AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER ELOISE GÓMEZ REYES, ACTING CHAIR

MONDAY, APRIL 22, 2019

2:30 PM, STATE CAPITOL, ROOM 127

ITEMS TO BE HEARD

NON-DISCUSSION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 1: OSHPD DEPARTMENT AND BUDGET OVERVIEW

PANELISTS

- **Robert David**, Director, Office of Statewide Health Planning and Development
- **CJ Howard**, Deputy Direct, Healthcare Workforce Development Division, Office of Statewide Health Planning and Development
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Jacob Lam**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 2: MEMBER PROPOSAL: HEALTH CARE WORKFORCE FUNDING

PANELISTS

- **Assemblymember Rudy Salas**

Public Comment

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 3: EMSA DEPARTMENT AND BUDGET OVERVIEW

PANELISTS

- **Daniel Smiley**, Chief Deputy Director, Emergency Medical Services Authority
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 4: DMHC DEPARTMENT AND BUDGET OVERVIEW

PANELISTS

- **Shelley Rouillard**, Director, Department of Managed Health Care
- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director of Legislative Affairs, Department of Managed Health Care
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Jacob Lam**, Principal Program Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: STRENGTHENING PREVENTATIVE SERVICES FOR CHILDREN IN MEDI-CAL (SPRING FINANCE LETTER ((SFL)) ISSUE 312)

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 6: STAKEHOLDER PROPOSALS: OPTIONAL BENEFITS

PANELISTS

- **Assemblymember Heath Flora**
- **Dr. John Chisholm**, President, California Podiatric Medical Association
- **David Redman, OD**, Legislation and Regulation Committee Chair, California Optometric Association
- **Linda Nguy**, Policy Advocate, Western Center on Law and Poverty
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 7: STAKEHOLDER PROPOSALS: DURABLE MEDICAL EQUIPMENT, COMPLEX REHAB TECHNOLOGY AND CLINICAL LABORATORY RATES

PANELISTS

- **Bob Acherman**n, Executive Director and Legislative Advocate, California Association of Medical Products Suppliers
- **Kristi Foy**, Legislative Advocate, California Clinical Laboratory Association
- **Tonya Hammat**, Vice President, Payer Relations West Region, National Seating & Mobility
- **Karen Farley**, Executive Director, California WIC Association
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 8: HOME AND COMMUNITY BASED ALTERNATIVES WAIVER OVERSIGHT AND STAKEHOLDER PROPOSAL ON CALIFORNIA COMMUNITY TRANSITIONS

PANELISTS

- **Jenny McLelland**, Parent Advocate, Medically Complex Children of California
- **Elissa Gershon**, Litigation Counsel, Disability Rights California
- **Karen Keeslar**, Legislative Advocate, East Bay Innovations
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

8860 DEPARTMENT OF FINANCE

ISSUE 9: PROPOSITION 55 MEDI-CAL FUNDING OVERSIGHT

PANELISTS

- **Maia Schneider**, Executive Director, Business Development, Marshall Medical Center
- **Barbara Glaser**, Senior Legislative Advocate, California Hospital Association
- **Ann Hollingshead**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Susan Wekanda**, Principal Program Budget Analyst, Department of Finance
- **Carla Castaneda**, Assistant Program Budget Manager, Department of Finance

Public Comment

ITEMS TO BE HEARD

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 1: OSHPD DEPARTMENT AND BUDGET OVERVIEW

PANELISTS

- **Robert David**, Director, Office of Statewide Health Planning and Development
- **CJ Howard**, Deputy Direct, Healthcare Workforce Development Division, Office of Statewide Health Planning and Development
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Jacob Lam**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED BUDGET

The Department's proposed budget is summarized in the table on the next page. For 2019-20, the Governor's Budget proposes $199.7 million for the support of OSHPD. The proposed budget reflects a 14 percent ($32.2 million) decrease from the current year budget, primarily reflecting: 1) one-time funding of $60 million for the creation of a health care cost database included in the 2018 Budget Act; and 2) the completion of funding for the Mental Health Services Act (Proposition 63) Workforce, Education and Training ("WET") program.

Governor's Health Care Workforce Funding Proposal
The 2017 Budget Act included $100 million General Fund, for $33.3 million in each of three years (2017-18, 2018-19, and 2019-20), to support increasing medical residency slots and other health care workforce strategies. This funding has gone primarily to the Song Brown Program, which supports medical residency programs, and has resulted in the establishment of 72 new residency slots.

The Governor's January budget proposes to make this $33.3 million per year an on-going appropriation, beginning in 2020-21, following the full expenditure of the $100 million included in the 2017 Budget Act.

OSHPD Budget *(Dollars in Thousands)*					
Fund Source	**2017-18 Actual**	**2018-19 Projected**	**2019-20 Proposed**	**CY to BY $ Change**	**% Change**
General Fund	$21,280	$105,387	$83,333	($22,054)	-20.9%
Hospital Building Fund	$63,485	$65,750	$65,762	$12	0.02%
Health Data & Planning Fund	$33,651	$32,670	$33,407	$737	2.3%
Registered Nurse Education Fund	$1,911	$2,192	$2,192	$0	0%
Health Facility Construction Loan Insurance Fund	$6,069	$5,078	$5,079	$1	0.02%
Health Professions Education Fund	$1,567	$1,111	$1,111	$0	0%
Federal Trust Fund	$1,559	$1,464	$1,463	($1)	-0.07%
Reimbursements	$868	$868	$868	$0	0%
Mental Health Practitioner Education Fund	$141	$396	$821	$425	107%
Vocational Nurse Education Fund	$186	$225	$225	$0	0%
Mental Health Services Fund	$27,480	$14,051	$3,051	($11,000)	-78.3%
Medically Underserved Account For Physicians, Health Professions Education Fund	$2,707	$2,724	$2,402	($322)	-11.8%
TOTAL EXPENDITURES	**$160,904**	**$231,916**	**$199,714**	**($32,202)**	**-13.9%**
Positions	420.0	430.5	434.5	4	0.9%

BACKGROUND

The Office of Statewide Health Planning and Development (OSHPD) develops policies, plans and programs to meet current and future health needs of the people of California. Its programs provide health care quality and cost information, ensure safe health care facility construction, improve financing opportunities for health care facilities, and promote access to a culturally competent health care workforce. OSHPD is made up of the following Department Divisions:

Cal-Mortgage Loan Insurance Division

This division administers the California Health Facility Construction Loan Insurance Program and provides credit enhancement for eligible nonprofit healthcare facilities when they borrow money for capital needs. Cal-Mortgage insured loans are guaranteed by the "full faith and credit" of the State of California. This guarantee permits borrowers to obtain lower interest rates, similar to the rates received by the State of California.

Eligible Health Facilities must be owned and operated by private nonprofit public benefit corporations or political subdivisions such as cities, counties, healthcare districts or joint powers authorities. Health facilities eligible for Cal-Mortgage Loan Insurance include:

- Hospitals, of any type
- Skilled nursing facilities
- Intermediate care facilities
- Public health centers
- Clinics and other outpatient facilities
- Multi-level facilities (which include a residential facility for the elderly operated in conjunction with an intermediate care facility, a skilled nursing facility, or a general acute care hospital)
- Laboratories
- Community mental health centers
- Facilities for the treatment of chemical dependency
- Child day care facilities in conjunction with a health facility
- Adult day health centers
- Group homes
- Facilities for the developmentally disabled or mentally disordered
- Offices and central service facilities operated in connection with a health facility

Loans may be insured to finance or refinance the construction of new facilities; to acquire existing buildings; to expand, modernize, or renovate existing buildings; and to finance fixed or moveable equipment needed to operate the facility.

The Facilities Development Division (FDD):

1. Reviews and inspects health facility construction projects.
2. Has projects, currently under plan review or construction, valued in excess of $20 billion.
3. Enforces building standards, per the California Building Standards Code, as they relate to health facilities construction.
4. Is one of the largest building departments in the State of California.

The Healthcare Workforce Development Division (HWDD)

This division supports healthcare accessibility through the promotion of a diverse and competent workforce while providing analysis of California's healthcare infrastructure and coordinating healthcare workforce issues. The division's programs, services and resources address, aid and define healthcare workforce issues throughout the state by:

1. Encouraging demographically underrepresented groups to pursue healthcare careers.

2. Identifying geographic areas of unmet need.

3. Encouraging primary care physicians and non-physician practitioners to provide healthcare in health professional shortage areas in California.

HWDD staff collect, analyze and publish data about California's healthcare workforce and health professional training, identify areas of the state in which there are shortages of health professionals and service capacity, and coordinate with other state departments in addressing the unique medical care issues facing California's rural areas.

Health Professions Education Foundation (HPEF)

A nonprofit 501(c)(3) corporation, HPEF improves access to healthcare in underserved areas of California by providing scholarships, loan repayments, and programs to health professional students and graduates who are dedicated to providing direct patient care in those areas.

The Healthcare Information Division (HID)

This division collects and disseminates healthcare quality, outcome, financial, and utilization data, and produces data analyses and other products. The Division collects and publicly discloses facility level data from more than 5,000 CDPH-licensed healthcare facilities - hospitals, long-term care facilities, clinics, home health agencies, and hospices. These data include financial, utilization, patient characteristics, and services information. The Division produces more than 100 data products, including maps and graphs, summarizing rates, trends, and the geographic distribution of services. Risk-adjusted hospital and physician quality (outcome) ratings for heart surgery and other procedures are also published. The Division provides assistance to the members of the public seeking to use OSHPD data and, upon request, can produce customized data sets or analyses for policymakers, news media, other state departments and stakeholders.

Health Care Cost Transparency Database

AB 1810 (Committee on Budget, Chapter 34, Statutes of 2018) requires OSHPD to establish, with the intent to be completed by July 1, 2023, the California Health Care Cost Transparency Database to collect information on the costs of health care in order to create transparency on health care costs, and to inform policy decisions, reduce disparities, and reduce costs. The 2018 Budget Act includes $60 million one-time General Fund for this purpose.

AB 1810 also requires OSHPD to convene a review committee, composed of health care stakeholders and experts, as specified, to provide advice on the establishment, implementation and ongoing administration of the database, including a business plan for long-term sustainability without General Fund. Finally, the bill requires OSHPD to submit a report to the Legislature based on recommendations of the review committee and any third-party vendor, no later than July 1, 2020.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD:

1. Provide a brief overview of OSHPD's core functions, activities and budget;
2. Provide an update on the establishment of the health care cost transparency database funded through the 2018 Budget Act; and

3. Present the Governor's proposal to make $33.3 million General Fund for health care workforce programs ongoing funding beginning in 2020-21 and describe progress addressing health care workforce shortages being made by OSHPD programs.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 2: MEMBER PROPOSAL: HEALTH CARE WORKFORCE FUNDING

PANELISTS

- **Assemblymember Rudy Salas**

Public Comment

PROPOSAL

Assemblymember Rudy Salas, with the support of approximately 21 other Members, requests one-time additional funding of $50 million General Fund to OSHPD for the purpose of increasing the health care workforce in rural and underserved areas, and to expand opportunities to students from underrepresented and low-income areas to enter health careers. Specifically, the funding would support programs that would:

- Expand the number of primary care physicians and psychiatry residency positions, and prioritize residency programs in HPSAs.
- Recruit and train students from areas with a large disparity in patient-to-doctor ratios to practice in health centers in the area from which each student was recruited.
- Expand and strengthen loan repayment programs for primary care physicians and clinicians that agree to serve in HPSAs.
- Expand and strengthen programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers.

OSHPD's Healthcare Workforce Development Division and the Health Professions Education Foundation would administer the funding through existing programs.

BACKGROUND

Assemblymember Salas provided the following background to the Committee:

"Our state faces a growing demand and significant health care workforce shortage that jeopardizes the health and well-being of Californians. There will be an inadequate number of health care workers to meet the health care needs of Californians if we do not make significant investments in the workforce, particularly in underserved communities. According to the California Future Health Workforce Commission, the state will face a shortfall in the next decade of 4,103 primary care clinicians and will have only two-thirds of the psychiatrists needed in 2030. These shortages are most severe in some of California's fastest growing regions, particularly in underserved, rural and ethnically and linguistically diverse communities.

The Council on Graduate Medical Education (COGME) recommends 60 to 80 primary care physicians per 100,000 population, but the statewide average is only 50. The average number of primary care physicians is significantly lower in underserved regions like the San Joaquin Valley and the Inland Empire, where there are only 39 and 35 primary care physicians per 100,000 residents, respectively. In addition, COGME recommends 85 to 105 specialists per 100,000 population, but the San Joaquin Valley currently has only 65 and the Inland Empire has just 64, well below the recommended level. The most disadvantaged areas of the state, like the Central Valley and Inland Empire – where there are already significant barriers to health care access – will be among the most adversely impacted by the health care workforce shortage if we do not take immediate action to address this issue.

There are 7 million Californians who currently live in federally designated Health Professional Shortage Areas (HPSAs), the vast majority of them – 70 percent – are Latino, black and Native American. Furthermore, Latinos comprise only 7 percent of doctors despite the fact that they now represent nearly 40 percent of the population. According to the California Future Health Workforce Commission, communities of color will make up over 65 percent of California's population by 2030, yet they are severely underrepresented in the health workforce and educational pipeline. With the growing diversity of our state, it is difficult to find health care providers who match the diversity of our communities. These communities will be hit hardest by the health care workforce shortage, creating major health equity concerns in our state.

In addition to the growing diversity of our state, there is also a rapidly increasing segment of the population that will be made up of older adults who will need critical health care services. In California, the older adult population will increase 64 percent by 2035 to 12 million adults age 60 and above. By that same time, the U.S. Census Bureau projects senior citizens will outnumber youth for the first time in our nation's history. At the same time, many of the doctors and health care workers are part of this aging population and will soon retire. More than one-third of California's physicians are over age 55 and many are partially retired. Less than half of California's 139,000 physicians provide 20 or more hours of patient care per week. Given the increasing population of older adults and the number of health care workers that will retire in the coming years, California will not have the number of physicians we need to meet the demands for quality health care.

The California education system is not keeping pace with our growing and increasingly diverse population. The state is expected to grow by six million people by 2030, but medical school enrollment rate is the third lowest in the country. As our state strives to increase access to health care, if we do not make significant investments in recruiting, training and retaining qualified health care providers, with a particular focus on HPSAs, the significant gaps in health care access for the most disadvantaged communities will continue to grow.

It is critical that the state make significant investments in the health care workforce in disadvantaged and underserved communities to meet the growing demand for quality health care. For these reasons, we request your support for augmenting the current budget to ensure access to quality, affordable health care."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Salas to present this proposal.

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

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 3: EMSA DEPARTMENT AND BUDGET OVERVIEW

PANELISTS

- **Daniel Smiley**, Chief Deputy Director, Emergency Medical Services Authority
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED BUDGET

The Department's proposed budget is summarized in the table on the next page. For 2019-20, the Governor's Budget proposes $34.1 million for the support of EMSA, a 24 percent ($10.8 million) decrease over the 2018-19 current year budget. Of this amount, approximately $15.2 million is budgeted for State Operations, while the remaining is for Local Assistance. EMSA explains that this 24 percent decrease in funding does not represent a cut to programs or services, and states the following:

> "In FY 2018-19, EMSA submitted a Section 28.5 request for increased Reimbursements budget authority in the amount of $7.4 million to implement the Health Information Technology for Emergency Medical Services (HITEMS) program. This additional budget authority is not included in the FY 2019-20 Governor's budget. Additionally, as part of the MBR (Mission Based Review) process, EMSA worked with DOF to reduce budget authority (Reimbursements and Federal) in both State Operations and Local Assistance to align with actual program expenditures and funding levels. "

The primary source of funding for this department is federal funds, which is included in the lines below labeled "Federal Trust Fund" and "Reimbursements," as those are federal funds that come through other departments first, namely the Departments of Health Care Services and Public Health.

