being reviewed by the Department of Technology, with formal approval expected in April 2018. Approval of funding in 2018-19 and 2019-20 will allow expansion of the pilot using a contract awarded in July 2017 and approved by CMS in September 2017.

DHCS has made significant progress in implementing the new contract. DHCS started meeting with the contractor to discuss the project schedule, implementation requirements, data use and security agreements, and data acquisition issues. Currently, most planning and implementation requirements have been completed. The contractor is projecting full implementation of the expanded service in April 2018.

The federal government supports states taking advantage of these data analytic services for their Medicaid programs and has provided enhanced federal funding for these services, CMS approved a revised Advance Planning Document Update on February 12, 2018. Because this request is to enter into an IT contract and not build a system for Medi-Cal, this request assumes a 75 percent FFP share.

Due to procurement challenges, DHCS did not fully award a contract for data analytics services until July 2017. This proposal would extend funding for this pilot to allow for a full three years of data to be evaluated.

The 2013 MPES found that 7.96 percent of payments to FFS Medi-Cal providers in 2013 were not billed appropriately nor paid accurately. The report also identified a potential fraud rate of 1.61 percent, for a total potential loss from fraud of $275 million. The report did not include non-FFS Medi-Cal providers, including mental health. Drug Medi-Cal services, and managed care. Furthermore, the size and complexities of the health care delivery system makes it difficult to monitor and respond effectively to newly emerging program integrity issues

The current contract will provide DHCS with access to a cloud-based interactive dashboard that will include geo-mapping capabilities. Provider and beneficiary information in the dashboard will be sorted, grouped, and flagged based upon fraud indicator flags. These services use very sophisticated proprietary technology that the state cannot replicate to identify patterns not readily apparent in the voluminous amounts of payment data. Strengths of the new data analytics tools include the ability to identify patterns of suspicious behavior based on historical data and changing behaviors, thereby creating an opportunity for additional system edits and other front-end measures to prevent future overpayments. This means the service is not static and can be continually enhanced to keep pace with emerging trends in fraud and allow A&I to focus its efforts on providers that demonstrate high indications of fraudulent activity and minimize the use of resources on providers that have shown no indication of fraud, waste, or abuse.

The service also uses several public records databases to perform link analysis, which can identify a provider's known business associates to determine if there are warning signs of fraud, if other providers are engaged in similar fraudulent behavior, or if the fraudulent behavior is part of an organized scheme. The service would give A&I staff the ability to quickly access information not previously available and do a more thorough review of providers under investigation in order to establish stronger cases against those providers suspected of fraud. The information generated by the service and the link analysis will bolster the amount of evidence A&I can provide to the Attorney

General's Office which would likely lead to an increased number of providers charged and successfully prosecuted for Medicaid fraud.

The effort to identify fraud in the DMC program confirms that a data analytics service for the entire Medi-Cal program will be cost effective and provide DHCS with an important tool to identify and prevent fraud. Initial results from the service highly correlated to the field work performed by A&I. Suspect DMC providers identified via A&I's labor-intensive field visits of the entire DMC provider population were independently flagged by the data analytics service in a fraction of the time spent by A&I. These results demonstrated the potential for increased efficiencies and significant time-savings for A&I's continual search for suspect providers that warrant a closer review, audit or investigation. Leveraging this technology will not only reduce the labor hours involved with identifying occurrences of fraud via manual means, it will allow A&I to achieve a more comprehensive and expansive assessment of risk within the program as a whole

The service will be especially helpful to the A&I SIU, which uses a multi-disciplinary approach to identify and investigate Medi-Cal fraud, waste and abuse. The SIU uses sophisticated data analysis techniques to identify fraud quickly and target resources efficiently, while developing new tools and techniques to identify fraudulent activity by analyzing suspicious patterns in claims data and social linkages. The SIU's approach to combating fraud and abuse has been remarkably successful. Much of the SIU's success can be contributed to the utilization of data analytics. Since 2015, the SIU has issued temporary suspensions due to Credible Allegations of Fraud (CAF) on providers that were paid over $18.5 million by Medi-Cal in FY 2013-14. Additionally, the SIU issued Demands for Payment to specified providers for approximately $6 million. Recently, the SIU has also completed data driven reviews and is expected to recover overpayments for approximately $15 million dollars. These examples are a sample of the success the SIU has had using data analytics as a key component of their work. The service will expand current A&I data analytic capabilities.

The data analytics service will not be a stand-alone remedy, but a paramount first tool for the investigative process. DHCS auditors and investigators will use the suspicious activities alerts to focus their efforts in a more effective direction, reducing the amount of time spent on field reviews. Thus, with these tools, DHCS' investigative teams will have sufficient resources to efficiently regulate the Medi-Cal program, increase recoveries and discourage future abuse. Furthermore, the service would allow A&I and provider enrollment staff to conduct a more thorough review of provider applications.

Entering into a limited term service contract as opposed to building an in-house data analytics system limits the initial cost and time needed to procure, design, and develop a system and allows DHCS to continually monitor and evaluate the effectiveness of the data analytics service contract to determine if continuing or possibly expanding the service capabilities is warranted.

