AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, APRIL 24, 2017

2:30 P.M. - STATE CAPITOL ROOM 127

ITEMS TO BE HEARD

LIST OF PANELISTS IN ORDER OF PRESENTATION

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: NEWBORN HEARING SCREENING PROGRAM UPDATE

- **Jennifer Kent**, Director, Department of Health Care Services
- **Sergio Aguilar,** Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 2: NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL TRAILER BILL

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Jacob Lam,** Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 3: SAN FRANCISCO COMMUNITY-LIVING SUPPORT BENEFIT WAIVER TRAILER BILL

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Jacob Lam,** Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 4: THIRD PARTY RECOVERY CONTRACTING AUTHORITY TRAILER BILL

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar,** Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 5: 50 PERCENT RULE AND PERSONAL INJURY LIEN RECOVERY TRAILER BILL

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar,** Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 6: STAKEHOLDER PROPOSALS: OPTIONAL BENEFITS

- **Various Stakeholders** (Health Access, California Pan Ethnic Health Network, Western Center on Law and Poverty, VSP)
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 7: OVERVIEW OF DENTI-CAL PROGRAM, AND MEMBERS' AND STAKEHOLDERS' DENTI-CAL PROPOSALS

- **Jennifer Kent,** Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon,** Principal Program Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

- **Assemblymember Caballero**
- **John Luther**, DDS, Clinical Director, Western Dental
- **Assemblymember Maienschein**
- **Brianna Pittman**, Legislative Director, California Dental Association
- **Tam Ma**, Policy Counsel, Health Access California

Public Comment

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 8: OVERVIEW OF ORAL HEALTH PROGRAMS, UPDATE ON DENTAL DISEASE PREVENTION PROGRAM, AND PROPOSITION 56 TOBACCO TAX REVENUE BUDGET CHANGE PROPOSAL

- **Jayanth Kumar**, **DDS,** State Dental Director, Department of Public Health
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: NEWBORN HEARING SCREENING PROGRAM UPDATE

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Sergio Aguilar,** Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE

The Subcommittee heard this oversight issue at its hearing on Monday, March 27, 2017 and, at that time, asked DHCS to come back to the Subcommittee today to provide an update on their progress on restoring an automated system within this program. For additional background, please see the Subcommittee's agenda for March 27, 2017, Issue #7, page 21.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an update on this program and on how DHCS intends to restore automation to the program.

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

ISSUE 2: NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Jacob Lam,** Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The DHCS (Medi-Cal) Nursing Facility / Acute Hospital Transition and Diversion (NF/AH) Waiver expired on December 31, 2016 and DHCS is in the process of negotiating a renewal of this waiver with the Federal Centers for Medicare and Medicaid Services (CMS). DHCS engaged stakeholders to develop the Waiver renewal application which has been formally submitted to CMS. CMS has agreed to the basic structure of the proposed program and DHCS is in the process of negotiating details with them. DHCS is proposing this trailer bill to codify the basic structure of their proposed Waiver, which they state would accomplish the following:

- The NF/AH wavier may maximize independent living allowing frail and vulnerable Medi-Cal members the opportunity to remain in their own homes and/or community or transition out of an institution into their own home and/or community;

- The NF/AH waiver would offer participants with an institutional alternative choice;

- Waiver services would provide participants with flexibility to self-direct some benefits;

- The new model would allow for a local qualified non-state entity to perform comprehensive care management and care coordination ;

- New slots will reduce the existing waitlist;

- Moving to an aggregate cost limit would allow the services that will be authorized to a participant to be determined based on assessed medical care needs and not individual cost limits;

- The proposal would allow for a seamless transition of all In-Home Operations waiver participants to the NF/AH waiver; and

- The proposal would provide that home settings, including Congregate Living Health Facilities (CLHFs) and Intermediate Care Facilities, for the

Developmentally Disabled-Continuous Nursing Care (ICF/DD-CNCs) meet new Federal regulations or are transitioned to the State Plan as long-term care providers.

In order to project the fiscal impact of this proposal, DHCS must trend actual NF/AH Waiver costs and members' State Plan costs, attribute assumed reductions in preventable or avoidable institutional services and include any unmet needs for long-term services and supports (LTSS), plus the cost of providing care coordination to accurately determine any fiscal impact. The Administration's fiscal analysis indicates that:

1. Transition to local care coordination and aggregate cost neutrality will have implications of cost avoidance or savings.

2. Removal of the annual individual cost limit on NF/AH Waiver is also estimated to be budget neutral as the transition to increase lower level services will decrease the higher cost institutional based services and allow for alignment with higher quality of care, increase health outcomes and reduced health care costs.

3. There is no discernible fiscal impact on other state departments.

4. Additional state operations funding is not needed to change the NF/AH Waiver.

5. No additional positions are required to carry out the proposal, assuming there are no associated challenges or litigation pertaining to the resultant waiver changes.