EMERGENCY MEDICAL SERVICES AUTHORITY *(Dollars In Thousands)*					
Fund Source	**2017-18 Actual**	**2018-19 Projected**	**2019-20 Proposed**	**CY to BY Change**	**% Change**
General Fund	**$7,600**	**$9,223**	**$9,680**	**$457**	**5.0%**
Emergency Medical Services Training Program Approval Fund	$214	$218	$218	$0	0%
Emergency Medical Services Personnel Fund	$2,739	$2,630	$2,682	$52	2.0%
Federal Trust Fund	$3,191	$6,321	$4,285	($2,036)	-32.2%
Reimbursements	$13,301	$24,970	$15,560	($9,410)	-37.7%
Emergency Medical Technician Certification Fund	$1,266	$1,564	$1,695	$131	8.4%
Total Expenditures	**$28,311**	**$44,926**	**$34,120**	**($10,806)**	**-24.1%**
Positions	70.6	70.0	76.0	6	8.6%

BACKGROUND

The Emergency Medical Services Authority's (EMSA) mission is to coordinate emergency medical services (EMS) statewide; develop guidelines for local EMS systems; regulate the education, training, and certification of EMS personnel; and coordinate the state's medical response to any disaster.

The EMSA is comprised of the following three divisions:

- ***Disaster Medical Services Division*.** The Disaster Medical Services Division coordinates California's medical response to disasters. It is the responsibility of this division to carry out the EMS Authority's mandate to provide medical resources to local governments in support of their disaster response, and coordinate with the Governor's Office of Emergency Services, Office of Homeland Security, California National Guard, California Department of Public Health, other local, state, and federal agencies, private sector hospitals, ambulance companies and medical supply vendors to improve disaster preparedness and response.

- ***EMS Personnel Division*.** The EMS Personnel Division oversees licensure and enforcement functions for California's paramedics, personnel standards for pre-hospital emergency medical care personnel, trial studies involving pre-hospital emergency medical care personnel, first aid and CPR training programs for child day care providers and school bus drivers.

- ***EMS Systems Division*.** The EMS Systems Division oversees EMS system development and implementation by the local EMS agencies, trauma care and other specialty care system planning and development, EMS for Children program, California's Poison Control System, emergency medical dispatcher standards, EMS Data and Quality Improvement Programs, and EMS communication systems.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff requests EMSA provide a brief overview of the department and budget.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 4: DMHC DEPARTMENT AND BUDGET OVERVIEW

PANELISTS

- **Shelley Rouillard**, Director, Department of Managed Health Care
- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director of Legislative Affairs, Department of Managed Health Care
- **Lorine Cheung**, Finance Budget Analyst, Department of Finance
- **Jacob Lam**, Principal Program Budget Analyst, Department of Finance
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

As summarized in the table below, the Governor's 2019-20 budget proposes $86.8 million, an increase of approximately $2.8 million (3.4%) from current year spending for DMHC's overall budget.

The DMHC receives no General Fund and is supported primarily by an annual assessment on each HMO. The annual assessment is based on the Department's budget expenditure authority plus a reserve rate of 5 percent. The assessment amount is prorated at 65 percent and 35 percent to full-service and specialized plans respectively. The amount per plan is based on its reported enrollment as of March 31st of each year. The Knox-Keene Act requires each licensed plan to reimburse the department for all its costs and expenses.

DEPARTMENT OF MANAGED HEALTH CARE
(Dollars In Thousands)

Fund Source	2017-18 Actual	2018-19 Projected	2019-20 Proposed	CY to BY Change	% Change
Managed Care Fund	$74,493	$83,782	$86,670	$2,888	3.4%
Reimbursements	$55	$171	$171	$0	0%
Total Expenditures	**$74,548**	**$83,953**	**$86,841**	**$2,888**	**3.4%**
Positions	423.4	417.6	437.6	20	4.8%

BACKGROUND

The mission of the Department of Managed Health Care (DMHC) is to regulate, and provide quality-of-care and fiscal oversight for health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

The Department achieves this mission by:

- Administering and enforcing the body of statutes collectively known as the Knox-Keene Health Care Service Plan Act of 1975, as amended.
- Operating the 24-hour-a-day Help Center to resolve consumer complaints and problems.
- Licensing and overseeing all HMOs and some PPOs in the state. Overall, the DMHC regulates approximately 90 percent of the commercial health care marketplace in California, including oversight of enrollees in Medi-Cal managed care health plans.
- Conducting medical surveys and financial examinations to ensure health care service plans are complying with the laws and are financially solvent to serve their enrollees.
- Convening the Financial Solvency Standards Board, comprised of people with expertise in the medical, financial, and health plan industries. The board advises DMHC on ways to keep the managed care industry financially healthy and available for the millions of Californians who are currently enrolled in these types of health plans.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to provide a brief overview of the department and its budget.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: STRENGTHENING PREVENTATIVE SERVICES FOR CHILDREN IN MEDI-CAL (SPRING FINANCE LETTER ((SFL)) ISSUE 312)

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Department of Health Care Services (DHCS) requests the establishment of 12.0 permanent positions and expenditure authority, and limited-term funding for staff resources and contractual services to support DHCS' Strengthening Preventive Services for Children (SPSC). Limited-term (LT) funding will be in the amount of $15,000,000 ($7,500,000 General Fund (GF)/$7,500,000 Federal Funds (FF)); and other permanent, ongoing costs in the amount of $4,000,000 ($2,000,000 GF/$2,000,000 FF).

Total funding request:

- Fiscal year (FY) 2019-20: $22,682,000 ($11,079,000 GF/$11,603,000 FF)
- FY 2020-21 thru 2022-23: $7,493,000 ($3,495,000 GF/$3,998,000 FF)
- FY 2023-24 and ongoing: $5,996,000 ($2,848,000 GF/$3,148,000 FF)

The proposal requests to add the following provisions to Item 4260-001-0001:

8. Of the amount appropriated in this item, up to $3,743,000 shall be available to the Department of Health Care Services to reimburse the Office of Systems Integration Item 0530-001-9745 for the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) Project system integrator contract transition activities upon determination of the Department of Finance that the Office of Systems Integration has finalized the vendor selection.

9. Of the funds appropriated in this item, up to $5,500,000 is available for contract services related to strengthening oversight and quality of preventative services for children, and shall be available for encumbrance or expenditure until June 30, 2021.

The proposal also requests to add the following provisions to Item 4260-001-0890:

3. Of the amount appropriated in this item, up to $11,702,000 shall be available to the Department of Health Care Services to reimburse the Office of Systems Integration Item 0530-001-9745 for the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) Project system integrator contract transition activities upon determination of the Department of Finance that the Office of Systems Integration has finalized the vendor selection.

4. Of the funds appropriated in this item, up to $5,500,000 is available for contract services related to strengthening oversight and quality of preventative services for children, and shall be available for encumbrance or expenditure until June 30, 2021.

BACKGROUND

Necessity of Preventive Services
According to the Centers for Disease Control and Prevention, preventive services significantly reduce the risk of illness, disability, early death, and expensive medical care while providing cost savings. In 2014, the American Academy of Pediatrics (AAP) published a national report stating that the immunization of 4.3 million children, a key preventive health service, would prevent approximately 42,000 deaths and 20 million cases of disease, with net savings of nearly $14 billion in direct costs and $69 billion in total societal costs. A 2015 report published by the National Bureau of Economic Research on the long-term impact of Medicaid expansion analyzed increases in Medicaid spending caused by the expansion of the Patient Protection and Affordable Care Act and the government's return on investment. The report found that the government recoups its investment in a child's preventive care by age 36 through additional tax payments, concluding that preventive services results in the government earning a 550% return on investment by age 60.

Early and Periodic Screening, Diagnostic, and Treatment Services Benefit
In 1967, Congress expanded the benefit for children. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services benefit is set forth in the Social Security Act (SSA), Section 1905(r) and Title 42 of the United States Code, Section 1396d. The EPSDT benefit provides a comprehensive array of preventive, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal.

Under the EPSDT benefit, states are required to provide any Medicaid-covered service listed within the categories of mandatory and optional services in the SSA, Section 1905(a), regardless of whether such services are covered under the Medi-Cal State Plan when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent

a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable."

Under the ESPDT benefit, states are required to screen and provide preventive services to children under the age of 21 in accordance with a periodicity schedule that specifies reasonable standards for child health care. To comply with this requirement, DHCS has adopted the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule. MCPs are required to provide preventive health visits and screenings for all members under 21 years of age at times specified by the most recent AAP periodicity schedule.

Methods of Measuring the Quality of Preventive Services in Medi-Cal
CMS requires that states measure and report on the quality and appropriateness of care and services provided to beneficiaries. DHCS states that it strives to accomplish this by means of contractual requirements for MCP care quality data reporting, as well as through activities conducted by an EQRO.

In order to assess the experiences of Medi-Cal managed care members, DHCS contracts with an EQRO to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This is an optional Medicaid external quality review to assess beneficiary experience and satisfaction with health care services. DHCS currently administers the CAHPS survey triennially for the entire managed care population, by county, by plan, and annually, for children on a statewide level. DHCS publicly posts the CAHPS survey results on DHCS' website.

Additionally, the EQRO assists in analysis of External Accountability Set (EAS) measures, which are performance measures selected by DHCS to evaluate the quality of care delivered by MCPs to their members. DHCS selects most EAS measures from the Healthcare Effectiveness Data Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA). HEDIS measures are designed to evaluate a variety of aspects of care quality, including access/availability, utilization, and effectiveness. This offers a standardized method by which DHCS can objectively assess the quality of care each MCP provides.

Each MCP is required to calculate and report performance metrics at the county or reporting unit level. MCPs must meet or exceed a Minimum Performance Level (MPL), set by DHCS using NCQA benchmarks, and perform quality improvement activities when performance is poor. Currently, DHCS' contracts set the MPL at the 25th percentile, meaning MCPs must perform at least as well as the bottom 25 percent of all Medicaid plans nationwide on each EAS measure.

Problem to Address
DHCS states that it is committed to improving Medi-Cal's EPSDT benefit by strengthening the preventive services that are provided to Medi-Cal's EPSDT children. This goal aligns with DHCS' and Governor Newsom's objectives to invest in prevention to improve overall health outcomes. Medi-Cal managed care is an instrumental part in executing this objective as there are nearly 5 million children under the age of 21 enrolled in Medi-Cal, of which 82% are enrolled in managed care.

Various efforts are necessary to provide the most comprehensive preventive care, including:

- Increasing beneficiary/familial awareness of the EPSDT benefit and the services that are available.
- Obtaining more accurate data from MCPs on screenings and the utilization of preventive services.
- Conducting effective oversight and enforcing suitable standards of compliance.

Due to recently identified deficiencies and the demonstrated importance of preventive services, DHCS is seeking resources for SPSC to:

- Add all child and adult core set administrative measures to the EAS, as feasible.
- Initiate an outreach campaign to families with children in targeted age ranges (or for targeted screenings).
- Increase the performance requirement for MCP EAS measures (i.e., increase the MPL from the 25th percentile to the 50th percentile). MCPs not meeting the MPL would be immediately sanctioned in addition to being placed on a corrective action plan (CAP).
- Require the EQRO to pull utilization data from encounter data and create metrics to assess plan performance.
- Improve the FSR process by collecting information at the beneficiary level and establishing hybrid measures that assess MCP and provider performance. These data would be collected by MCPs and DHCS.
- Conduct the CAHPS survey every two years, rather than triennially, with follow-up.
- Create an annual compliance report that would be issued publically including additional measures on preventive services to the quarterly Managed Care Performance Dashboard.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 6: STAKEHOLDER PROPOSALS: OPTIONAL BENEFITS

PANELISTS

- **Assemblymember Heath Flora**
- **Dr. John Chisholm**, President, California Podiatric Medical Association
- **David Redman, OD**, Legislation and Regulation Committee Chair, California Optometric Association
- **Linda Nguy**, Policy Advocate, Western Center on Law and Poverty
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSALS

1. Assemblymember Heath Flora and the California Podiatric Medical Association request $4.6 million General Fund annually to restore the podiatry optional benefit in Medi-Cal and trailer bill which:

    - Fully reinstates podiatric services in Medi-Cal; and

    - Eliminates unnecessary authorizations, billing, and service policies that apply to podiatrists, but not physicians when performing the same service, including treatment authorization requests (TARs) and the 2 visit per month limitation that applies to podiatrists in Medi-Cal but not physicians performing the same exact service.

2. The California Optometry Association request $26 million General Fund annually to fund the restoration of optical benefits, in accordance with the 2017 Budget Act.

3. Western Center on Law & Poverty requests $40.5 million General Fund annually to restore the remaining un-restored optional benefits, including audiology, incontinence creams and washes, optician/optical lab, podiatry and speech therapy.

BACKGROUND

States establish and administer their own Medicaid programs (Medi-Cal in California) and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to provide other "optional benefits."

Through the 2009 Budget Act and health trailer bill, the state eliminated several Medicaid optional benefits from the Medi-Cal program. These benefits were eliminated for budgetary reasons in response to the fiscal crisis.

Although these benefits were "eliminated," there were exceptions for certain facilities and populations for which the benefits continue to be covered, including: Federally Qualified Health Centers and Rural Health Centers, emergency room services, patients with developmental disabilities, pregnant women, children (i.e. EPSDT) and PACE programs.

A few of these benefits have been restored already including:

2013:

- ***Dental Benefits*** - $55.3 million ($16.9 million General Fund) to restore basic adult dental benefits in Medi-Cal beginning May 1, 2014.

- ***Enteral Nutrition Benefit*** - $13.6 million General Fund to restore the enteral nutrition optional Medi-Cal benefit so that it is no longer restricted to either tube feeding or specific diagnoses, beginning May 1, 2014.

2016:

- ***Acupuncture Benefit*** - $3.7 million General Fund for 2016-17, $4.4 million General Fund on-going and trailer bill to restore the acupuncture optional benefit in the Medi-Cal program, beginning July 1, 206.

2017:

- ***Dental Benefits*** - $34.8 million (General Fund) in 2017-18 and $73 million in 2018-19 and ongoing and trailer bill to restore the remaining uncovered optional Medi-Cal dental benefits beginning January 1, 2018.

- ***Optical Benefits*** - Trailer bill established legislative intent to restore the Optician/Optical Lab optional Medi-Cal benefits beginning January 1, 2020. Specifically, the trailer bill states: "The restoration of optometric and optician services pursuant to this subdivision is contingent upon the Legislature including funding for these services in the state budget process."

As shown in the chart below, the annual cost to restore the optical benefits is estimated to be approximately $26 million General Fund annually.