Data analytics for fraud detection will be expanded from Short-Doyle to the entire Medi-Cal program. DHCS and the vendor will conduct a joint analysis to determine and triage program integrity risks. An analysis of the Medi-Cal FFS Provider Master File, eligibility files, and paid claims data to identify which subprograms in Medi-Cal have the highest

potential risk and rate of return and which aspects should be analyzed across the entire Medi-Cal program.

DHCS will perform similar analyses to ensure they are making optimum use of state resources and protect public funding on a regular basis. The contract includes a clause giving the State the option of implementing two one-year extensions to the contract. DHCS submits monthly progress reports to CMS as part of the lAPDU requirements.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 26: OMBUDSMAN CUSTOMER RELATIONS MANAGEMENT SYSTEM SPRING FINANCE LETTER

PANELISTS

- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Managed Care Operations Division (MCOD), requests $500,000 ($250,000 General Fund (GF)/$250,000 Federal Fund (FF)) in Fiscal Year (FY) 2018-19 and $173,000 ($86,000 GF/$87,000 FF) for FY 2019-20 and ongoing. The funds will be used to procure a new cloud-based Customer Relations Management (CRM) Software as a Service (SaaS) solution from the Office of Technology Services (OTech) and increased ongoing subscription costs to support MCOD's Ombudsman (0MB) Call Center.

BACKGROUND

The 1995 Budget Act and California Code of Regulations, Title 22, Section 53893, authorized DHCS to establish an 0MB function within its Medi-Cal Managed Care Operations Division. The primary mission of the 0MB office is to investigate and find resolution for health plan member issues regarding access to all medically necessary services. The 0MB accomplishes this mission by assisting beneficiaries in navigating the managed care system, by facilitating discussions between beneficiaries and their health plans so appropriate actions are taken for beneficiaries to get the care and services they need, and by coordinating any care and services with facilities and providers.

Chapter 52 of Senate Bill (SB) 97 includes the requirement to provide quarterly reporting to the Legislature on the calls that the 0MB receives. The added language requires DHCS to create quarterly reports containing data on the calls received, as specified, including demographic information and contacts from county mental health plan beneficiaries. The fourth quarterly report of each year must also include information on the training of staff, the assessment of contacts trends, and actions DHCS takes that result from the contacts received. DHCS has posted quarterly reports to the DHCS Internet website; however these reports do not fully meet the requirements set forth in SB 97. The purpose of this quarterly reporting is to identify patterns of inquiries, complaints, and grievances that may be indicators of systemic problems that may warrant further consideration.

MCOD's 0MB serves as a resource for Medi-Cal members enrolled in managed care health plans (MCPs), helping solve problems from a neutral standpoint so that members receive all medically necessary covered services. In addition to assisting Medi-Cal beneficiaries, the 0MB provides guidance and assistance to county eligibility workers, legislative staff, stakeholders, other departments within the state, and various associations (such as those related to foster children, pregnancy, and other topics that may involve Medi-Cal managed care

Currently, the 0MB utilizes an 11-year-old CRM system. The 0MB uses this system to input beneficiary issues. The system is currently on a 2008 Microsoft server environment that is no longer a supported platform, and it allows DHCS to comply with some, but not all, of the reporting requirements of SB 97. The requirements currently being met are those regarding the number of contacts received, the average talk and wait times, spoken language, number and rate of calls abandoned, results of contacts, and number of calls referred to another area. A new SaaS CRM solution with cloud-based software will be procured from OTech to replace the current CRM and to meet the mission critical requirements for the 0MB Call Center operation. The new SaaS CRM solution will provide the ability to satisfy the unmet SB 97 reporting requirements of demographic information of beneficiaries—including race, ethnicity, age, gender, preferred language, county of residence, and health plan—and the ability to report the destinations of referred calls from contacts. This user-friendly, cloud-based software does not require implementation akin to traditional projects. The solution is available through OTech and has been used by many state entities.

On average, the 0MB has a six (6) minute wait time. Updates to the CRM could help to further reduce the wait time our beneficiaries experience when contacting the 0MB. Growth in MCP enrollment would indicate an increase in contacts to the 0MB. Currently, the 0MB has not seen an increase in hold and talk times; however, these times could potentially be reduced further with an upgraded and more efficient CRM system. The outdated CRM system, used to input beneficiary issues, freezes during peak usage hours and lengthens the wait times. Replacing it will augment efficiency, a vital goal for 0M B to track and report beneficiary issues successfully. Additionally, with the new reporting requirements, a new CRM system is necessary to capture various demographic information of beneficiaries along with referred calls from contacts. Consistent with the State Administrative Manual section 4983 and the policy from the California Department of Technology (CDT) described in Technology Letter 17-06 (released in August 2017), this proposal is for a cloud-based CRM solution through CDT's OTech

Replacing OMB's current CRM system is critical for DHCS in order to track and support Medi-Cal beneficiary calls, activities, and issues successfully. The existing CRM version is obsolete, the server operating system is being phased out, and legislatively mandated SB 97 reporting requirements cannot be fully met with the existing system. Replacing the existing system with a new cloud-based CRM system procured through OTech will allow DHCS to align with current technical standards, implement efficiencies throughout program operations, and provide the data elements needed to meet all reporting requirements of SB 97. By replacing the outdated CRM system, which freezes and does not allow users to input cases during peak usage, the wait times would improve further.