BACKGROUND

The NF/AH model of care provides a medical/social service delivery system using a person-centered planning approach that provides and coordinates all needed LTSS. Services are provided to adults who would otherwise reside in nursing facilities. The NF/AH Waiver affords eligible individuals the opportunity to remain independent and in their homes for as long as possible. The NF/AH Waiver reimburses for services on a fee-for-service basis and requires each participant to maintain an annual individual cost limit. The NF/AH Waiver expired December 31, 2016. DHCS initiated a stakeholder engagement process to identify current challenges and recommend specific criteria or changes for the new NF/AH Waiver proposal.

This Waiver provides an alternative to costly institutional care and affords frail and vulnerable Medi-Cal members the opportunity to remain in their own homes and/or community or transition out of an institution into their own home and/or community. It is held to the principle of federal budget neutrality which means that the cost of the waiver program (waiver services and state plan services) must cost no more than the services incurred by an institutional peer group. In order to maintain cost neutrality, individuals on the NF/AH Waiver are assigned, at the point of enrollment, their annual "institutional cost limit" based on assessed level of care, and are reassessed periodically (minimally once a year or whenever there is a change in health status). NF/AH Waiver participants have care plans and a menu of services from which they can select and self-direct as

long as the cost of these services are within their annual individual cost limit. Nurse case managers have been managing the care plans and the annual individual cost limits and require participants who are at their "cost limit" to adjust the care plans, even when there is no change in the health status. An example of exceeding the "cost limit" would be In-Home Supportive Services (IHSS) hours are increased by County IHSS, resulting in nurse case managers requiring the participants to reduce Waiver Personal Care Services (WPCS) hours (at no net loss of IHSS-WPCS combined hours).

The proposed trailer bill includes the following key components:

1. ***Authorizes the DHCS Director, when renewing the NF/AH Waiver, to take the following actions:***

    a. Contract with one or more "Case Management Contractors" qualified to provide care management and Waiver services, as specified. The "Care Management Contract" may require the Case Management Contractor to perform activities, as specified.

    b. Propose that the waiver demonstrates cost neutrality in the aggregate to the Centers for Medicare and Medicaid Services (CMS).

    c. Expand the number of waiver slots by 5,000 beginning January 1, 2017. During the duration of the waiver, the Director may seek federal approval to include additional slots, as specified.

    d. Require Care Management Contracts to enroll at 60 percent of all total enrollments from institutional settings, as specified, to assist members back to the home and/or community settings.

    e. Establish a managed fee-for-service (FFS) model, as defined in applicable CMS guidance, as specified.

    f. Identify performance outcomes to evaluate quality of services provided by a Care Management Contractor, as specified.

    g. Develop criteria to evaluate the fiscal solvency of the Care Management Contractor, as specified.

    h. Provide the Director the option, if the Care Management Contractor is in danger of becoming fiscally insolvent, to 1) immediately terminate the Care Management Contract or 2) require the Care Management Contractor to submit a compliance plan addressing fiscal solvency concerns.

    i. Require a Care Management Contractor to immediately notify DHCS in writing of any fact or facts that are likely to result in their inability to meet its financial obligations.

j. Allow renewal of a Care Management Contract, as specified. The Care Management Contract shall be renewed if the need to provide waiver services to the waiver population is necessary to continue improving the waiver participants' health outcomes, transitioning institutionalized residents to home or community-based settings and provide access to an adequate provider network.

k. DHCS requires a Point of Contact, if at any event, either party needs to makes changes to the Care Management Contract.

l. DHCS can terminate or decide not to renew the Care Management Contract for specified reasons.

2. Authorizes DHCS to implement this section by means of all-county letters, provider bulletins, policy letters or other means to further execute policy direction.

3. Exempts contracts under this section from Department of General Services review and approval.

4. Requires DHCS to implement this section only to the extent it can demonstrate fiscal neutrality on the overall health care costs spent by DHCS for Waiver participants, as specified and only to the extent federal financial participation is available.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this trailer bill proposal.

Staff Recommendation: Subcommittee staff recommends approving of placeholder trailer bill for the purpose of codifying the key components of the new NF/AH Waiver application.

ISSUE 3: SAN FRANCISCO COMMUNITY-LIVING SUPPORT BENEFIT WAIVER TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Jacob Lam,** Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The current term for the San Francisco Community Living Support Benefit (SF CLSB) Waiver expires on June 30, 2017. The City and County of San Francisco Department of Public Health (SF DPH) has decided not to renew the SF CLSB for an additional five-year waiver term. As a result, DHCS seeks to amend Welfare and Institutions Code (WIC) Section 14132.24, to sunset the SF CLSB Waiver effective July 1, 2018, and transition the participants currently being served by the SF CLSB Waiver into the Medi-Cal Assisted Living Waiver (ALW).