Optional Benefits Costs

The chart below shows the various optional benefits that were eliminated in 2009 (that still have not been restored) and the estimated costs to restore the benefits:

November 2018 Estimate
Optional Benefits Restoration, Effective July 1, 2019

FY 2019-20 *(lagged)**	FFS	Managed Care	TF	GF	FFP
Optional Benefits Restoration:	A	B	A+B		
Audiology	$3,814,000	$6,126,000	$9,940,000	$3,085,000	$6,855,000
Chiropractic	$477,000	$4,714,000	$5,191,000	$1,371,000	$3,820,000
Incontinence Cream and Washes	$7,019,000	$8,984,000	$16,003,000	$5,105,000	$10,898,000
Optician / Optical Lab	$16,939,000	$58,645,000	$75,584,000	$22,024,000	$53,560,000
Podiatry	$2,105,000	$11,721,000	$13,826,000	$3,397,000	$10,429,000
Speech Therapy	$243,000	$2,159,000	$2,402,000	$676,000	$1,726,000
Grand Total	$30,597,000	$92,349,000	$122,946,000	$35,658,000	$87,288,000

FY 2019-20 *(no-lag)*	FFS	Managed Care	TF	GF	FFP
Optional Benefits Restoration:	A	B	A+B		
Audiology	$4,479,000	$6,683,000	$11,162,000	$3,475,000	$7,687,000
Chiropractic	$560,000	$5,143,000	$5,703,000	$1,510,000	$4,193,000
Incontinence Cream and Washes	$8,244,000	$9,801,000	$18,045,000	$5,773,000	$12,272,000
Optician / Optical Lab	$19,895,000	$63,976,000	$83,871,000	$24,517,000	$59,354,000
Podiatry	$2,473,000	$12,787,000	$15,260,000	$3,767,000	$11,493,000
Speech Therapy	$285,000	$2,355,000	$2,640,000	$744,000	$1,896,000
Grand Total	$35,936,000	$100,745,000	$136,681,000	$39,786,000	$96,895,000

Notes:

1/ Optional Benefits restoration for Audiology, Chiropractic, Incontinence Cream and Washes, Optician/Optical Lab, Podiatry, and Speech Therapy is assumed effective July 1, 2019.
2/ ACA Optional Funding for FY 2019-20 is 93% FF / 7% GF (Jul-Dec 2019), and 90% FF / 10% GF (Jan-Jun 2020).
3/ For fee-for-service (FFS), payment lags are assumed with a July 1, 2019 Implementation date.
4/ SB 97 (Chapter 52, Statutes of 2017) includes language in Welfare & Institutions Code (W&I) 14131.10(g) to restore the Optical Lab and optician services no sooner than January 1, 2020 or January 1st of the subsequent calendar year following an act from the Legislature.
5/ For managed care, trend factors and Member Months (MMs) were updated to projected FY 2019-20 amounts.
6/ Applied MMs to each Category of Aid. The cost impact depends on the weight of the population type. Typically, SPDs will cost more than adults.
7/ Prior optional benefits restoration (OBR) managed care estimates used May 2009 estimate data. This current OBR estimate uses FFS claims data from FY 2007-08 and FY 2008-09 to come up with the per-benefit PMPM.
8/ Assumed a one month lag for managed care payments.

Annual	FFS	Managed Care	TF	GF	FFP
Optional Benefits Restoration:	A	B	A+B		
Audiology	$4,479,000	$6,683,000	$11,162,000	$3,538,000	$7,624,000
Chiropractic	$560,000	$5,143,000	$5,703,000	$1,707,000	$3,996,000
Incontinence Cream and Washes	$8,244,000	$9,801,000	$18,045,000	$5,779,000	$12,266,000
Optician / Optical Lab[3]	$19,895,000	$63,976,000	$83,871,000	$25,783,000	$58,088,000
Podiatry	$2,473,000	$12,787,000	$15,260,000	$4,624,000	$10,636,000
Speech Therapy	$285,000	$2,355,000	$2,640,000	$791,000	$1,849,000
Grand Total	$35,936,000	$100,745,000	$136,681,000	$42,222,000	$94,459,000

Annual Notes:

1/ Funding for Annual estimate assumes 90% FF / 10% GF for ACA Optional with FY 2019-20 caseload from the November 2018 Estimate.
2/ Payment lags were not applied to the Annual Fiscal Impact.
3/ SB 97 (Chapter 52, Statutes of 2017) includes language in Welfare & Institutions Code (W&I) 14131.10(g) to restore the Optical Lab and optician services no sooner than January 1, 2020 or January 1st of the subsequent calendar year following an act from the Legislature.

Proposal to Restore Podiatry Benefit

The California Podiatric Medical Association (CPMA) provided the following background information:

"The elimination of Medicaid coverage for podiatry was done by a type of provider (podiatrist), but not the services themselves. The same services provided by a physician or surgeon are covered in Medi-Cal, but podiatrists are prevented from providing many of those same services to Medi-Cal patients in California.

Currently, podiatrists perform physician services and have full medical staff admitting and surgical privileges in hospitals and surgery centers. However, they are prohibited from providing podiatric services to patients in the Medi-Cal system unless certain conditions are met or the treatment is providing in a specific setting. For example, podiatrists may be reimbursed only if the treatment was performed in a federally qualified health center, rural health clinic, emergency room, or in-patient hospital setting. Additionally, the services performed in clinics are limited to two visits per month, regardless of the condition of the patient's condition. Podiatrists must also submit treatment authorization requests that are not required of physicians performing the exact same service. These limitations and requirements on podiatry have led to a delay in cases of diabetic foot care, traumatic foot, and ankle injuries.

The restrictions on podiatric services in Medi-Cal have exacerbated an already acute access problem for the low income and disabled population. It saves very little money in the short run, but results in much more expensive complications down the road. Essential foot and ankle services for Medi-Cal patients are now being provided at a costlier rate, or care is being delayed as patients attempt to find a provider under the Medi-Cal system. Recent studies show access to podiatrists can prevent complications for patients and actually provide savings for delivery systems.

Diabetic ulcerations are the primary factor leading to lower extremity amputations. According to a study conducted by Thomson Reuters Healthcare1, among Medicare eligible patients, a savings of $4,271 per patient with diabetes can be realized over a three-year period if there is at least one visit to a podiatrist in the year preceding ulceration. Each $1 invested in care by a podiatrist results in $9 to $13 of savings for the state. Overall, patients with diabetes were less likely to experience a lower extremity amputation if a podiatrist was a member of the patient care team according to Thomson Reuters Healthcare.

Additionally, a recent report detailed an alarming increase in the amputation of toes, legs, ankles and feet of patients with diabetes in California. Statewide, lower limb amputations increased by more than 31 percent from 2010 to 2016 when adjusted for population change. Although there is currently no definite answer to this rise in amputations, some experts in the field have attributed this increase to the 2009 exclusion of podiatry services. Podiatrists are highly skilled in providing wound management and reducing the risk of infection and amputation. If more patients within Medi-Cal had access to podiatrists for treatment, better outcomes may have been possible."

Proposed Podiatry Trailer Bill:
The CPMA states that it does not make sense that while the department agrees that a condition is medically necessary when a physician performs the service (no TAR required), a podiatrist – a specialists in foot care – who performs the same service must submit a TAR. Accordingly, these unnecessary requirements delay and impede access to care. The proposed trailer bill language states that when podiatrists performs the same exact service as physicians, they will be subject to the same exact Medi-Cal billing, treatment, and authorization rules as physicians.

Proposal to Restore Optometry Benefit
The California Optometric Association (COA) provided the following background information:

"According to the National Eye Institute, nearly 32 percent of Californians have a refractive error for which glasses would be the prescribed treatment. This data suggests there are over two million Medi-Cal beneficiaries between the ages of 21 and 64 with refractive error. People with uncorrected refractive error can have difficulty holding down a job and doing day-to-day activities. Access to glasses reduces or eliminates these limitations and is a fundamental part of improving the quality of life for this population.

As optometrists, we know that Medi-Cal beneficiaries are more likely to receive a routine eye exam when they know glasses are a covered benefit. The lack of the optical benefit has other negative health implications beyond simply being unable to see well. Eye care is one of the few health care specialties that may routinely engage healthy patients and many eye examinations are scheduled as a result of minimal or no symptoms. Routine procedures included in a comprehensive eye examination allow doctors of optometry to diagnose systemic conditions like diabetes and hypertension. A study conducted by the UCLA Center for Health Policy Research estimates that some 13 million adults in California, or 46 percent, have prediabetes or undiagnosed diabetes, while another 2.5 million adults, or 9 percent, have already been diagnosed with diabetes. Combined, the two groups represent 15.5 million people — 55 percent of the state's population. According to the Centers for Disease Control and Prevention (CDC), diabetes is the leading cause of kidney failure, nontraumatic lower limb amputations, and new cases of blindness among adults in the United States. Diabetes is also a major cause of heart disease and stroke. The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). Six different HEDIS measures focus on treating diabetic patients, one of which is the number of patients who receive an annual eye exam. Early diagnosis and treatment of these conditions yields better patient outcomes and saves millions of dollars downstream.

Finally, many families are now receiving health insurance for the first time. It is important to foster a culture of coverage in which families understand what their benefits are and how to access them. COA is concerned children who are Medi-Cal beneficiaries may not be accessing their vision benefit and optical coverage, even though they need it. A recent study in Los Angeles County found that only 19% of school age children, ages 5 to 18, on Medi-Cal received vision services such as an exam or the dispensing of glasses. Additionally, a new study shows 60 percent of children identified as "problem learners"

actually suffer from undetected vision problems. Reading, writing, chalkboard work, and using computers are among the critical vision tasks students perform daily. A child's eyes are constantly in use in the classroom and at play. When his or her vision is not functioning properly, education and participation in sports can suffer. Our experience tells us that ensuring adult Medi-Cal beneficiaries have access to optometry and optical benefits significantly increase the likelihood that children have access to those same benefits."

Proposal to Restore All Optional Benefits

Western Center provided the following background information:

"Access to these optional benefits prevents deterioration of health and the need to utilize costlier emergency services. For example, podiatry services are particularly critical for many diabetics who often need more expensive services from complications if they do not get the podiatric services, including amputations. Access to podiatrists can prevent complications for patients and provide savings in addition to improved quality of life. Restoring audiology, podiatry, speech therapy, and incontinence cream & washes benefits would only cost the state about $13 million in General Fund dollars but would greatly improve the health outcomes for low-income Californians."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Flora and the stakeholder panelists present their proposals related to Medi-Cal optional benefits.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 7: STAKEHOLDER PROPOSALS: DURABLE MEDICAL EQUIPMENT, COMPLEX REHAB TECHNOLOGY AND CLINICAL LABORATORY RATES

PANELISTS

- **Bob Acherman**n, Executive Director and Legislative Advocate, California Association of Medical Products Suppliers
- **Kristi Foy**, Legislative Advocate, California Clinical Laboratory Association
- **Tonya Hammat**, Vice President, Payer Relations West Region, National Seating & Mobility
- **Karen Farley**, Executive Director, California WIC Association
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Ben Johnson**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSALS

1. ***Durable Medical Equipment (DME) Rate Floor*** - The California Association of Medical Product Suppliers (CAMPS) and the California Children's Hospital Association (CCHA) request trailer bill that would require that DME receive Medi-Cal reimbursement of 100% of Medicare rates rather than 80% of Medicare Rates.

2. ***AB 97 (2011) Ten Percent Rate Cut Restoration*** - A coalition of organizations, including the California Clinical Laboratory Association, California Society of Pathologists, California Radiological Society, and others, requests the repeal of the AB 97 10% across the board cuts to Medi-Cal fee-for-service provider rates. This ten percent cut is still applied to durable medical equipment (DME), clinical laboratory rates, and other Medi-Cal providers.

3. ***Clinical Laboratory Rate Methodology Change*** - The California Clinical Laboratory Association (CCLA) is requesting repeal of the 80% of Medicare cap on reimbursement rates for clinical laboratory services.

4. ***AB 97 (2011) Ten Percent Rate Cut Restoration for*** **Complex Rehabilitation Technology** -- The National Coalition for Assistive & Rehab Technology requests elimination of the AB 97 ten percent rate cut specifically for complex rehabilitation technology and modification of the Upper Billing Limit (UBL) regulation via trailer bill language to allow inclusion of labor costs and apply a single UBL at the configured chair level.

5. ***Medi-Cal Rate Increase for Breast Pumps*** - The California WIC Association requests a Medi-Cal rate increase for breast pumps.

BACKGROUND

Durable Medical Equipment (DME) Rate Floor - CAMPS and the CCHA request trailer bill that would require that DME receive Medi-Cal reimbursement of 100% of Medicare rates rather than 80% of Medicare Rates. CAMPS provided the following background:

"Current law requires that Medi-Cal reimburse DME items at either 80% of the comparable Medicare rate for most DME and 100% of Medicare for custom rehab equipment and accessories. Reimbursement rates for the rental or purchase of DME includes all provider costs for delivery, set-up, maintenance, patient/caregiver instruction, TAR authorization, billing etc. Depending upon the type of DME the ongoing service costs can be substantial, i.e. home respiratory equipment requires 24/7 response to equipment failure/malfunctions. In addition, due to provider rate reductions from 2011 those rates were further reduced by 10%.

Since the 10% provider rate reduction there have now been serious changes in how Medicare reimbursement rates are determined causing the Medi-Cal rates to begin substantial reductions which endanger continued patient access to DME. Those changes include;

(1) CMS has implemented a Competitive Bidding process for some DME items. There is a myriad of problems now recognized that has caused Congress to pass and the President to sign legislation that slows down the application of those bid rates to rural areas and assess the impact of those rate reductions on patient access to DME. As a result of Competitive Bidding Medicare rates in California impact a wide variety of DME including, CPAP, beds, walkers, standard wheelchairs etc. The reductions off previous Medicare payment rates for Ca. are 40-60%. Medi-Cal then further will reduce those to 80% of Medicare for most DME and 100% of Medicare for wheelchairs. We have attached a chart that shows some of the common impacted DME codes and how those rental rates are being reduced. DHCS has yet to implement the full brunt of those reductions but they have filed a State Plan Amendment that once approved would cause substantial reductions in the reimbursement rate for a wide variety of DME. When implemented likely fall of this year the reductions would be retroactive to 1/1/19 causing a recoupment of "overpayments". There has already been a substantial reduction in the number of providers in California.

(2) We have seen growing concerns from patients and caregivers that they have difficulty in obtaining prescribed DME or long delays in accessing. A report from the Lucille Packard Foundation issued late last year focused on CCS patient access to prescribed medically necessary equipment. The report highlighted the impact of a reduced number of providers and the impact of low reimbursement rates.

Specifically, the report found:

- 22% of respondents waited over a year for equipment and supplies;
- 18% experienced delays that resulted in longer hospital stays;
- 38% of children who faced delays reported exacerbated health conditions;
- 37% of respondents faced challenges with vendors including: 1) providers not willing to order equipment due to low reimbursement, 2) limited availability for appointments, and 3) limited availability of vendors who take CCS Medi-Cal.

(3) We wanted to also focus on complex ventilator rental rates which have been reduced from about $1,100 per month to $717.56 based upon elimination of multiple HCPCS codes to only two new codes. The rental rate includes a variety of expensive supplies which are not separately reimbursed. This is life support equipment with a small number of providers statewide that provide and maintain this type of equipment. We are hearing from CCS providers that they are sometimes not able to timely discharge a CCS child from the hospital because there is not an available provider of the necessary ventilator and support services. Ventilator dependent patients require 24/7 availability for service/ problems and staff to include Respiratory Therapists.

(4) Reimbursement for Custom Rehab Technology such as powered wheelchairs that include custom fitting/ assessment and accessories are also seeing the prospect of continued reimbursement reductions if DHCS Medi-Cal does not adhere to the nuances that Medicare employs to recognize the uniqueness of the chair and components.

(5) In addition to the current reductions to DME reimbursement and those that are pending providers are also facing a claw back of the 10% rate reduction. DHCS is in the process of a 10% claw back for DME payments for the period July 2011 – October 2014. That is when the 10% cut was implemented prospectively. This will unduly penalize those providers that remain in the Medi-Cal program. These reduced DME rates though applicable to Fee for Service payments are often implemented by Medi-Cal managed care organizations.

We would respectfully request that your Sub-committee include this issue as an item for the May Medi-Cal hearing and that the following changes be considered and adopted;

(1) Amend Welfare and Code section 14105.48 to establish that all categories of DME be reimbursed at 100% of the lowest maximum allowance for California for Medicare. In the case of DME where the rate is established under the Medicare Competitive bidding program the rate shall be based on the average rate between rural and non-rural areas. DHCS in its State Plan Amendment filed and pending approval the cost savings by using the current 80% of Medicare was $3.7 Million.