Procuring a new CRM with cloud-based software will augment efficiency, a vital goal for 0MB to track and report beneficiary issues successfully. The new CRM will improve the call center experience for beneficiaries by providing accurate information to DHCS representatives to disseminate because staff who use the system will have all associated information available to them in one location.

The new cloud-based CRM will eliminate ongoing issues. The new system is expected to be efficient and run smoothly while backing up records to the cloud-based software. The existing, outdated CRM system will be decommissioned once DHCS is fully functional within the new CRM system.

MCOD requests funding in FY 2018-19 of $500,000 ($250,000 GF/$250,000 FF) and ongoing funding beginning FY 2019-20 of $173,000 ($86,000 GF/$87,000 FF) to replace the current CRM system to be more efficient and assist staff with providing a level of service that best benefits the beneficiary experience.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 27: FREE-STANDING NON-HOSPITAL CLINICS SUPPLEMENTAL REIMBURSEMENT PROGRAM AND COMMUNITY TREATMENT FACILITIES PROGRAM TECHNICAL ADJUSTMENT TRAILER BILL

PANELISTS

- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Brian Metzker,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS proposes trailer bill to:

1) Repeal of the Public Freestanding Non-Hospital Based Clinics (PFNC) Supplemental Reimbursement Program; and

2) Eliminate the annual appropriation of $45,000 General Fund to DHCS for the Community Treatment Facilities Program.

BACKGROUND

PFNC Supplemental Reimbursement Program Repeal:
Existing law and California State Plan, Supplement 10 to Attachment 4.19-B, authorize DHCS to establish the PFNC Supplemental Reimbursement program for public clinics (Welfare and Institutions Code (WIC) Section 14105.965). This program was authorized by AB 959 (Frommer, Chapter 162, Statutes of 2006) and is designed to allow State veteran homes and public clinics to obtain additional federal funding reimbursement without the use of State General Funds (GF).

Once implemented, PFNC would provide supplemental reimbursement to eligible public outpatient clinics for the uncompensated care costs of providing Medi-Cal covered ambulatory services to Medi-Cal beneficiaries on or after October 14, 2006. As a condition of receiving supplemental reimbursement payments, the PFNC Supplemental Reimbursement Program would require participating clinics to reimburse DHCS for the non-federal share cost of administering the program.

DHCS received approval from the federal Centers for Medicare and Medicaid Services (CMS) for a revised cost report necessary to implement the program in June 2017. DHCS organized training webinars for potentially eligible clinics and sent out notification letters to approximately 300 clinics based on a listing of all known provider types that may be eligible to participate. In response to the notification letters, 16 clinic representatives expressed interest and participated in the training webinars and a couple clinics have submitted the required program eligibility documents for participation

in fiscal year 2017-18, which were due July 31, 2017. In response to the limited interest from potential participants, DHCS reached out to stakeholder groups for assistance in identifying potentially eligible clinics.

Due to the strict eligibility requirements set forth in California State Plan, Supplement 10 to attachment 4.19-B, many clinics are not eligible to participate. Specifically, clinics that provide services to Medi-Cal enrollees in local initiatives, managed care health plans, and geographic managed care health plans are not eligible to seek reimbursement under the PFNC Supplemental Payment Program. Federally qualified health centers and rural health clinics are also ineligible to participate in the program. Given that managed care is now available in all counties and serves roughly 80 percent of the Medi-Cal population, most clinics that participate in the Medi-Cal program serve Medi-Cal managed care enrollees, making them ineligible for the PFNC Program. This limited number of eligible providers, coupled with the cost to participating clinics to reimburse DHCS for the non-federal share of administrating the program, has resulted in the program not generating interest from clinics.

Although DHCS has worked to implement the PFNC Supplemental Reimbursement Program, the limited interest and number of eligible providers would not meet the level required to support DHCS's administrative costs. As a result, DHCS is proposing to repeal the PFNC Supplemental Reimbursement Program.

Community Treatment Facilities Program Technical Adjustment:
Per Welfare and Institutions Code (WIC) Section 4094, DHCS (due to the dissolution of the Department of Mental Health) has the responsibility to develop regulations for and certification of community treatment facilities that provide mental health services in a locked environment for children who have been diagnosed as Severely Emotionally Disturbed. Statute appropriated $45,000 General Fund annually to DHCS to comply with the requirements of WIC Section 4094. DHCS has adopted the necessary regulations and complies with the required activities under this Section. This proposal eliminates the annual appropriation of $45,000 General Fund to DHCS, which has historically remained unexpended.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposed trailer bill.

Staff Recommendation: No action is recommended at this time.