There is an anticipated cost savings by expanding ALW into San Francisco and increasing institutional transitions (as compared to simply allowing the SF CLSB to end without any expansion of the ALW). The Governor's Budget assumes savings of $918,000 ($459,000 General Fund) in 2017-18. The SF CLSB Waiver currently serves 22 members. DHCS plans to expand the ALW unduplicated user counts to serve the current SF CLSB Waiver Participants (22 members) and an additional 22 members who will transition from institutional settings to community living within SF County.

Expansion and integration of the SF CLSB Waiver population into the ALW provides an opportunity for savings and cost avoidance, as the expansion will increase long-term institutional transitions to home and community-based care as well as divert avoidable long-term institutional costs. The Administration's fiscal analysis indicates:

1) There are no discernible fiscal impacts on other state departments.

2) Additional state operations funding is not needed to expand the ALW and transition the SF CLSB population.

3) No additional positions are required to carry out the proposal, assuming there are no associated challenges or litigation pertaining to the proposed changes.

BACKGROUND

The SF CLSB Waiver assists eligible individuals to move into available community settings and to exercise increased control and independence over their lives. The Waiver is administered by the SF DPH, on behalf of DHCS. It provides or coordinates an array of services at community-based housing sites that enable beneficiaries to remain in the least restrictive and most homelike environment while receiving the health-related services, including personal care and psychosocial services, necessary to protect their health and well-being. These community-based housing units may include, but are not limited to, the living area or unit within a facility that is specifically designed to provide ongoing assisted living services, licensed residential care facilities for the elderly, publicly funded senior and disabled housing projects, or supportive housing sites that serve chronically homeless individuals with chronic or disabling health conditions.

The SF CLSB Waiver serves Medi-Cal members who are:

- 21 years of age and older;
- Residents of San Francisco who would otherwise be homeless, living in shelters, or institutionalized; and
- Eligible for skilled nursing facility level of care.

The ALW offers services in an assisted living or public-subsidized housing setting to Medi-Cal members who would likely otherwise receive care in a skilled nursing facility. Eligibility for the ALW is based on the beneficiary qualifying for a skilled nursing level of care, which is determined by a Care Coordination Agency utilizing an assessment tool to assess potential participants. At present, the ALW is offered in 14 counties, not including San Francisco County, and the waiver term ends February 28, 2019.

The goals of the ALW are to: 1) Facilitate a safe and timely transition of Medi-Cal members from a nursing facility to a community home-like setting in a Residential Care Facility (RCF), an Adult Residential Care Facility (ARF), or public subsidized housing, utilizing ALW services; and 2) Offer eligible seniors and persons with disabilities, who reside in the community, but are at risk of being institutionalized, the option of utilizing ALW services to develop a program that will safely meet his/her care needs while continuing to reside in an RCF, ARF, or public subsidized housing.

The services provided through the SF CLSB waiver are comparable and available under the ALW. Under this proposal, the ALW would expand to serve San Francisco County. Transitioning from the SF CLSB Waiver to the ALW will provide existing SF CLSB Waiver participants with access to waiver services, and result in additional ALW enrollments from institutional providers within the City and County of San Francisco, in particular, from the highest cost skilled nursing facility in the state, Laguna Honda.

The ALW provides greater flexibility than the SF CLSB Waiver. The SF CLSB Waiver's requirements limited its ability to contract with available assisted living facilities (ALFs)

and direct access housing in San Francisco County. As a result, it relied upon contracted ALFs outside of San Francisco County. The ALW's flexibility would allow it to enroll additional ALFs in San Francisco County and to increase its network of ALFs in surrounding ALW counties.

The proposed trailer bill language would:

1) ***Transition the SF CLSB Population***: The proposed legislation would allow DHCS to initiate the process to transition, in its entirety, the current SF CLSB population into the ALW to ensure their continuum of care is maintained. DHCS plans to work in conjunction with SF DPH to notify waiver stakeholders, participants and providers that an end date has been set for their service program and that all waiver participants and providers would be assisted in transitioning to other available services and waivers including, but not limited to, the ALW. Working closely with SF DPH, the care management of the SF CLSB Waiver participants will transition to established local care coordination agencies (CCA) enrolled in the ALW or other available programs/settings of their choice. If the waiver participant elects to transition to the ALW program, the CCA will then provide the SF CLSB population with the same frequency of case management that they are currently receiving under the SF CLSB Waiver. The SF CLSB population will be able to maintain their current place of residence, as all of these facilities have already been approved by DHCS as ALW providers, or will be assisted with enrolling as Medi-Cal providers and trained on how to bill for ALW services. Program participants will continue to receive medically necessary services prior to, during, and following the transition. The stakeholder notification and transition process will begin no sooner than January 1, 2017 and upon that date DHCS and SF DPH will also have the option to discontinue enrolling new participants into the waiver, and directing them into the ALW.

2) ***Provide a Sunset Date***: DHCS' proposed legislation would sunset the SF CLSB Waiver effective July 1, 2017, subject to approval by the Centers for Medicare and Medicaid Services (CMS). This sunset date coincides with the end date for the current SF CLSB Waiver term.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Subcommittee staff recommends approval of placeholder trailer bill to sunset the San Francisco Community-Living Support Benefit Waiver and authorize the transition of its participants into the Assisted Living Waiver.