(2) Require the Medi-Cal program when reimbursing for custom rehabilitation equipment when reimbursing using 100% of the Medicare rate to recognize the KU modifier and increase reimbursement according to the applicable Medicare rate.

We are not able to determine the cost impact but assume it is small and less than $3 million.

AB 97 (2011) Ten Percent Rate Cut Restoration - A coalition of organizations, including the California Clinical Laboratory Association (CCLA), California Society of Pathologists, California Radiological Society, and others, request the repeal of the AB 97 10% across the board cuts to Medi-Cal fee-for-service provider rates. This ten percent cut is still applied to durable medical equipment (DME), clinical laboratory rates, and other Medi-Cal providers. CCLA provided the following background:

"Though the 10% cut has not been applied to some provider types and other provider categories have not been subject to retroactive recoupments, there remain some physicians, clinical labs, and others that continue to be subject to the 10% reduction. Proposition 56 funds have only been used to increase a handful of visit codes with no increases to the bulk of services such as radiology, pathology, laboratory, and other services. The provider rate reductions enacted in 2011 were solely due to the size of the overall state budget deficit of $25 billion. Since then, the costs for most providers to render medical services have continued to escalate. The coalition believes that as the number of Medi-Cal enrollees continues to grow through expansion it is imperative that payment rates remain equitable. They request the repeal of the budget deficit driven AB 97 10% cut."

Clinical Laboratory Rate Methodology Change - The California Clinical Laboratory Association (CCLA) is requesting repeal of the 80% of Medicare cap on reimbursement rates for clinical laboratory services. CCLA provided the following background:

"In 2003, as a part of the state budget negotiations, reimbursement for clinical laboratory services was capped at no more than 80% of the Medicare rate for each test.

In 2012, AB 1494 required DHCS to develop a new rate setting methodology for clinical laboratory services based on the lowest prices other third-party payers are paying for similar services. This California market-based approach requires clinical laboratories to submit data and requires the DHCS to collect the data and establish rates based on the "average of the lowest" commercial market rates. This process resulted in significant reductions in the clinical laboratory Medi-Cal rates. Market-based rates developed by DHCS have been in place for several years and represent the current reimbursement rates for California clinical laboratories. The 80% of Medicare cap did not have a substantial impact on the rate methodology because the Medicare rates were historically much higher than the Medi-Cal rates.

In 2018, the federal government implemented the Protecting Access to Medicare Act (PAMA). As a part of PAMA, Congress directed the Centers for Medicare and Medicaid Services (CMS) to establish new national Medicare rates for clinical laboratory services based on commercial market rates. This resulted in a substantial reduction for most Medicare clinical lab rates. Now, for the first time, the Medicare rates have been set to a national market rate. Because of the new Medicare rates, the old 80% of Medicare cap now creates a huge problem. California has gone thru a lengthy process to establish fair

market-based rates for clinical laboratory tests. It does not make sense to now cut those rates to 80% of the new national market rate. If we allow this to happen, California clinical labs will be reimbursed at only 80% of the market based reimbursement rates paid by Medicare in all other states. For the first time, when DHCS applies the 80% of Medicare cap, the resulting Medi-Cal rates would be lower than California market-based rates that DHCS has painstakingly developed to serve the California market. This entirely undermines the purpose behind developing Medi-Cal's market-based rates. This unintended and inequitable result can be fixed by repealing the 80% of Medicare cap."

AB 97 (2011) Ten Percent Rate Cut Restoration for **Complex Rehabilitation Technology** -- The National Coalition for Assistive & Rehab Technology (NCART) requests elimination of the AB 97 ten percent rate cut specifically for complex rehabilitation technology and modify the UBL regulation via trailer bill language to allow inclusion of labor costs and apply a single UBL at the configured chair level. NCART provided the following background:

"Although billed under the standard Durable Medical Equipment (DME) structure, CRT products and services involve a significantly different and more laborious delivery cycle. This specialized equipment requires clinical evaluation, configuration, fitting, adjustment, and in some cases programming to meet the individual's medical needs and maximize function and independence. Unlike standard DME, specialized CRT products require a significant amount of personnel and labor costs. Federal and state governments have recognized these distinctions and, in some instances, have treated CRT reimbursement differently. Unfortunately, certain policies within Medi-Cal have continued to lump CRT into the same class as DME, creating access issues to some of California's most vulnerable Med-Cal participants.

Studies have shown that on average, a CRT company spends roughly 49% of revenue on product acquisition costs and 46% of revenue on operating costs, leaving a narrow 2%--5% pre-tax profit margin. This difficult business involves maintaining the required trained and credentialed staff, supporting systems and facilities, and related company accreditations to perform all the necessary activities. Meeting these requirements comes with significant operating challenges and costs, and narrow margins. As a consequence, there are a very limited number of companies that provide CRT and that number is decreasing across the country. There are only a limited number of qualified CRT suppliers in California and they are struggling to serve the CRT needs of the Medi-Cal beneficiaries with significant disabilities. The Lucille Packard Foundation issued a report in May 2018 highlighting significant access issues that exist for California Children's Services (CCS), a program within Medi-Cal for 200,000 children with extreme health care needs. The report focused on access to prescribed medically necessary equipment, including CRT, finding several issues stemming from a limited number of suppliers and from low payment rates. Specifically, the report found:

- 22% of respondents waited over a year for equipment and supplies;
- 18% experienced delays that resulted in longer hospital stays;
- 38% of children who faced delays reported exacerbated health conditions;

- 37% of respondents faced challenges with vendors including: 1) providers not willing to order equipment due to low reimbursement, 2) limited availability for appointments, and 3) limited availability of vendors who take CCS Medi-Cal.

Two outdated policies and a pending action by the Department of Health Care Services (DHCS) specifically related to DME have created a significant threat to adequate access and timely services of CRT products:

- *AB 97 10% Reimbursement Cuts* – In 2011, California was facing unprecedented budget deficits. As a budget savings exercise the Governor and Legislature included a 10% provider payment reduction to most categories of services in Medi-Cal under budget bill AB 97. Although these cuts have been forgiven for a small number of specific providers, the 10% still applies to DME products.

- *Upper Billing Limit Restrictions* – The CA Upper Billing Limit (CCR, title 22, Sec 51008.1) was promulgated as an emergency regulation in 2003 specifically to prevent unscrupulous providers from over-charging the Medi-Cal fee-for-service (FFS) program for equipment and supplies obtained at little or no cost from flea-markets, obsolete inventory liquidations, manufacturers' demo sales, etc. This regulation capped what DME providers could bill Medi-Cal at 100% of their net acquisition cost. Since the upper billing limit (UBL) cap is broadly applied across the DME benefit, it creates two unique challenges for CRT providers: 1) The 100% acquisition cost cap does not take into account the significant labor costs that are required for CRT through a team of certified providers. With acquisition cost making up only 49% of the total CRT cost this cap makes it difficult for a provider to configure these products at cost, especially with a 10% cut to the already low rates still in place. 2) The UBL methodology applies to each specific part of the CRT product, further complicating the difficult CRT delivery process. A complex wheelchair may contain 15 billable line items meaning, if one part is billed over the UBL cap, the provider would be considered to have over-billed for the wheelchair even if the entire wheelchair is below the total UBL calculation for the entire chair. This creates administrative complexity that makes it even harder to simply breakeven on CRT products.

- *State Plan Amendment (SPA) 19-0005 (Pending)* – DHCS recently proposed SPA 19-0005 to be submitted to the federal government to adjust certain Medi-Cal reimbursement rates for DME. The SPA proposes that the state will use the 2019 Medicare fee schedule at the "non-rural rate" for DME. DHCS currently follows a higher Medicare fee schedule, meaning the 2019 update will result in another rate cut for DME, which will include CRT. Additionally, the proposal to apply the non-rural rate to all areas in the state means rural areas with different delivery and service costs will see even larger cuts, creating worse access to the most difficult areas of our state. These changes are proposed to be retroactive applying back to January 1, 2019. Although DHCS estimates a $3.7 million impact, we believe the fee schedule updates could have an even greater impact as the new fee schedule will also be used in the rate setting process for Medi-Cal managed care plans, effectively lowering their rates. With CRT providers already subject to a 10% cut

and restrictive UBL requirements, CRT providers simply cannot absorb another cut in the Medi-Cal system.

The layers of reimbursement cuts to DME severely jeopardizes the state's ability to provide access to CRT products for the small population of children and adults with significant disabilities and medical conditions enrolled in the Medi-Cal program. Access negatively impacts these Medi-Cal beneficiaries who are the most medically fragile and who are at the greatest risk for high health care costs. The combination of ongoing cuts and the addition of another pending retroactive cut cannot be absorbed and should not be accepted by this Legislature.

Revise the Upper Billing Limit to Include Labor Costs – The 100% UBL cap was selected as an amount that should allow more than enough "profit" for reputable suppliers. In theory, for CRT, a 100% markup over net acquisition cost of 49% produces a 51% Gross Profit; however, a typical CRT company has labor and operating expenses in excess of 48% of revenue (prior to UBL reductions) and would, therefore, generate a pre-tax margin of less than 3% under the formula. When you take into consideration the 10% Medi-Cal reimbursement reductions and pending additional cuts through the SPA, the payment levels will be well below the actual cost of providing the service."

Medi-Cal Rate Increase for Breast Pumps - The California WIC Association requests a Medi-Cal rate increase for breast pumps, and provided the following background:

"Rates for these breast pumps have not been raised since 1998! Low quality breast pumps may yield little or no milk, preventing mothers from establishing or maintaining breastfeeding, which impacts their baby's feeding and ultimately overall health. Lack of quality breast pumps through Medi-Cal has forced new mothers to search for alternative providers, such as WIC, to cover gaps in breast pumps and related supplies. This is supposed to be the responsibility of Medi-Cal.

Our proposal would focus upon breast pumps known as "personal single use pumps" and would take the low $93 rate up to $186. The total maximum cost estimate for this State Budget proposal would be $7 million per year, although with some of the quality breast pumps also available at local WIC sites, we believe that the annual cost would actually end up being much lower.

Science proves that when infants are breastfed, their risk for obesity is reduced. Breastfeeding is also responsible for the reduction in many childhood illnesses including ear infections, digestive and lower respiratory infections and other serious illnesses. Studies also show that breastfeeding leads to reduced risk of both breast and ovarian cancer in mothers.

By providing this modest rate increase for quality breast pumps and related supplies in Medi-Cal, CA could realize a savings from $405,00 to $940,000 per 100,000 women by providing this improved breastfeeding service and support. Access to high quality breast pumps can also help lead to optimal breastfeeding rates, which could reduce medical costs related to infant illness by $1.6 million per 100,000 women."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the panelists present their proposals and requests that DHCS provide technical assistance in the form of sharing any legal or other challenges associated with implementation of these proposals (excluding increased costs).

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 8: HOME AND COMMUNITY BASED ALTERNATIVES WAIVER OVERSIGHT AND STAKEHOLDER PROPOSAL ON CALIFORNIA COMMUNITY TRANSITIONS

PANELISTS

- **Jenny McLelland**, Parent Advocate, Medically Complex Children of California
- **Elissa Gershon**, Litigation Counsel, Disability Rights California
- **Karen Keeslar**, Legislative Advocate, East Bay Innovations
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE AND PROPOSAL

The purpose of this issue in the agenda is two-fold:

1. To provide oversight over the implementation of the Home and Community Based Alternatives (HCBA) Waiver; and

2. To hear a stakeholder proposal for $19 million General Fund for the California Community Transitions Program, a program related to the HCBA Waiver, in anticipation of the loss of federal funding. Although an appropriation is necessary to operate the program, stakeholders contend that the program ultimately results in net savings to the state.

BACKGROUND

Various stakeholders have shared their concerns about the implementation of the new organization of the HCBA Waiver, as of spring 2018, with the Subcommittee. Disability Rights California (DRC) submitted the following background information which summarizes the major concerns with the Waiver implementation:

?The Home and Community Based Alternatives (HBCA) waiver is a Medi-Cal Home and Community Based Services waiver formerly known as the Nursing Facility/Acute Hospital (NF/AH) waiver. The HCBA Waiver provides Medi-Cal beneficiaries with long-term medical conditions with services such as personal care and in-home nursing, which allows them to return to and/or remain in their homes in lieu of institutionalization.

In August of 2018, administration of the HCBA Waiver was transitioned from DHCS to nine HCBA Waiver Agencies throughout California. Since that transition, DRC has received a number of complaints about delays in processing of applications and authorization of services once approved for the Waiver. These unreasonable delays put vulnerable adults and medically fragile children at acute risk of institutionalization and cause others to remain in hospitals and nursing facilities longer than necessary.

Heather, who lives in Sacramento, needs 24-hour attendant care to remain safely at home. She applied for the HCBA Waiver in November 2017. Several months later, she received a letter confirming that her application had been received and she was on the waitlist. Several more months later, after DRC intervened, she learned that she was number 2602 on the waitlist and that she must just wait her turn. Alarmed because of the urgency of her plight, Heather's Senator's office helped intervene and her application was expedited. She was finally found eligible for the Waiver in October 2018. To date, she has not begun to receive services because of delays and confusion by her Waiver Agency and DHCS.

Concerns About The Waitlist: Although the Waiver has doubled in size since 2016 (in 2019 it has capacity for more than 8000 participants), we were recently informed that approximately 2322 individuals remain on the waitlist; more than 1800 of them applied for the Waiver before July 2018. Waiver applicants have no way of knowing where they are on the waitlist and how long they must wait. There is no expedited assessment process for those at imminent risk of institutionalization. Seven Waiver Agencies have more than 100 children and adults on their waitlists; one Waiver Agency has over 1000. Some of these individuals have waited months or years to have their applications processed and languish without services.

Children Needing the Waiver for Medi-Cal Eligibility: Some children with complex medical needs require Medi-Cal in-home nursing to leave the hospital or remain safely at home. Private insurance provides limited, if any, in-home nursing. The HCBA Waiver allows children under 18 with severe disabilities to be "institutionally deemed" and thereby qualify for Medi-Cal in cases where the child would not otherwise be eligible as a result of family income. DHCS has initiated a "priority review" process for such children which directs that children requiring institutional deeming not be placed on the waitlist; 249 children under 18 are waitlisted, however. DRC continues to receive calls from families of children who experience confusion among Waiver Agencies, and long delays in assessment for Waiver eligibility, and authorization of, Waiver services.

Long Delays and No Timelines for Assessment or Provision of Services: DHCS imposes no timelines on itself or on Waiver Agencies for conducting Waiver assessments or authorizing services. As a result, individuals are left waiting for months without Waiver services that they desperately need. This includes infants who remain hospitalized and severely disabled youth who turn 21 and are supposed to transition seamlessly to the Waiver but instead precipitously lose all of their in-home nursing."

California Community Transitions Proposal

In January 2007, DHCS was awarded a special grant to participate in the Money Follows the Person Rebalancing Demonstration, known in California as the California Community Transitions (CCT) project. The goal of this project is to transition long-term nursing home residents back to community settings. CCT was slated to cease transitions due to the federal program expiring, effective December 31, 2018. In January 2019, federal funding was appropriated to last through at least March 31, 2019. Last week, the House of Representatives approved further funding anticipated to last through the federal fiscal year (September 30, 2019).

According to stakeholders, to date, the CCT program has successfully transitioned more than 3,600 from institutional settings to the community resulting in an average of approximately $60,000 in savings per participant per year.