ISSUE 4: THIRD PARTY RECOVERY CONTRACTING AUTHORITY TRAILER BILL

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar,** Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS is proposing this trailer bill in order to update the program by: eliminating mandated outsourcing of Workers' Compensation recovery to ensure DHCS complies with existing law; removing unnecessary regional contracts; ensuring the contractor is operating consistently with DHCS policies; and streamlining the administrative process.

BACKGROUND

Federal and state laws require DHCS to recover Medi-Cal costs from liable third parties, so that Medi-Cal is the payer of last resort. Specifically, California Welfare and Institutions Code (W&I) Sections 14124.70-14124.94 guide DHCS' Personal Injury (PI) and Workers' Compensation (WC) program activities. DHCS works all PI recovery cases in-house and uses a contractor to perform WC recovery activities. In 2015-16, the PI and WC programs collected $60.4 million and $2.5 million, respectively, from members' tort actions.

In 1981, the Legislature enacted W&I Code Sections 14124.80 et seq. to introduce a pilot program allowing contracting and outsourcing of some Medi-Cal Third Party Liability (TPL) recoveries. The Legislature required DHCS to enter into contracts with private entities to obtain missing information that was held by private companies on a contingency basis. In the 35 years since the legislative mandate to outsource this recovery activity, the Department of Industrial Relations (DIR) has developed a Workers' Compensation Information System (WCIS) which is a centralized repository of WC claims. This eliminates the need to outsource discovery of WC claims. However, many PI actions remain solely in private sector databases that are unreported to the State. As such, DHCS still needs a contractor to gain information about these unreported PI cases.

The proposed trailer bill includes the following key components:

1) ***Eliminates Mandated Outsourcing of Workers' Compensation that Conflicts with Government Code.*** Government Code (GC) Section 19130 guides the State's contracting authority and mandates the use of State staff to complete work unless management can justify contracting work consistent with narrow guidelines. Several portions of W&I Code Sections 14124.80 et seq. mandate outsourcing of WC casework, which is inconsistent with GC 19130 given that State staff have access to the WC claims in the WCIS. DHCS proposes several amendments to eliminate the WC outsourcing mandate, which would allow State staff to perform the recovery work, and increase flexibility in contracting authority to facilitate outsourcing of TPL recovery work only when State staff cannot perform the work consistent with GC 19130.

2) ***Eliminates Mandate for Regional Contracts.*** W&I Code Section 14124.82(a) requires that DHCS divide the contracting work into two regional contracts for northern and southern California. Over the last five procurement cycles, DHCS has awarded both regional contracts to the same bidder in each bidding cycle. Due to advances in technology, having two regional contracts offers no tangible benefit and creates additional administrative and procurement costs for DHCS and contractors. DHCS proposes amendments to allow for more than one contract, but no longer mandate DHCS have two regional contracts.

3) ***Provides a Finite End to Contracts Consistent with State Contracting Policy.*** Current law allows a contractor to continue working its existing cases indefinitely. As a result, at least two contracts have lasted as many as 18 years, which is not consistent with State policy, which expects contracts will be limited to a three to five-year term. DHCS proposes amending W&I Code Section 14124.86 to create a finite end to how long a contractor can retain rights to work a case, but ensure a contractor is paid for work already completed on those cases.

4) ***Eliminates References to the "Pilot Project" and Other Technical Updates.*** DHCS proposes removing references to the "pilot project" since it expired over 30 years ago (W&I Code Section 14124.80 et seq.,). In addition, DHCS proposes repealing the intent language of WIC Sections 14124.80(a-c), because only some of these findings have proven accurate over the past 30 years. DHCS proposes to retain WIC Section 14124.80(d) as proposed WIC Section 14124.81(b) to preclude beneficiaries, their attorneys and related parties from claiming compensation for doing mandatory reporting of filed claims.

5) ***Provides Flexibility in How the Contracts are Procured***. DHCS proposes adding WIC Section 14124.82(c) because prospective bidders may possess different sources of information about filed insurance claims that may not necessarily overlap, the flexibility to offer non-exclusive or non-competitive contracts to multiple contractors offers increased opportunities for recoveries and General Fund savings.

6) ***Provides Flexibility in the Work the Contracts Contain***. DHCS proposes to repeal WIC Section 14124.85 because contractor authority will be defined within future contracts to mitigate the risk of a contractor working inconsistently with State policy, ensuring the State complies with federal law, and reducing susceptibility to lawsuits.

Finally, DHCS proposes to repeal WIC Section 14124.88 because it is no longer necessary and duplicative after removing references to the "pilot project," mandated workers' compensation outsourcing, and required regional contracting. Because WIC Section 14124.83 already contains contracting requirements and remains valid, DHCS proposes moving WIC Section 14124.88(d) to that section of law.

Stakeholder Concern

Stakeholders have shared a concern with Subcommittee staff that the drafting of this proposed trailer bill has inadvertently removed language that clarifies that these proposed changes would only apply to PI and WC, despite that being DHCS's stated intent. They are concerned that, as currently drafted, this language would cover all of their claims including all private health insurer claims. Therefore, they suggest inclusion of a technical, clarifying amendment to this effect.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposed trailer bill.

Staff Recommendation: Subcommittee staff recommends approval of placeholder trailer bill to reform the third party liability program for Personal Injury and Workers' Comp at DHCS, including a clarifying amendment that the changes only apply to PI and WC.

ISSUE 5: 50 PERCENT RULE AND PERSONAL INJURY LIEN RECOVERY TRAILER BILL

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar,** Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS proposes trailer bill to address ongoing legal concerns and General Fund revenue loss. According to DHCS, this proposal would: 1) align existing law with original legislative intent; 2) align existing state law with federal law; and 3) reduce General Fund losses.

The Governor's January budget assumes $12.2 million General Fund savings as a result of this proposal.

BACKGROUND

Federal and state laws require DHCS to recover Medi-Cal treatment costs from liable third parties, so that Medi-Cal is the payer of last resort. DHCS' Personal Injury (PI) Program reviews Medi-Cal expenditures paid for treating a member's injury and files a request for reimbursement ("lien") with the liable third party. The PI Program may settle its lien directly with the liable third party or assert the lien against any settlement, judgment, or award ("settlement") resulting from a member's claim or action.

In Fiscal Year (FY) 2015-16, the PI Program collected $60.4 million from members' claims and tort actions. When a Medi-Cal member seeks treatment for an injury, the federal government pays a percentage of the cost of treating the injury known as federal financial participation (FFP). One of many conditions to the receipt of FFP is that DHCS must seek recovery of medical costs caused by a liable third party. When DHCS makes a recovery, federal law requires the State to reimburse the federal government a portion of the recovery equal to the FFP provided for the services to treat the injury. DHCS uses the State's share of the recovered amounts as an abatement to General Fund (GF) expenses.

California Welfare and Institutions (W&I) Code 14124.70 et seq. was last updated in 2007. According to DHCS, recent court decisions, along with the implementation of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (PL. 111-152), have highlighted weaknesses in existing law that some attorneys are applying in ways that are inconsistent with the

Legislature's original intent and causing lost GF revenue. In addition, DHCS states that the federal Centers for Medicare and Medicaid Services (CMS) has identified some sections of state law that are in conflict with Federal Law. CMS has been recouping lost FFP due to those conflicts, causing lost GF savings.

The proposed trailer bill includes the following three components:

Clarifies the Formula that Defines the State's Portion of Litigation Costs. W&I Code Section 14124.72(d), allows for a reduction of the Medi-Cal PI lien so each party pays a proportionate share of litigation costs based on the amount they receive when an attorney facilitates the settlement. Originally, this provision applied only to settlements that were sufficient to pay the Medi-Cal PI lien in full. A recent court decision, Aguilera v. Cal. Dept. of Health Care Services (2015) Cal.App.4th (Aguilera), enables the provision to apply to the medical allocation of the settlement, which may be much smaller than the lien. Hence, instead of paying a proportionate share of litigation costs based on the amount DHCS receives from a settlement, current law now creates situations where DHCS must reduce its lien by amounts greater than the actual litigation costs incurred by the member. This amendment clarifies that each party pays only a proportionate share of actual litigation costs based on the proportion of the settlement received (W&I Code Section 14124.72(d)).

Clarifies Code to Director's Right to Recover When There Are Multiple Settlements. While many injury claims result in only a single settlement, medical malpractice cases and other severe injuries may result in multiple settlements. However, existing law does not explicitly address the DHCS Director's rights to recover the costs of treating a member's injury when there are multiple settlements, and plaintiff's attorneys have found a way to use W&I Code Section 14124.785 to limit DHCS recovery when there are multiple settlements. The law limits the Director's recovery to the amount derived from applying the lowest of the three statutory reductions defined in W&I Code 14124.70 et seq. Thus, when a PI action has multiple settlements, some attorneys provide information about only the first settlement, which is often the smallest, and use the Aguilera decision to limit the lien, which often includes the bulk of treatment services, to the medically allocated portion of that first settlement. The attorneys then disclose all subsequent settlements relating to the same injury, but then use the law to omit all services that DHCS could not recover on the first settlement. This results in a loss of GF savings. DHCS proposes making three associated amendments to W&I Code 14124.70 et seq. to stop this loss:

1. Clarify that the limit to the Director's recovery is based on the aggregated amount of all settlements once the entire action has been resolved, not just a single settlement (W&I Code Section 14124.785).

2. Rename five references to the amount to be collected from "reasonable value of benefits so provided" to "amount of the director's lien as defined in subsection (d) of Section 14124.70" (W&I Code Section 14124.785).