Stakeholders state that this project successfully demonstrated, and continues to demonstrate, that the State is able to accomplish three goals: 1) Medi-Cal beneficiaries living in skilled nursing institutions for longer than 90 days can successfully be transitioned back into community living; 2) California can comply with the Olmstead decision requiring the State to enable people with disabilities to live in the most integrated setting possible; and 3) the State can realize substantial savings since community living is far more cost effective for the State.

DHCS states that going forward, nursing home residents will receive CCT services through the HCBA Waiver, and intends to delegate administration of the waiver to contracted non-state providers called Waiver Agencies. However, stakeholders assert that the HCBA waiver cannot truly replace the CCT program because:

- HCBA Waiver agencies lack authority to pay for all of what the CCT program was authorized to pay for, such as first and last month's rent.

- HCBA Waiver agencies do not get paid if the transition is not complete within 90 days, and many of these transitions are extremely challenging to complete within 90 days, thereby creating a disincentive for agencies to take on the most difficult transitions.

- Many of the people served by the CCT program are not eligible for the HCBA Waiver, which also has a cap and a waiting list.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff requests:

1. Stakeholders on the panel to share their concerns with the implementation of the HCBA Waiver and to present their CCT funding proposal.
2. DHCS to share their perspective on the implementation of the Waiver, respond to the concerns and recommendation's included in DRC's letter, and respond to the following:
    a) What is the cap on the HCBA Waiver enrollment?
    b) How many adults and children are on the HCBA waiting list?

3. Department of Finance provide any additional technical assistance they have on these issues and respond to the following:
    a) Does the CCT result in net savings to the state?

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

8860 DEPARTMENT OF FINANCE

ISSUE 9: PROPOSITION 55 MEDI-CAL FUNDING OVERSIGHT

PANELISTS

- **Maia Schneider**, Executive Director, Business Development, Marshall Medical Center
- **Barbara Glaser**, Senior Legislative Advocate, California Hospital Association
- **Ann Hollingshead**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ryan Woolsey**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Susan Wekanda**, Principal Program Budget Analyst, Department of Finance
- **Carla Castaneda**, Assistant Program Budget Manager, Department of Finance

Public Comment

ISSUE

As requested by various health and hospital systems, including the California Hospital Association (CHA), Tenet Health, SHARP, California Children's Hospital Association, Providence St. Joseph Health, and Private, Essential, Access Community Hospitals (PEACH), this issue is to better understand the requirements and Department of Finance calculations of Proposition 55 as it relates to funding for Medi-Cal, and to hear CHA's proposal for such funding. Specifically, CHA requests $700 million in one-time Proposition 55-generated General Fund to be appropriated to the Medi-Cal program for the following purposes:

1. **Address the workforce shortage**. Allocate $250 million to bolster the state's physician workforce by expanding the number of primary care and psychiatrists trained and supporting efforts to retain them. If managed in accordance with federal requirements, this funding could serve as the non-federal share to draw down federal matching dollars. This one-time investment would fund multi-year residency programs, adding value for years to come without any disruption in physician training. In addition, based on a recommendation from the California Future Health Workforce Commission, the funds could also be used to develop a psychiatric nurse practitioner program that recruits from, and trains providers to serve in underserved rural and urban communities.

2. **Improve the state's behavioral health infrastructure.** Direct $100 million in grants to improve infrastructure and care systems for individuals in crisis with behavioral health needs. Care and treatment for patients with mental health and/or substance use disorders can be handled in settings more appropriate than hospital emergency rooms. Increased crisis stabilization services can direct these patients to care settings that better meet their needs, while also supporting the broader

community. Grants could also be used for hospital efforts to mitigate ligature risks, improving patient safety.

3. **Expand access to care in rural communities.** Allocate $100 million to hospitals in rural, remote, or low-population density areas to support greater access to medical services, particularly telepsychiatry and regional crisis stabilization services. Medi-Cal patients in these communities should be able to access care from psychiatrists, specialists, and other providers without having to delay treatment or drive hundreds of miles.

4. **Disproportionate share hospitals.** Allocate $250 million to enhance payments for providers that serve a disproportionate number of Medi-Cal and uninsured patients; this is particularly important given recent payment cuts at the federal level. As a result of federal changes to public charge regulations, hospitals are seeing an increased number of individuals delaying needed care. When these patients go to hospital emergency departments, they typically require more costly and less efficient services.

BACKGROUND

In 2016, voters passed Proposition 55, which extended tax rate increases on high-income Californians. Proposition 55 includes a budget formula that went into effect in 2018-19. This formula requires the Director of Finance to annually calculate the amount by which General Fund revenues exceed constitutionally required spending on schools and the "workload budget" costs of other government programs that were in place as of January 2016. One-half of General Fund revenues that exceed constitutionally required spending on schools and workload budget costs, up to $2 billion, are directed to increase funding for existing health care services and programs in Medi-Cal. The Director of Finance is given significant discretion in making calculations under this formula. Under calculations made for the 2018-19 and 2019-20 budgets, the Director of Finance found that General Fund revenues do not exceed constitutionally required spending on schools and workload budget costs. As a result, the Governor's budget provides no additional funding for Medi-Cal pursuant to the Proposition 55 formula.

LAO Analysis:

The Legislative Analyst's Office (LAO) issued a report last year on Proposition 55, *The 2018-19 Budget: The Administration's Proposition 55 Estimates*, and more recently provided the following updated analysis:

"***Background on the Measure.*** For context, the Proposition 55 calculation has three major inputs. First, the measure directs DOF to estimate the upcoming year's available revenues. Second, DOF subtracts from this total the constitutional minimum funding level for schools and community colleges under Proposition 98. Third, DOF subtracts an estimate of the "workload budget" costs of government programs that were in place as of January 1, 2016. If a surplus results from this third step, half of it, up to $2 billion, is dedicated to increase spending on Medi Cal. If a deficit results, there is no additional funding for Medi Cal. (More information on Proposition 55 and the administration's

approach to the Medi-Cal calculation is included in our previous report, *The 2018-19 Budget: The Administration's Proposition 55 Estimates*). The constitution gives DOF sole discretion over the Proposition 55 calculation.

Last Year's Report Raised Two Concerns With the Administration's Calculation. In our report last year, we identified two issues with the way the administration was administering the Proposition 55 calculation. First, we noted that the administration excluded optional reserve deposits from available revenues. Second, we raised questions about how the administration was interpreting the workload budget provisions of the measure. We found that the administration took a very broad interpretation of the measure's language such that the vast majority of its new proposals were counted as "workload budget."

Administration Takes Similar Approach for 2019-20, Resulting in No Additional Funding to Medi-Cal in 2019-20. Our findings last year are relevant to how the administration is implementing Proposition 55 in 2019-20, as well. In particular, the administration has taken the same approach to calculating the workload budget, counting all but $34 million of the new proposals for 2019-20 as workload budget related. (The administration estimates that $77 million of overall 2019-20 spending is not "workload budget," but $43 million of this total is related to spending enacted in 2018-19.) As a result, the calculation results in a deficit of $1.5 billion and no additional funding is dedicated to Medi-Cal under this interpretation of the measure.

This Approach Is Unlikely to Result in Additional Funding for Medi-Cal in the Future. Ultimately, the method by which DOF administers the calculation means it is unlikely to ever result in increased funding for Medi-Cal. This is largely because the administration considers the workload budget to include policy changes to existing programs. If the Governor's May Revision budget proposals dedicate any additional resources either to reserves or to new spending on existing programs, the Proposition 55 calculation would be unlikely to result in a surplus that would provide additional dedicated funding for Medi-Cal. Moreover, to the extent that future budgets similarly dedicate available resources either to reserves or to new spending in existing programs, additional funding dedicated to Medi-Cal by the Proposition 55 calculation is similarly unlikely.

A Different Approach Would Likely Result in a Medi-Cal Spending Requirement Under the Measure. Taking a different interpretation of this workload budget provision could result in hundreds of millions, up to $2 billion, in additional General Fund spending requirements for Medi-Cal in 2019-20. For example, our January report, *The 2019-20 Budget: Overview of the Governor's Budget*, estimated that the administration has proposed nearly $8 billion in new discretionary program spending. (We define "discretionary spending" as new programmatic spending that is not related to constitutional requirements, providing funds for caseload, price growth, and new legislation, or federal or court requirements.) These discretionary spending proposals include, for example, $1.3 billion for grants and loans to local governments to increase housing production, $750 million for constructing new or retrofitting existing school facilities, and nearly $350 million to increase CalWORKs grant payments. Under an alternate interpretation of Proposition 55, much (or perhaps the vast majority) of these discretionary spending augmentations would not be counted as "workload budget." In

particular, counting most of these spending proposals as non-workload budget would result in an additional General Fund spending requirement of $2 billion for Medi-Cal."

Stakeholder Concerns:

The hospital systems state that, similar to last year, in this year's budget the Department of Finance continues to use a broad interpretation of Proposition 55's "workload budget" calculation – effectively eliminating hundreds of millions of dollars from the Medi-Cal program.

They state further that this methodology does not comply with Proposition 55's intent and that it is precedent-setting for future calculations. In fact, the March 2018 Legislative Analyst's Office analysis of the calculation provides recommended alternatives that could augment Medi-Cal services by at least $700 million in the coming fiscal year. Stakeholders request the Subcommittees urge the Department of Finance to reconsider the Proposition 55 workload budget calculation, using the January 1, 2016 effective date as the base and adjusting appropriately.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff requests:

1. Stakeholders on the panel present their concerns, requests, and proposal related to Proposition 55 calculations not resulting in any increased funding to Medi-Cal;

2. The LAO provide an overview of their analysis, and calculations, of Proposition 55.

3. Department of Finance explain how they calculated the workload budget for purposes of the Proposition 55 calculation and respond to the following:

    a) Please explain how the services included by DOF meet the Proposition 55 requirements and statute which defines the "workload budget" as "the budget-year cost of currently authorized services.....as it was interpreted by the Department of Finance on January 1, 2016."

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

NON-DISCUSSION ITEMS

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

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 10: SKILLED NURSING FACILITIES: DISCLOSURE OF INTERESTS IN BUSINESSES PROVIDING SERVICES (AB 1953) BUDGET CHANGE PROPOSAL (BCP)

PROPOSAL

The Office of Statewide Health Planning and Development (OSHPD) requests 1.0 position and increased expenditure authority of $369,000 in Fiscal Year (FY) 2019-20, and $119,000 ongoing from the California Health Data and Planning Fund (Data Fund) to implement AB 1953 (Wood, Chapter 383, Statutes of 2018), contingent upon approval of Project Approval Lifecycle documents.

BACKGROUND

OSHPD is required to develop and maintain uniform systems of accounting and reporting for licensed skilled nursing facilities (SNF). Each of the approximately 1,100 SNFs licensed by the California Department of Public Health are required to submit to OSHPD a Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report (Cost Report) within four months of the facility's fiscal year end. The report contains detailed financial and utilization information about the facility, such as type of ownership, services provided, number of beds, utilization statistics, and income and expense statements. Data from these Cost Reports are used by purchasers and providers of healthcare services, policy makers, patient advocates, media outlets, and the Department of Health Care Services (DHCS) to establish Medi-Cal reimbursement rates for SNFs.

OSHPD collects and reviews financial data submitted by California SNFs. Annual reports are prepared by SNFs using OSHPD-approved software and uploaded directly to OSHPD's electronic reporting system. Reports are reviewed for accuracy and compliance with Generally Accepted Accounting Principles (GAAP) and OSHPD's uniform system of accounting and reporting. Copies are made available on OSHPD's website.

AB 1953 requires that SNF-related-party profit loss statements are submitted to OSHPD when filing the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report to assist in the verification of cost due to the related-party transactions. Additionally, OSHPD's publication of the report will provide greater cost transparency to the public.

Effective January 1, 2020, AB 1953 requires licensees of SNFs to disclose specified information to OSHPD regarding ownership or interest in a related party that provides any service to a SNF. For goods and services worth $10,000 or more, the disclosure shall

also include the related party's profit and loss statement and the SNF's Payroll-Based Journal data from the previous quarter.

In May 2018, the California State Auditor Report released a report on the state oversight of SNFs. The report recommended that OSHPD consolidate SNF-related-party transactions, currently reported separately in two different areas of the Cost Report, and expand the detail of the transactions. OSHPD is currently working with DHCS to design a new form implementing this change and the use of the data in the Medi-Cal audits and rate setting process.

To implement the bill, OSHPD must update its data collection forms, accounting system, and program regulations. OSHPD requests resources for contract services in the amount of $250,000, which includes $75,000 for project management and business analysis, and $175,000 for system software development and engineering. Information technology contract resources would conduct business analysis, develop system requirements, and design required changes to collect the new data elements.

In addition, OSHPD requests $119,000 for 1.0 permanent, full-time Health Program Auditor II to assist in the development of regulations and accounting system changes, and the review of submitted data to ensure consistency with OSHPD's accounting and reporting system standards. While the number of annual reports will not increase, the number of data elements per file will increase more than 1,000 and will therefore require more time per file to review.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 11: ADMINISTRATIVE SUPPORT COSTS BCP

PROPOSAL

The Emergency Medical Services (EMS) Authority requests $186,000 ($98,000 General Fund) in 2019-20 and 2020-21, and $190,000 ($98,000 General Fund) in 2021-22 and annually thereafter to support increased administrative costs in the areas of contracted fiscal and personnel services, facilities, and utilities.

BACKGROUND

The EMS Authority contracts with the Department of General Services (DGS)/Contract Fiscal Services (CFS) for accounting and budgeting services and with the DGS/Office of Human Resources (OHR) for personnel services. Between Fiscal Year (FY) 2014-15 and FY 2017-18, CFS increased service rates by 146 percent, from $113,000 to $278,000, and OHR increased service rates by 42 percent, from $166,000 to $236,000.

In order to meet the increased operating costs, permanent positions funded with General Fund and Special Funds have remained unfilled to achieve salary savings. Leaving positions vacant to achieve salary savings in the Paramedic Program (licensing and enforcement), as well as. Emergency Medical Technician (EMT) Registry Program has resulted in delays in issuing new certifications, renewal of existing certifications, investigation of charges of paramedic malfeasance, and also reduced technical assistance provided to the 69 EMT certifying entities throughout California. Additionally, leaving positions vacant in the Disaster Medical Services Division has reduced the EMS Authority's capacity to coordinate emergency medical care during an emergency or unexpected disaster.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 12: AMBULANCE PATIENT OFFLOAD TIME REPORTING (AB 2961) BCP

PROPOSAL

The Emergency Medical Services (EMS) Authority requests 1 permanent position and $189,000 General Fund in 2019-20 and $141,000 annually thereafter to analyze ambulance patient offload time (APOT) data reported by local EMS agencies. The resources will also support the development of a one-time report of its findings to the Legislature (by December 1, 2020) and biannual reports to the Commission on EMS thereafter, pursuant to AB 2961 (O'Donnell, Chapter 656, Statutes of 2018).

BACKGROUND

APOT is defined as the time interval between the arrival of an ambulance at an emergency department and the time that the patient is transferred to an emergency department gurney, bed, chair or other acceptable location and the emergency department assumes responsibility for care of the patient.

AB 2961 requires, on or before July 1, 2019, local EMS agencies to transmit APOT data to the EMS Authority, and upon receipt of the data, to calculate APOT by local EMS agency's jurisdiction and by each facility in a local EMS agency jurisdiction. AB 2961 also requires the EMS Authority to analyze the data and report its findings to the Commission on EMS biannually and also to submit a report to the Legislature on APOT, and make recommendations to reduce or eliminate APOT, on or before December 1, 2020.