3. Require the Medi-Cal member or DHCS Director, whoever initiates a claim with a carrier for a member's injury, to notify the other party, so both parties' are

protected in their rights to recover injury related losses (W&I Code Section 14124.73).

Revises Fifty Percent Rule to Comply with Federal Law and Stop General Fund Losses. In 1992, an audit from the former Health Care Financing Administration (HCFA), now known as CMS, found W&I Code Section 14124.78, commonly known as the "Fifty Percent Rule," did not comply with the federal Social Security Act (the Act). The Fifty Percent Rule requires DHCS to take no more than half of a settlement after all attorney's fees and legal costs are paid. However, Section 1902(a)(25)(b) of the Act requires states to seek recovery from a third party to the extent that it is cost-effective, and Section 1912(b) of the Act requires the federal government's share of financing for injury-related services in a third party liability action to be fully reimbursed prior to the Medicaid member receiving funds. The former HCFA found DHCS had no valid justification under the Fifty Percent Rule for allowing Medi-Cal members to obtain settlement funds prior to the federal government being fully reimbursed and required DHCS to make the federal government whole in cases settled under the Fifty Percent Rule. DHCS must reimburse CMS for its share for cases settled under the Fifty Percent Rule from the GF.

Prior to the ACA, most Medi-Cal members had a FFP percentage of 50 percent. When a lien is reduced under the Fifty Percent Rule for a member who has a FFP percentage of 50 percent, DHCS reimburses CMS up to 100 percent of the amount recovered, meaning there is not GF reimbursement. The ACA expansion in January 2014 introduced a new ACA group with a FFP percentage of 100 percent. For these members, DHCS reimburses CMS up to 200 percent of the amount recovered, resulting in a GF loss. The table below provides an example of recovery of a case settled under the current Fifty Percent Rule at 50% FFP and 100% FFP:

Member FFP	Settlement After Attorney Costs	Member's Portion	DHCS' Portion	CMS' Portion
50% FFP	$15,000	$7,500	$0	$7,500
100% FFP	$15,000	$7,500	-$7,500	$15,000

DHCS proposes to limit DHCS' recovery to no more than the settlement after deducting reasonable attorney's fees and litigation costs (W&I Code Section 14124.78). This approach conforms to federal law, stops GF losses, guarantees plaintiffs' attorneys receive their expected fees, and avoids making the member liable for attorney's fees or litigation costs.

Stakeholder Concerns

The Subcommittee has received letters of opposition raising significant concerns about this proposal from the California Advocates for Nursing Home Reform (CANHR), Consumer Attorneys of California, and other attorneys. The concerns are primarily focused on the third component above, the proposed changes to the "50% Rule." CANHR, in its letter, states the following:

> "The Department's proposal to eliminate the 50% recovery rule for personal injury liens should be rejected entirely. This proposal is inequitable to victims of abuse and neglect and will ensure that, rather than increase recoveries, few, if any, aged and disabled

abuse victims will even want to pursue justice. While the Department contends that their proposal will stem the loss of general funds and/or result in increased General Funds, the proposed 100% rule will clearly have the opposite effect and result in additional General Fund losses. If the abused victim will recover nothing – and nothing is what they would recover under the Department's proposal – there is no incentive to bring a lawsuit. Thus the parties who injured them will pay nothing to the victim or to the state."

The Consumer Attorneys wrote:

"The DHCS Trailer bill attempts to undermine important protections for low-income, elder, and disabled Californians by overturning established federal and state case law….The DHCS proposed 100% Rule will not produce greater recovery for the Department and instead will prevent low-income, elder, and disabled Californians from pursuing justice…..by allowing the Department to recover 100% of the settlement the Department leaves the victim with nothing…..there would be no incentive to bring a suit in the first place since the entire recovery would go to the Department rather than the injured individual."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal in plain language and respond to the following:

1) What is the importance of implement the findings of a 1992 audit now in 2017?

2) If the federal government is requiring states to provide the full recovery to them, how is this fair to the Medi-Cal member who brought the suit, and how is it not a disincentive from bringing lawsuits of this nature?

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

ISSUE 6: STAKEHOLDER PROPOSALS: OPTIONAL BENEFITS

PANELISTS

- **Various Stakeholders** (Health Access, California Pan Ethnic Health Network, Western Center on Law and Poverty, VSP)
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Several advocates and stakeholders request the restoration of one or more of the optional benefits that were eliminated from the Medi-Cal program in 2009. All the restorations combined are estimated to cost $316,544,000 ($116,795,000 General Fund) annually, as shown in the chart on the next page.

BACKGROUND

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. There is considerable support for restoring these benefits to the Medi-Cal program.

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." Although these benefits were "eliminated," there were exceptions for certain facilities and populations for which the benefits continue to be covered; they include: Federally Qualified Health Centers and Rural Health Centers, emergency room services, patients with developmental disabilities, pregnant women, children (i.e. EPSDT) and PACE programs. The chart below shows the various optional benefits that were eliminated in 2009 (and still have not been restored) and the estimated costs to restore the benefits. The following optional benefits also were eliminated in 2009 but have been restored since then: acupuncture, limited adult dental, and enteral nutrition.