The EMS Authority requests 1 permanent position and $189,000 General Fund in 2019-20 and $141,000 annually thereafter to implement the workload associated AB 2961, specifically:

- $159,000 General Fund in 2019-20 and $141,000 ongoing for 1 permanent Research Program Specialist I to:
    - Develop a statewide program to collect, consolidate, analyze and report submitted APOT data from all 33 local EMS agencies,
    - Identify an appropriate automation system for data entry and analysis,
    - Provide ongoing technical assistance and establish relationships with local EMS data staff to facilitate compliance with and consistency in data collection,
    - Prepare required a one-time report for the Legislature, including recommendations to reduce or eliminate APOT.
    - Prepare biannual reports to the Commission on EMS.
- One-time $30,000 General Fund in 2019-20 for a consultant to assist in setting up the database, program reports, and train EMS Authority staff on a statistical software suite to develop reports. Currently, all data is submitted and analyzed using a manual excel-format.

The additional resources are needed as the EMS Authority will collect and analyze a larger quarterly dataset (from 17 to all 33 local EMS agencies) and to provide a one-time report to the Legislature and biannual reports to the Commission on EMS thereafter.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 13: CHILD CARE PROVIDER LEAD POISONING TRAINING (AB 2370) BCP

PROPOSAL

The Emergency Medical Services (EMS) Authority requests one-time $177,000 General Fund in 2019-20 to add the topic of lead poisoning prevention to the preventive health practices course for child care providers, as required by AB 2370 (Holden, Gonzalez Fletcher, Chapter 676, Statutes of 2018).

BACKGROUND

Health and Safety Code Section 1797.191 requires the EMS Authority to establish minimum standards for the review and approval of child care provider training programs. The EMS Authority sets standards via regulations for the review and approval of child care provider training curriculums. The training curriculums are developed and submitted to the EMS Authority by private industry health and safety trainers.

AB 2370 requires that, as a condition of licensure by the California Department of Social Services on and after July 1, 2020, a child day care facility have specified child care providers complete a training curriculum that includes instruction in the prevention of lead exposure as part of the existing eight-hour preventative health practices course, as approved by the EMS Authority. The instruction in the prevention of lead exposure shall be consistent with the most recent California Department of Public Health's training curriculum on childcare lead poisoning prevention, which takes between 30 minutes to an hour. •

To meet the requirements pursuant to AB 2370, the EMS Authority requests one-time $170,000 General Fund in 2019-20 for the equivalent of 2 positions to add the topic of lead poisoning prevention to the preventive health practices course for child care providers. The workload includes the following:

- Updating regulations to include prevention of lead exposure to meet the EMS Authority's requirement as the certifying entity for child care provider training curricula under Health and Safety Code Section 1797.191.

- Providing technical assistance to current private industry training programs as they update program curricula. This includes notifying existing preventative health training programs of the required additional training topic through bulletins, informal documents, and an updated EMS Authority website.

- Providing technical assistance to certain child care providers. Although the EMS Authority does not regulate child care providers, the EMS Authority provides technical assistance to child care providers, foster parents, group home directors and care providers, children's summer camp directors, and camp counselors regarding the requirements set forth in the regulations. The EMS Authority also provides these populations with referrals to training in their communities.

- Reviewing and re-certifying preventative health and safety training programs.

Currently, training programs are required to teach 27 topics during the preventive health and safety eight-hour training course. AB 2370 requires an additional topic in lead poisoning prevention to be added to the course without increasing the eight-hour allotted time frame. The EMS Authority will review the updated training curriculum to verify the existing required topics are covered within the shortened timeframe of 7:30 hours, allowing for 30 minutes of training on lead poisoning prevention. The existing EMS Authority regulations require preventative health and safety training programs to be reviewed and certified every two years. For the EMS Authority to review and re-certify the existing 24 preventative training programs by July 1, 2020, approximately 12-15 training programs would need to submit their updated curriculum for early reevaluation. On average, the EMS Authority requires three to four months to work with the training programs for re-certification of each program. The requested resources will allow the EMS Authority to review and re-certify submitted preventative training programs by July 1, 2020.

The EMS Authority requests General Fund resources because the EMS Training Program Approval Fund cannot absorb the one-time costs. The EMS Training Program Fund has a structural imbalance, where annual revenues are approximately $18,000 lower than expenditures in 2018-19, and projected to be $20,000 lower in 2019-20 as of the 2019 Governor's Budget. The 2019-20 ending fund balance is projected to be $20,000 in 2019-20 as of the 2019 Governor's Budget.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 14: EMT CERTIFICATION DENIAL REPORTING (AB 2293) BCP

PROPOSAL

The Emergency Medical Services (EMS) Authority requests 1 permanent position and $159,000 General Fund in 2019-20 and $152,000 General Fund annually thereafter to meet the legislative requirements of AB 2293 (Reyes, Chapter 342, Statutes of 2018).

AB 2293 requires each local EMS agency or other Emergency Medical Technician (EMT)-certifying entity to annually submit to the EMS Authority by July 1 of each year, data on the approval or denial of EMT-I or EMT-II applicants. AB 2293 also requires the EMS Authority to annually report to the Commission on EMS on the extent to which prior criminal history may be an obstacle to certification as an EMT, and requires the EMS Authority to annually submit the same report to the Legislature

BACKGROUND

The EMS System and the Prehospital Emergency Medical Care Personnel Act (Act) designates the EMS Authority to establish training, scope of practice, and continuing education standards for EMT I and EMT-lls and paramedics (EMT-P). The Act authorizes local EMS agencies to conduct investigations and take disciplinary action against an EMT-I or EMT-II for specified conduct to protect the public health and safety.

Currently, there are 69 agencies that certify EMT-ls, 33 LEMSAs that certify EMT-lls, and one centralized agency (EMSA) to license paramedics. Local EMS agencies can deny, suspend, revoke or place on probation an EMT-I or EMT-II certification for conduct that violates the Health and Safety Code.

Certifications and licenses may be denied, suspended or revoked for, but not limited to, acts of theft, violence, negligence, incompetence, abuse of drugs and alcohol, serious felony convictions, certain sexually related offenses, patient mistreatment and failing to maintain the confidentiality of patient medical information. Under the current statutory and regulatory framework, local EMS agency medical directors and the EMS Authority director may consider specific rehabilitation criteria when determining whether to grant an EMT or an EMT-II certification or paramedic license.

Certifying entities use the EMT central registry to certify approximately 31,000 EMT-ls and EMT-lls every year. Each certifying entity is required to use a central registry to enter certification data in order to print a certification card. Local EMS agencies are also required to enter EMT-I and EMT-II disciplinary information into the central registry. Both certification and disciplinary information are available for the public to lookup on EMS Authority's web page at www.centralregistrv.ca.gov.

AB 2293 requires local EMS agencies and other certifying entities to annually submit data on the approval or denial of EMT-I or EMT-II applicants. The data must capture specified information with respect to the preceding calendar year, including: 1) the number of applicants with a prior criminal conviction who were denied, approved, or approved with

restrictions; 2) the reasons stated for denying applicants with a criminal conviction; 3) the restrictions imposed on approved applicants with a criminal conviction; and 4) race, ethnicity, gender, and age demographic data on the aforementioned applicants.

The EMS Authority requests 1 Associate Governmental Program Analyst to make modifications to the EMS Authority's licensing system for the certifying entities to enter the required data, develop the process for collecting the required data from the 69 certifying entities, perform necessary data follow-up, and prepare an annual report. Specifically, the requested position would:

- Establish a scientifically reliable data collection system utilizing the Central Registry
- Convene a taskforce of experts and relevant stakeholders to identify data collection fields
- Work with Central Registry and vendor staff to update the Central Registry to collect data elements
- Create statewide policies and procedures for the submission of data into the Central Registry system
- Train the certifying entity stakeholders in the new data submission process
- Establish relationships with certifying entity stakeholders to ensure compliance with data submission
- Annually pull data from the Central Registry, analyze the outputs and produce a comprehensive report
- Provide ongoing technical assistance to stakeholders throughout the process

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 15: INDIVIDUAL TAX IDENTIFICATION NUMBER FOR EMERGENCY MEDICAL TECHNICIAN CERTIFICATION (SB 695) BCP

PROPOSAL

The Emergency Medical Services (EMS) Authority requests $100,000 Emergency Medical Technician (EMT) Certification Fund in 2019-20 to address the legislative requirements of SB 695 (Lara, Mitchell, Chapter 838, Statutes of 2018). SB 695 revises how the EMS Authority, local EMS agencies, and other certifying entities use identification numbers, and the use of citizenship or immigration status, in reviewing applicants for certification as an EMT and EMT-Paramedic (EMT-P).

BACKGROUND

The EMS Authority has oversight of EMT-P licensure and EMT certification, along with the disciplinary process associated with these professions. The EMS Authority is also statutorily mandated to provide and maintain a Central Registry for the processing and tracking of individuals certified as EMTs and EMT-Ps throughout the state. Historically, confirming the identity of individuals receiving emergency medical services professional licenses and certifications and matching these individuals to the appropriate Department of Justice (DOJ) / Federal Bureau of Investigation (FBI) background report(s) required the reporting of an applicant's Social Security Number (SSN) during the application process. The passage of SB 695 allows the EMS Authority, local EMS agencies, and other certifying entities to accept an Individual Taxpayer Identification Number (ITIN) for certification purposes when SSNs are unavailable.

An ITIN is a tax processing identification number issued by the U.S. Internal Revenue Service (IRS) for the administration of tax laws. Since 1996, the IRS has issued ITINs to taxpayers and their dependents that are not eligible for a SSN. The IRS issues ITINs because all wage earners, regardless of their immigration status, are required to pay federal taxes. ITINs allow people who are ineligible for a SSN to, comply with tax laws, and ITINs are issued regardless of immigration status. Examples of individuals who need ITINs include nonresident aliens, resident aliens, and their dependents or spouses

SB 695 requires EMS Authority, no later than July 1, 2019, to require an applicant to provide either an ITIN or SSN for purposes of applying for an EMT or EMT-P certificate or a renewal certificate with the EMS Authority, a LEMSA, or other certifying entity. SB 695 also prohibits the EMS Authority, local EMS agencies, and other certifying entities from requiring an applicant to disclose citizenship status or Analysis of Problem immigration status for purposes of licensure, or from denying certification to an otherwise qualified and eligible applicant based solely on his or her citizenship status or immigration status.

EMSA requests $100,000 EMT Certification Fund in 2019-20 to address the legislative requirements of SB 695, as it does not have the resources to absorb the workload associated with this bill. The one-time funds will be used for consulting services to conduct outreach and training to staff at the EMS Authority and the 69 certifying entities.

Specifically, the consultant would provide the following services in support of the implementation of SB 695:

- Work with the Central Registry vendor to gather information on the impact of adding ITINs as an acceptable form of identification for certification process purposes.
- Provide outreach to local EMS agencies and other certifying entities.
- Work with the DOJ to gather information on ITIN use on fingerprint forms.
- Create training documents to be shared with EMS Authority, local EMS agencies and other certifying entities' staff.
- Implement and facilitate statewide training for EMS Authority, local EMS agencies and other certifying entities' staff.
- Work with certifying entities to include ITINs in any additional certification systems they may be using.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 16: DIVISION OF PLAN SURVEYS WORKLOAD BCP

PROPOSAL

The DMHC requests 4.0 permanent positions and $2,077,000 for FY 2019-20, $2,045,000 for FY 2020- 21 and ongoing to address the additional routine and follow-up medical surveys resulting from the increased number of health plans licensed by the DMHC, and the increased rates charged by clinical consultants to assist the DMHC with conducting medical surveys. The requested positions are as follows:

Program/Classification	Permanent Positions
Associate Health Care Service Plan Analyst:	2.0
Attorney:	1.0
Senior Health Care Service Plan Analyst:	1.0
Total:	**4.0**

This request includes $1,447,000 in clinical consultant funding for FY 2019-20 and ongoing to assist in the completion of health plan medical surveys.

BACKGROUND

In accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Act), the DMHC's Division of Plan Surveys, housed within the Office of Plan Monitoring, performs medical surveys of licensed health plans. Routine surveys are on-site evaluations that must be conducted at least once every three years. This type of survey reviews procedures for obtaining health services and regulating utilization, peer review mechanisms and internal procedures for assuring quality of care and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees.

With the exception of one proposal, all proposals were submitted to address specific legislative changes impacting the scope of medical surveys or compliance with the federal Mental Health Parity and Addiction Equity Act of 2008. Only the FY 2009-10 Division of Plan Surveys Workload BCP obtained additional resources to right size the level of funding based on the workload experienced and costs incurred by the Division of Plan Surveys. Since the FY 2009-10 BCP was submitted, the number of health plans subject to medical surveys has increased by 23%, from approximately 100 to 123 plans as of December 31, 2017. As a result, DMHC has been unable to meet mandated timeframes for report production for preliminary, final and follow-up reports. An additional 4.0 positions are necessary to enable the DMHC to conduct medical surveys and issue the associated reports within the mandated timeframes.

In addition to routine surveys, the Act requires the DMHC to conduct follow-up and non-routine surveys when necessary. Follow-up surveys are performed when deficiencies identified in a routine survey remain uncorrected at the time of the final report. The purpose of a follow-up survey is to determine and report on the status of the health plan's efforts to correct uncorrected deficiencies within 18 months of issuance of the routine survey's final report. Non-routine surveys may be performed when deficiencies remain uncorrected at the issuance of the follow-up report, or when the DMHC discovers, or is alerted to, potential flaws in health plan business processes. Findings from non-routine surveys may result in a referral to DMHC's Office of Enforcement and be subject to enforcement action.

The Department detects systemic patterns of unlawful practices by health plans through the medical survey process, and requires health plans to correct deficiencies in a timely manner, thus protecting consumers and ensuring a stable health care delivery system.

Historical funding for medical surveys was based on 28 routine surveys, 5 follow-up surveys and 5 non-routine surveys per year. Based on the number of medical surveys conducted the last two fiscal years and the survey calendar for FY 2018-19, DMHC anticipates conducting an average of 35 routine surveys (an increase of 7), 25 follow-up (an increase of 20) and 5 non-routine surveys per year on an ongoing basis. DMHC has identified the following staffing and consultant funding needs to complete the anticipated workload increase.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 17: HEALTH CARE SERVICE PLAN MERGERS AND ACQUISITIONS (AB 595) BCP

PROPOSAL

DMHC requests expenditure authority of $1,031,000 in FY 2019-20 and ongoing to meet the requirements of AB 595 (Wood, Chapter 292, Statutes of 2018). This amount consists of consultant funding to analyze and assess the impact of applicable transactions or agreements on subscribers, enrollees, provider networks, the overall stability of the health care delivery system and expert opinions regarding potential anti-competitive impacts of transactions or agreements, as well as costs associated with public meetings required by the bill.

BACKGROUND

Prior to the passage of AB 595, DMHC's merger review did not include review for the impact on competition, as those considerations were outside of the DMHC's authority. Conversely, the California Department of Insurance (CDI) has had the broad authority to review insurance company transactions for the impact on market competition for the health insurers under its jurisdiction. The Insurance Code (IC) provides the Insurance Commissioner the ability to deny a transaction if it "would substantially lessen competition in insurance in this state or create a monopoly therein," IC §1215.2(d)(2). The Knox-Keene Act did not provide DMHC's Director similar authority, even though the majority of health coverage products in California's private, commercial market and the Medi-Cal managed care program fall under the jurisdiction of DMHC and not CDI.

AB 595 addresses this problem by providing the DMHC with the authority to disapprove a health plan merger or acquisition upon finding the merger either violates the Knox-Keene Act, substantially lessens competition in health care service plan products or creates a monopoly in this state. AB 595 also ratifies the DMHC's existing authority to review mergers and secure health plan undertakings to benefit consumers, and adds requirements to ensure transparency and public participation for major mergers. Historically the DMHC has exercised its discretion to hold public meetings for major mergers, but this bill codifies a requirement for the DMHC to continue to engage interested persons through public meetings, for all major transactions or agreements. The bill impacts the DMHC as follows:

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

- Requires the health plan to provide the DMHC all information necessary for the DMHC to approve, conditionally approve, or disapprove the transaction or agreement, including information required under Article 11 (commencing with section 1399.70) when an entity involved in the transaction is a nonprofit corporation.

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

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

- Allows the DMHC to disapprove a transaction or agreement if it fails to satisfy the Knox-Keene Act, substantially lessens competition in health care service plan products or creates a monopoly in this state, including, but not limited to, health coverage products for a specific line of business. This bill also allows the DMHC to obtain an opinion from an expert consultant to assess the competitive impact of a transaction.

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

- Requires the DMHC to prepare a statement describing the transaction or agreement if the DMHC determines that a material amount of health plan assets is subject to purchase, acquisition or control, and to make the statement available to the public before any public meeting.

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

The DMHC's Office of Financial Review (OFR) works to ensure stability in California's health care delivery system by actively monitoring the financial status of health plans and provider groups to ensure they meet their financial obligations to consumers and purchasers. AB 595 requires the DMHC to obtain an independent analysis of the impact of each transaction agreement on subscribers and enrollees, the stability of the health care delivery system, when the transaction or agreement affects a significant number of enrollees or involves a material amount of assets, etc. (i.e., when the transaction or agreement is major). The bill also requires the DMHC to assess the competitive impact of the transaction. The OFR will be responsible for administering external consultant contracts to perform the independent analyses of the impact of the transactions. The OFR is requesting $1,000,000 in FY 2019-20 and ongoing to complete the independent analyses. This amount is based on 10 transactions per year, $100,000 per analysis.

The DMHC's Office of Administrative Services (OAS) encompasses all departmental support services functions with the exception of information technology. These functions include accounting, budgeting, human resources, training, organizational effectiveness and business management. The OAS will provide administrative support related to the

public meetings required by AB 595, including but not limited to the preparation of the associated contracts, payment of invoices, processing of travel expenses and preparation of meeting materials. The OAS has determined that the staff time associated with these activities is absorbable; however, the OAS is requesting $15,000 per year to cover venue costs associated with the public meetings and $16,000 to cover travel expenses for staff required to attend the meetings, totaling $31,000 in FY 2019-20 and ongoing.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 18: PHARMACY BENEFIT MANAGEMENT (AB 315) (SFL ISSUE 300)

PROPOSAL

The DMHC requests 2.0 permanent positions and $2,180,000 in FY 2019-20, $904,000 in FYs 2020-21 and 2021-22, $775,000 in FY 2022-23 and ongoing to meet the requirements of AB 315.

This request includes limited-term expenditure authority in the amount of $151,000 in FY 2019-20 and $129,000 in FYs 2020-21 and 2021-22 as well as $1238,000 for consulting services in FY 2019-20.

In addition, this request includes $483,000 in platform licensing costs in FY 2019-20. The IT consulting funds and platform licensing costs will be made available contingent upon the approval of Project Approval Lifecycle documents.

This proposal seeks to add the following provision to Item 4150-001-0933:

> 2. Of the funds appropriated in Schedule (1), $1,121,000 is for the support of information consulting costs to implement Chapter 905, Statutes of 2018 (AB 315), which requires pharmacy benefit managers to register with the Department. This amount is available contingent upon approval of Project Approval Lifecycle documents by the Department of Finance and the Department of Technology.

BACKGROUND

The DMHC regulates health plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act). The Knox-Keene Act requires health plans that cover prescription drugs to provide all medically necessary prescription drugs and includes consumer protections governing a health plan's use of drug formularies, which are used to create lists of preferred and non-preferred drugs and establish cost-sharing amounts. Under existing law, when a health plan delegates the management of its prescription drug benefits to a third party, the health plan is still responsible and liable for providing coverage that is compliant with the Knox-Keene Act. As part of its oversight of health plans, the DMHC reviews delegation contracts to ensure that such contracts are compliant with and will not lessen the consumer protections of the Knox-Keene Act. Any violations of the Knox-Keene Act committed by a delegated entity are the responsibility of the health plan and can be the subject of an enforcement action.

AB 315 established a new article within the Knox-Keene Act, effective January 1, 2020, outlining contractual requirements that must exist if a health plan uses a Pharmacy Benefit Manager (PBM). PBMs are defined in this article as a person, business, or other entity that, pursuant to a contract with a health care service plan, manages the prescription drug coverage provided by the health care service plan, including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting

with network pharmacies and controlling the cost of covered prescription drugs. Licensed health plans and their employees and contracted providers (including medical groups) that perform these services for the health plan are excluded from the definition.

Under these new Knox-Keene Act provisions:

- Health plans must disclose to pharmacy providers the information that is required to be included on enrollees' prescription drug benefit cards, including information for how providers may contact the plan for assistance and information necessary to process a claim.

- Health plans may not include in a contract with a pharmacy provider a provision that prohibits a provider from informing a patient of a less costly alternative to a prescribed medication, also referred to as a "gag clause".

- If a health plan contracts with a PBM, the contract must require the PBM to:

    - Comply with the disclosure of information and prohibition of gag clauses listed above.

    - Register with the DMHC as a PBM in accordance with new registration requirements.

    - Exercise good faith and fair dealing in the performance of its contractual duties with the plan.

    - Comply with provisions of the California Business and Professions Code applicable to PBMs.

    - Inform pharmacists subject to contracts with the PBM of their rights as providers under the Knox-Keene Act to submit complaints to the DMHC and have contractual protections specified in Health and Safety Code Section 1375.7.

- PBMs must notify their contracted health plan in writing of any activity, policy, or practice of the PBM that presents a conflict of interest that interferes with its duty to exercise good faith and fair dealing in the performance of its contractual duties.

- PBMs contracted with health plans must register with the DMHC, under provisions that:

    - Prohibit the registration from being transferable.

    - Require the DMHC to develop an application form that includes the PBM's contact information, the names and addresses of persons beneficially interested in the PBM, and other specified information.

  - Require the PBM registration applicant to state that it has not been convicted of a felony, or describe why it is unable to make that statement.
  - Authorize the DMHC to set a registration fee.
  - Require PBMs to notify the DMHC of changes in the registration information within 30 days.

- The failure of a health plan to comply with these contractual obligations constitutes grounds for disciplinary action and theDMHC shall periodically evaluate contracts between health plans and "BMs.

AB 315 also added Section 1385.007 to the Health and Safety Code requiring the DMHC to create a Task Force on Pharmacy Benefit Management Reporting by July 1, 2019, to determine what information related to pharmaceutical costs should be gathered through reporting by health care services plans or their contracted PBMs. The DMHC will report recommendations to the Legislature no later than February 1, 2020, on which date the task force shall cease to exist.

Additionally, AB 315 added Section 1368.6 to the Health and Safety Code as follows:

- Effective January 1, 2020, a pilot project is established in the Counties of Riverside and Sonoma to assess the impact of health care service plan and PBM prohibitions on the dispensing of certain amounts of prescription drugs by network retail pharmacies.
- On or before July 1, 2020, health care service plans shall report annually to the DMHC information and data relating to change, if any, to costs and utilization of prescription drugs attributable to the prohibition of contract terms.
- DMHC will solicit and receive any additional information relevant to changes in costs or utilization attributable to the pilot project from other interested stakeholders.
- DMHC shall summarize data received pursuant to this subdivision and provide the summary to the Governor and Legislature on or before December 31, 2022.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 19: HEALTH CARE SERVICE PLAN DISCIPLINARY ACTION (AB 2674) (SFL ISSUE 301)

PROPOSAL

The DMHC requests 9.0 permanent positions and $2,072,000 in FY 2019-20, $1704,000 in FY 2020-21 and ongoing to meet the requirements of AB 2674 (Chapter 303, Statutes of 2018).

This request includes $296,000 for IT consulting costs and $472,000 for platform licensing costs in FY 2019-20 available contingent upon the approval of Project Approval Lifecycle documents.

This proposal seeks to add the following provision to Item 4150-001-0933:

> 3. Of the funds appropriated in Schedule (1), $768,000 is for the support of information consulting costs to implement Chapter 303, Statutes of 2018 (AB 2674), which requires the Department to review complaints filed by providers against health plans for unfair payment patterns and authorizes the Department to conduct audits and take enforcement action. This amount is available contingent upon approval of Project Approval Lifecycle documents by the Department of Finance and the Department of Technology.

BACKGROUND

AB 2674 establishes mandates for the DMHC to review, at least annually, all complaints submitted to the ÓMHC by health care providers alleging that a health care service plan has engaged in an unfair payment pattern, in violation of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), as amended. The bill authorizes the DMHC to conduct an audit or take an enforcement action pursuant to its existing regulations if the review of complaint data indicates a possible unfair payment pattern.

Specifically, California Code of Regulations, Title 28, section 1300.71 (s) is cited in the bill. This regulation specifies in detail the standards for health plans on payment of claims, what constitutes an unfair payment pattern and how the DMHC may engage in enforcement of the claims payment rules.

The Knox-Keene Act directs the DMHC to receive provider complaints of instances of unfair payment (as well as instances of unfair billing by providers). The DMHC administers this law through the Provider Complaint Unit (PCU), which receives individual complaints from contracted and non-contracted providers. Existing law prohibits health plans from engaging in unfair payment patterns, defined generally in law as demonstrable, unjust or repeated patterns of delaying, reducing or denying payments or not including interest due on late payments. The DMHC conducts financial audits of health plans to determine whether health plans engage in patterns of unfair payment practices. Through audits, the DMHC reviews a variety of health plan paid claims and provider dispute resolution (PDR) decisions to determine if they were processed

correctly. If the DMHC determines a health plan processed more than five percent of claims and/or PDRs incorrectly in the same or similar manner, the DMHC will find that the health plan engaged in a pattern of unfair payment..

The DMHC received 5.0 positions for the PCU in FY 2006-07, and has subsequently redirected additional department resources to this effort due to the increased volume of complaints over time. However, there have been times in the past where the DMHC was not able to follow up on the provider complaints it received due to resources becoming limited or strained by other duties mandated by statute. Based on staffing levels, PCU conducts individual case reviews of provider complaints to verify that the facts asserted by the complaining provider are supported by backup documentation. The PCU subsequently makes a preliminary determination as to whether claims should have been paid and whether interest and/or penalties are due.

The documentation and data collected by the PCU is regularly used during DMHC's financial audits of health plans. The PCI-J also compiles monthly and quarterly reports to quantify and help determine whether there are any patterns of complaints. These are shared with the DMHC's financial reviewers as they prepare to conduct the periodic claims payment audits.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 20: OFFICE OF CIVIL RIGHTS INCREASED WORKLOAD (SFL ISSUE 303)

PROPOSAL

The Department of Health Care Services (DHCS), Office of Civil Rights (OCR) requests 2.0 permanent positions and expenditure authority of $296,000 ($148,000 General Fund (GF) and $148,000 Federal Fund (FF)) in fiscal year (FY) 2019-20 and $278,000 ($139,000 GF and $139,000 FF) in FY 2020-21 and ongoing. The resources will address the workload increase in the Equal Employment Opportunity (EEO), Reasonable Accommodations (RA), and Civil Rights Compliance (CRC) Programs.

BACKGROUND

The Office of Civil Rights is responsible for three main program areas: EEO, RA and CRC. Within EEO and RA, OCR is responsible for overseeing the employment rights of all DHCS employees. Within CRC, OCR is responsible for preventing and correcting civil rights violations in the delivery of services administered by DHCS. OCR's current staffing level was primarily based on workload in the areas of EEO and RA. CRC is a new and growing area of responsibility pursuant to the federal 2016 Final Rule implementing Section 1557 of the Affordable Care Act.

DHCS' EEO, RA, and CRC workload has increased over time although staffing has not increased in OCR. The total number of DHCS employees has grown from 2,861 in 2007-08 to 3,503 in 2017-18 and Medi-Cal beneficiaries now stand at approximately 13.2 million, almost double the number in 2008. The increase in the number of DHCS employees and Medi-Cal beneficiaries, as well as the public's focus on employment rights and civil rights, has resulted in significant increases in complaints.

The workload in CRC has resulted in OCR staff being diverted from work in the area of EEO/RA and delays in activities. Lack of staffing has also led to two investigations being contracted with external investigators in FY 2017-18 at a total cost of about $50,000, with similar projected annual costs if staff resources are not addressed. The result of understaffing is both increased cost and increased liability to DHCS.

Furthermore, OCR has seen an approximately ten-fold increase in proposed legislation regarding equal employment opportunity, sexual and other forms of harassment, and civil rights applicable to Medi-Cal beneficiaries

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 21: PROVIDER ENROLLMENT WORKLOAD INCREASES (SFL ISSUE 305)

PROPOSAL

The Department of Health Care Services (DHCS) requests two-year limited-term (LT) funding equivalent to 23.0 positions and associated expenditure authority. The resources are needed to address an increase in workload due to an increase in provider enrollment applications, including applications from Drug Medi-Cal (DMC), and Medi-Cal managed care health plan providers. In addition, these positions would be used to address a backlog of approximately 19,000 applications due to an increase in applications received.

The total expenditure authority request is $3,181,000 ($795,000 General Fund (GF) and $2,386,000 Federal Fund (FF)) for fiscal year (FY) 2019-20 and $2,974,000 ($744,000 GF and $2,230,000 FF) for FY 2020-21.

BACKGROUND

Provider Enrollment Division (PED) is responsible for the timely enrollment and re-enrollment of medical providers and applicants, who meet all participation standards defined by federal and state statutes as well as regulations, into the Medi-Cal fee-for-service (FFS) program. Pursuant to the California Welfare and Institutions Code (WIC), Section 14043.26, PED must complete an application review for a new physician or new physician group, which comprises the majority of applications processed by PED, within 90 days. Other types of provider applications, such as, psychologist, licensed clinical social workers, licensed midwives, nurse practitioner, physician assistant, podiatrists, etc. must be completed within 180 days. If PED fails to take an action on an application within the statutorily required timeframes, the applicant is enrolled by default into the Medi-Cal FFS program. Currently, there are approximately 185,000 providers enrolled in the Medi-Cal FFS program and this number continues to grow each year. PED has received an increased number of applications since FY 2015-16 while staffing levels have remained static. As of December 31, 2018, PED's backlog is approximately 19,000 applications, which represents an increase of over 200 percent when compared to the previous calendar year.

During the enrollment process, providers are screened to identify and reject potentially fraudulent providers from admission into the Medi-Cal FFS program and safeguard program integrity. Under provisions of the 2010 Patient Protection and Affordable Care Act (ACA), providers are to be revalidated every five years and monitored monthly to make certain they continue to meet state and federal standards of participation. The ability to identify and reject potentially fraudulent providers from admission into the Medi-Cal FFS program is the first component of any anti-fraud program, and PED has significant safeguards and tools to address program integrity. All applications are closely screened by PED against; inclusion on the federal List of Excluded Individuals/Entities, System for Award Management and Medicaid and Children's Health Insurance Program State Information Sharing System, which contain debarment and exclusion actions taken by various federal agencies. DHCS verifies providers on these databases with the initial

application screening and during monthly monitoring to prohibit excluded providers from enrollment into Medi-Cal program.