Adult Dental Services

Adult dental services, with the limited exception of "federally required adult dental services" (FRADS) and dental services to pregnant women and nursing home patients, were eliminated among other benefits. Generally, FRADS primarily involves the removal of teeth and treating the affected area. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013 partially restored adult optional dental benefits on May 1, 2014. The chart below shows the cost to fully restore all dental benefits, including partial dentures which currently are not covered.

Restoration Costs

The following table provides the costs associated with restoring these benefits. As pointed out in the table footnotes, these cost estimates assumes 95 percent (for 2017), 94 percent (2018) and 90 percent (annually, ongoing) federal financial participation (FFP) for the population covered under the ACA-related Medi-Cal expansion. For the balance of the Medi-Cal population, the services qualify for FFP at the state's usual 50:50 matching rate.

November 2016 Estimate
Optional Benefits Restoration

FY 2017-18 *(lagged)**	FFS	Managed Care	TF	GF	FFP
Optional Benefits Restoration:	A	B	A+B		
Audiology	$4,454,000	$9,444,000	$13,898,000	$4,372,000	$9,526,000
Chiropractic	$557,000	$1,181,000	$1,738,000	$547,000	$1,191,000
Incontinence Cream and Washes	$8,197,000	$20,084,000	$28,281,000	$8,856,000	$19,425,000
Optician / Optical Lab	$11,051,000	$56,902,000	$67,953,000	$20,879,000	$47,074,000
Podiatry	$2,459,000	$5,214,000	$7,673,000	$2,414,000	$5,259,000
Speech Therapy	$283,000	$600,000	$883,000	$278,000	$605,000
Dental	$175,430,000	$15,255,000	$190,685,000	$69,458,000	$121,227,000
Grand Total	**$202,431,000**	**$108,680,000**	**$311,111,000**	**$106,804,000**	**$204,307,000**

FY 2017-18 *(no-lag)*	FFS	Managed Care	TF	GF	FFP
Optional Benefits Restoration:	A	B	A+B		
Audiology	$5,350,000	$9,444,000	$14,794,000	$4,682,000	$10,112,000
Chiropractic	$669,000	$1,181,000	$1,850,000	$585,000	$1,265,000
Incontinence Cream and Washes	$9,846,000	$20,084,000	$29,930,000	$9,426,000	$20,504,000
Optician / Optical Lab	$13,275,000	$56,902,000	$70,177,000	$21,648,000	$48,529,000
Podiatry	$2,954,000	$5,214,000	$8,168,000	$2,585,000	$5,583,000
Speech Therapy	$340,000	$600,000	$940,000	$297,000	$643,000
Dental	$175,430,000	$15,255,000	$190,685,000	$69,458,000	$121,227,000
Grand Total	**$207,864,000**	**$108,680,000**	**$316,544,000**	**$108,681,000**	**$207,863,000**

FY 2017-18 Notes:

1/ ACA Optional Funding for FY 2017-18 is 95% FF / 5% GF (Jul-Dec 2017), and 94% FF / 6% GF (Jan-Jun 2018)
2/ For FFS (excluding Dental), assume payment lag with July Implementation date.

Annual	FFS	Managed Care	TF	GF	FFP
Optional Benefits Restoration:	A	B	A+B		
Audiology	$5,350,000	$9,444,000	$14,794,000	$4,956,000	$9,838,000
Chiropractic	$669,000	$1,181,000	$1,850,000	$620,000	$1,230,000
Incontinence Cream and Washes	$9,846,000	$20,084,000	$29,930,000	$9,985,000	$19,945,000
Optician / Optical Lab	$13,275,000	$56,902,000	$70,177,000	$23,007,000	$47,170,000
Podiatry	$2,954,000	$5,214,000	$8,168,000	$2,737,000	$5,431,000
Speech Therapy	$340,000	$600,000	$940,000	$315,000	$625,000
Dental	$175,430,000	$15,255,000	$190,685,000	$75,175,000	$115,510,000
Grand Total	**$207,864,000**	**$108,680,000**	**$316,544,000**	**$116,795,000**	**$199,749,000**

Annual Notes:

1/ Funding for Annual estimate assumes 90% FF / 10% GF for ACA Optional with FY 2017-18 caseload from November 2016 Estimate.
2/ Payment Lag not applied to Annual Fiscal Impact.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests stakeholders to present their proposals for restoration for one or more of these optional benefits, and requests the administration to provide technical feedback on restoring these optional benefits.