On November 14, 2017, DHCS issued All Plan Letter (APL)17-019, which outlined newly established provider screening and enrollment requirements mandated by the 2E' Century Cures Act and new federal Medicaid managed care regulations pursuant to the CMS Final Rule CMS-2390-F. The 2E' Century Cures Act and Title 42 CFR, Section 438.602, contained a significant change in provider enrollment requirements for managed care plans. This section requires that as a condition for receiving payment under Medi-Cal managed care plans (MCPs), the state must screen, enroll and periodically revalidate health plan network providers according to the requirements of the ACA of 2010. APL 17-019 conveyed these requirements to the Medi-Cal MCPs and gave them the choice to create their own enrollment processes, to include the federal requirements of Title 42 CFR, Section 455 Subparts B and E^ or to direct providers to enroll in Medi-Cal FFS, since the requirements have already been incorporated in enrollment procedures for Medi-Cal FFS. PED anticipates over 32,000 applications from Medi-Cal managed care health plan providers requesting enrollment into Medi-Cal FFS over a two-year period, and PED expects to receive approximately 7,000 applications annually thereafter. Through November 30, 2018, PED has received approximately 3,300 applications from Medi-Cal MCPs health care providers that are currently not enrolled in Medi-Cal FFS. The enrollment of MCP providers is a new workload for PED.

As a result of the Mental Health and Substance Use Disorder Services Information Notice (IN) 18-009 that was posted on February 8, 2018, PED estimates approximately 800 DMC providers, which includes DMC clinics and substance use disorder treatment professionals, to request certification into the Medi-Cal program each year. The IN requires 17 counties who are not currently providing all DMC services to become certified or contract with certified entities to provide those services. DMC is a treatment funding source for individuals who are Medi-Cal eligible (clients). In order to receive reimbursement for alcohol and other drug treatment services provided to individuals who are Medi-Cal eligible, a provider must become DMC certified. Pursuant to Government Code, Section 30025(b)(2)(B), the State distributes funds for the provision of DMC services to counties as part of each county's Behavioral Health Subaccount (BHS) allocation. Realignment statutes assign the counties the responsibility for Public Safety Services, to include the prevention, treatment, and provision of recovery services for substance abuse [Government Code Sections 30025(i) and 30026.5(a)]. Pursuant to WIC, Section 14124.24, subdivisions (c) and (d), to utilize the BHS allocation to provide DMC services, a county must contract with the Department to arrange, provide, or subcontract for the provision of DMC services for the Medi-Cal eligible residents of that county. In order for DMC to pay for covered services, Medi-Cal clients must receive substance abuse services at a program that is DMC Certified. This is also an increase in enrollment workload for PED.

Pursuant to WIC, Section 14043.65, applicants whose application for enrollment as a provider or whose certification is denied, or providers who are denied enrollment for a new location, have a statutory right to appeal the Department's action. Decisions on these appeals must be issued within 90 days of receipt of the appeal. As applications for enrollment increase, the number of application denials is also expected to increase,

thereby resulting in a higher number of appeals and an increased workload for the Office of Administrative Hearings and Appeals, the forum in which these appeals are adjudicated.

PED experienced a significant increase in applications received in the latter half of 2018 compared to prior fiscal years. From July 1, 2018 to November 30, 2018, PED received approximately 26,000 applications, which has contributed to a 214% increase in PED's application backlog in 2018.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 22: FEDERALLY QUALIFIED HEALTH CENTERS DRUG MEDI-CAL PROVIDERS (SFL ISSUE 306)

PROPOSAL

The Department of Health Care Services (DHCS), requests 1.0 permanent position and the associated expenditure authority of $139,000 ($70,000 General Fund (GF); $69,000 Federal Fund (FF)) for fiscal year (FY) 2019-20 and $130,000 ($65,000 GF; $65,000 FF) in FY 2020- 21 and ongoing to support the new workload resulting from the passage of Senate Bill (SB) 323 (Mitchell, Ch. 540, Statutes of 2017), which allows Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to participate in the Drug Medi-Cal (DMC) Program.

Effective January 1, 2018, SB 323 allows FQHCs and RHCs to enroll as a DMC certified provider and to receive reimbursement directly from a county or DHCS for providing Specialty Mental Health Services (SMHS) and DMC services to Medi-Cal beneficiaries.

To strengthen program integrity, DHCS needs resources to conduct compliance monitoring, fiscal oversight, and provide training and technical assistance to FQHCs and RHCs as they become DMC certified providers. DHCS requests position authority for 1.0 Associate Governmental Analyst (AGPA) for the Substance Use Disorder Program, Policy and Fiscal Division (SUD PPFD).

BACKGROUND

FQHCs and RHCs provide primary care services for all age groups and must provide preventative health services onsite, or by arrangement with another provider. Other services that may be provided directly by a FQHC or RHC, or by arrangement with another provider, include dental services, mental health and substance use disorder (SUD) services, transportation services necessary for adequate patient care, hospital services and specialty care. There are approximately 1,200 FQHCs and RHCs in California that serve vulnerable populations and medically underserved communities.

Under existing federal law, FQHCs and RHCs are reimbursed through their clinic-specific Prospective Payment System (PPS) rate, set by DHCS, for services provided to Medi-Cal beneficiaries. FQHCs and RHCs may provide any service that is included in their bundled PPS rate, including mental health and SUD services. If a Medi-Cal beneficiary receives mental health and/or SUD services at an FQHC or RHC, the clinic may only bill one daily PPS rate per beneficiary. FQHCs and RHCs can elect to add or subtract services, which will adjust the FQHCs or RHCs clinic base rate accordingly by DHCS through a Change in Scope of Service Request.

In order to maintain program integrity and prevent double billing issues, DHCS has historically issued policy and regulatory guidance that prohibits FQHCs and RHCs from participating in both DMC and SMHS programs. SB 323 allows FQHCs and RHCs to be reimbursed directly from DHCS, or a county, for providing SMHS or DMC services to MediCal beneficiaries, while preventing the occurrence of duplicative reimbursement. The

bill provides DHCS the authority to establish a process in which FQHCs and RHCs can become fee-for-service (FFS) providers under these carved-out delivery systems.

The DMC program is a "carve-out" of the broader Medi-Cal program. Currently, there are SUD services being provided at an undetermined number of FQHCs and RHCs that do not qualify as billable DMC services, but rather as part of the clinics' bundled PPS rate. Since these services do not qualify as billable, DMC services are not monitored by DHCS under Title 22, California Code of Regulations (CCR) Section 51341.1 requirements. Under the California Medicaid State Plan, DMC services are provided on a FFS basis that include perinatal residential drug treatment. Outpatient Drug Free treatment services. Intensive Outpatient Treatment, and narcotic (opioid) replacement therapy. In order for a FQHC or RHC to provide and bill for DMC services, a provider must go through the process set forth by the DHCS Provider Enrollment Division (PED) and become a DMC certified provider.

All current provisions of DMC services are applicable for approved DMC certified providers, including a county's choice not to enter into a contract with a DMC certified provider. In this case, the DMC certified provider has the option to contract directly with DHCS to provide DMC services. Because FQHCs and RHCs are new to DMC services, extensive training and technical assistance will be required to verify clinics are aware of regulatory requirements. In addition, DHCS attempts to monitor new providers within the first three years of providing treatment services, reducing non-compliance and risk of fraud, waste and abuse. New DMC providers will increase the number of compliance reviews required.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 23: REAPPROPRIATION: BEHAVIORAL HEALTH MODERNIZATION RESOURCES (SFL ISSUE 308)

PROPOSAL

The Department of Health Care Services (DHCS), Mental Health Services Division (MHSD), requests a reappropriation of expenditure authority of $2,053,000 ($808,000 General Fund (GF); $1 Federal Fund (FF)) in Fiscal Year (FY) 2019-20 to cover the planning costs of the Comprehensive Behavioral Health Data Systems Modernization (CBHDSM) project (see Attachment A — Reappropriation Language). DI-ICS received an appropriation for this project to cover contractor costs- in Budget Change Proposal (BCP) 4260-402-BCP2018-MR Mental Health Fiscal Oversight and Behavioral Health Data System Modernization.

The Centers for Medicare and Medicaid Services (CMS) must approve the Request For Offer (RFO) for IT vendor services to conduct the phase 1 planning work. The development of the RFO is complete and the document was submitted to CMS January 2019. CMS approved the RFO Mar 2019. It is estimated that the phase 1 planning work will begin in October 2019.

This proposal will draw down Federal Financial Participation (FFP), for enhanced funding, from CMS and requests GF authority to cover the costs of contractor services and monthly reporting fees to California Department of Technology (CDT). The enhanced FFP will fund existing staff involved in the project, as well as provide funds for contractor services to conduct the planning work and develop necessary state end federal deliverables.

Total funding request:

FY 2019-20	General Fund[€]	Federal Fund*	Total
Personnel[+]	[$228,000]	$289,000	$289,000
Contractor Services	$754,000	$956,000	$1,710,000
IT Project Reporting[~]	$54,000	$0	$54,000
Total	**$808,000**	**$1,245,000**	**$2,053,000**

[€] GF consists of state portion and state match for Medicaid and Children's Health Insurance Program (CHIP)
** FFP: Medicaid at 90% and CHIP at 88%*
[+] DHCS is not requesting $228,000 GF since it is utilizing the existing staff
[~] Fees to CDT

4260-491—Reappropriation, Department of Health Care Services. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for those appropriations and shall be available for encumbrance or expenditure until June 30, 2020:
0001—General Fund
(1) Item 4260-001-0001, Budget Act of 2018 (Chs. 29 and 30, Stats. 2018)

BACKGROUND

Federal requirements related to Medicaid, the Community Mental Health Block Grant, and the SAPT Block Grant mandate DI-ICS to monitor behavioral health services provided with these funds, which includes data collection and reporting. In addition, there are state data collection, reporting, evaluation, and/or monitoring requirements related to MHSA and the Bronzan-McCorquodale Act, as well as for community behavioral health services. To comply with these requirements, it is essential that the number and diverse characteristics of individuals served, the outcomes, and use/impact of the funds are accurately tracked, analyzed, and made available to the state and federal government, counties, the Legislature, the public, and other stakeholders.

DHCS collects data relevant to these mandates using multiple data systems; however, DHCS' current behavioral health data collection and reporting systems and the IT infrastructure, for data systems to collect and analyze data, are extremely labor intensive. This makes adding or changing data elements, within the existing 12 behavioral health data systems, very difficult. For each data systems to capture new state and federal required data, counties; with a local behavioral health data systems, extract and submit their data on a monthly basis. This current method develops gaps in data collection and duplicative or redundant data, in turn makes this collection of data process irrelevant and counterproductive, Finally, there are significant data quality issues caused by the antiquated platform, lack of validations, etc.

The specific problems that the CBHDSM Project will seek to address include:

1. DHCS is often unable to track key information about clients receiving services such as: number of clients served; specific programs in which clients are enrolled; appropriateness and characteristics of clients' services; clinical status of clients within individual programs and services; client-level outcomes; costs linked to services; specific funding sources used for a client's services; and client satisfaction levels.

2. DHCS is unable to add or change data elements easily, limiting the ability to respond to changes in federal reporting standards or requirements and negatively affecting counties' and providers' data collection and reporting efforts. This can affect funding for programs. For example, requirements in the Medicaid Managed Care (MMC) Final Rule (42 Code of Federal Regulations Part 438) necessitate additional and new data collection which cannot be implemented easily and require additional, manual data collection mechanisms. Data needs related to the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver also cannot be easily met within the current behavioral health data systems infrastructure. These issues are a direct result of the current processes and systems that support the collection and storage of behavioral health data. Currently, data is spread across multiple systems which have not been designed to support consolidation. Each system has a separate user interface for data entry and submission. Furthermore, each system is on a different technical platform and systems differ in how they store program data. Some critical key data elements, such as the Provider ID, are not captured

in each system. As a result, processes required for program data aggregation, evaluation, and reporting are manual and time consuming.

3. DHCS is unable to evaluate the effectiveness of behavioral health services and its ability to meet program goals. DI-ICS is often unable to efficiently identify and evaluate trends in program effectiveness; facilitate timely and accurate communications with stakeholders about program effectiveness; support problem identification and resolution; associate client satisfaction levels with specific programs; and work with programs to implement program improvements and efficiencies. These issues are a direct result of the lack of data integration between the processes and systems discussed above. They are also exacerbated by existing gaps in data collection.

4. DHCS cannot monitor and determine program compliance effectively. The ability to perform its program compliance responsibilities is constrained by the methods through which it acquires basic information from counties about behavioral health program offerings and program expenditures.

5. DHCS is often unable to enforce consistent data quality standards across systems. Data quality across the behavioral health data systems is inconsistent, which reduces the usefulness of data analysis as a tool for effective decision-making. The current process of redundant data entry across multiple systems also creates an undue burden on trading partners when they try to submit their data. In addition, counties submit manually generated reports because automated systems cannot support all of the State's reporting needs, which further contributes to data inconsistencies.

These issues are a direct result of the current processes and systems that support the collection and storage of behavioral health data. Currently, data is fragmented across multiple systems that lack a consistent set of data validations. Each of these systems differs in how they receive and store program data. For example, monthly batch submissions from counties and/or providers must be manually extracted and formatted for data analysis. Moreover, all data files extracted from each system must be manually imported into separate analytical software, which are then cleansed and prepared for analysis and reporting. Furthermore, the current manual data analysis process hinder efficient fulfillment of state and federal oversight and accountability requirements related to behavioral health services. This will also impact data reporting accuracy since there is a high number of manual steps that must be taken before the data is analyzed.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional discussion and debate.

ISSUE 24: HEALTH AND HUMAN SERVICES AGENCY AUTOMATION SFL ISSUES

PROPOSAL

The following four automation-related proposals represent the DHCS components of larger, multi-department proposals, contained in the California Health and Human Services (CHHS) Agency Spring Finance Letter. The full proposals will be heard in Sub 1 as a part of one of the human services hearings.

Electronic Visit Verification Phase ii Planning (Issue 313)—It is requested that Item 4260-001-0001 be increased by $172,000, Item 4260-001-0890 be increased by $1,548,000, and Item 4260-007-0890 be increased by $1,602,000 to support planning activities to comply with federal electronic visit verification requirements related to agency provided Personal Care Services and Home Health Care Services. See related issues in the California Health and Human Services Agency, Department of Developmental Services, and Department of Public Health Finance Letters.

Statewide Automated Welfare System Consolidation (issue 314)—It is requested that Item 4260-001-0001 be increased by $48,000 and Item 4260-001-0890 be increased by $426,000 for four-year limited-term resources to support the consolidation and implementation of a single Statewide Automated Welfare System. See related issues in the California Health and Human Services Agency and Department of Social Services Finance Letters.

Medi-Cal Eligibility Data System Modernization Resources (issue 315)—It is requested that Item 4260-001-0001 be increased by $2,066,000, Item 4260-001-0890 be increased by $18,579,000, and Item 4260-007-0890 be increased by $555,000 to provide four-year limited-term resources to support the multi-departmental effort to modernize the Medi-Cal Eligibility Data System. See related issues in the California Health and Human Services Agency and Department of Social Services Finance Letters.

California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) Integrator Contract Transition Activities (Issue 317)—It is requested that Item 4260-001-0001 be increased by $3,743,000 and Item 4260-001-0890 be increased by $11,702,000 to provide onetime funding to reimburse Item 0530-001-9745 (see related issue in the California Health and Human Services Agency Finance Letter) for anticipated costs related to transition activities for a new system integrator contract for the CalHEERS Project. The additional budget authority will allow CalHEERS to simultaneously support an incumbent and successor contract during the planned 12-month transition period. It is also requested that provisional language be added to Item 4260-001-0001 (see Attachment 2) and Item 4260-001-0890 (see Attachment 3) to authorize the expenditure of such funds only once the Office of Systems Integration finalizes the vendor selection.

STAFF COMMENTS/QUESTIONS

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

Staff Recommendation: Subcommittee staff recommends no action at this time, and recommends that any future action on these items conform to actions taken on the full CHHS proposals.

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