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

ISSUE 7: OVERVIEW OF DENTI-CAL PROGRAM, AND MEMBERS' AND STAKEHOLDERS' DENTI-CAL PROPOSALS

PANELISTS – ADMINISTRATION & LAO

- **Jennifer Kent,** Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Maricris Acon,** Principal Program Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal & Policy Analyst, Legislative Analyst's Office

PANELISTS – MEMBERS & STAKEHOLDERS

- **Assemblymember Caballero**
- **John Luther**, DDS, Clinical Director, Western Dental
- **Assemblymember Maienschein**
- **Brianna Pittman**, Legislative Director, California Dental Association
- **Tam Ma**, Policy Counsel, Health Access California

Public Comment

ISSUE AND PROPOSALS

The purpose of this issue to discuss the overall Denti-Cal program, including recent changes to, and new initiatives within, the program, and to hear Denti-Cal related stakeholder proposals which include:

Assemblymember Caballero and Western Dental: Western Dental proposes that 15 percent of Proposition 56 (2016 tobacco tax) revenue dedicated to the Medi-Cal program (or approximately $300 million) be allocated to the following three initiatives:

1) A Dental Transformation Initiative for Adults;
2) Incentives for comprehensive oral health care for children in the Dental Transformation Initiative; and
3) Building of oral health service capacity in underserved areas.

Assemblymember Maienschein: Assemblymember Maienschein proposes to invest $200 million to increase provide rates in order to incentivize more dentists to participate, modernize the administrative process, and make the program more accessible.

California Dental Association (CDA): The CDA proposes to use $300 million in Proposition 56 (2016 tobacco tax) funding to provide supplemental Denti-Cal payments on a sliding scale to dentists based on varying levels of Denti-Cal patient volume.

Health Access: Health Access proposes to invest at least $100 million of Proposition 56 funds to increase dental provider rates to a level that ensures meaningful access for beneficiaries.

Various Stakeholders: Restoration of full adult dental benefits (annual cost of $191 million Total Funds; $75 million General Fund), as discussed in more detail under Issue #6 on optional benefits.

BACKGROUND

The Denti-Cal program, a component of the Medi-Cal program, provides comprehensive dental care to pediatric and pregnant Medi-Cal beneficiaries and limited services to adult beneficiaries.

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

The 2009 Budget Act eliminated dental benefits for adults in the Medi-Cal program. However, a partial restoration of benefits, primarily diagnostic and preventative services, was enacted in the 2013 Budget Act and became effective May 1, 2014. The 2011 Budget Act required DHCS to reduce by 10 percent its payments for many Medi-Cal fee-for-service benefits, including dental services, however this rate cut for dental services was reversed in the 2015 Budget Act.

Dental Program Administration

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

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

First 5 Report on Sacramento's Geographic Managed Care

In 2010, First 5 of Sacramento commissioned the "Sacramento Deserves Better" report, produced by Barbara Aved Associates, which analyzed access, utilization, and quality of dental care under Sacramento's Geographic Managed Care (GMC) Dental Services model. Key findings from this report include the following:

- Only 20 percent of children in GMC Dental Services used a dental service in 2008 as compared to over 40 percent of children in Medi-Cal statewide who are predominately in Fee-For-Service;

- Only 30 percent of children in GMC Dental Services received a dental service in 2010;

- Sacramento GMC Dental Services is consistently one of the lowest-ranking counties for Medi-Cal dental access in the entire state;

- Dental plans have not complied with a "first tooth/first birthday" recommendation for the initial dental visit;

- Inadequate prevention services were provided; and,

- The state provided minimal oversight of GMC Dental Services contracts.

Early in 2012, through a series of articles and editorials, the *Sacramento Bee* brought attention to the dire conditions of Sacramento County's pediatric dental managed care program. The *Bee* coverage focused on the findings of the report commissioned by First 5 of Sacramento, which revealed shockingly low utilization rates and highlighted a series of examples of specific children who had been in desperate need of dental care, yet unable to access the care they needed without significant delays, worsening conditions, prolonged pain, and a significant amount of fear, frustration, and relentless advocacy on the part of their parents.

DHCS Response and Action

In response, DHCS has undertaken a substantial corrective action plan for dental managed care, with a focus on Sacramento's GMC. The DHCS actions in 2012 included:

- Met with the five Dental Plans serving Sacramento to discuss how to implement immediate actions to improve access to dental care for children;

- Provided a letter to Dental Plans articulating immediate expectations and necessary improvements;

- Convened a stakeholder work group to obtain recommendations for improvement, including suggestions for improving the DHCS draft Request for Application (RFA), which is used as the basis for contracting with Dental Plans;

- Communicated with beneficiaries by: 1) letter on the importance of dental care as well as on how to access care; and, 2) by phone with beneficiaries who have not accessed care in the past 12 months;

- Began collecting utilization data from plans which the department shares with the stakeholder group;

- Increased monitoring of plans and providers based on data that indicates low utilization rates;

- Implemented a beneficiary dental exception process, per 2012 budget trailer bill (summarized below); and,

- Implemented changes to all dental plan contracts, including adoption of all Healthy Families Program HEDIS measures.

2012 Budget Trailer Bill

Also in response to the First 5 report, subsequent press coverage, legislative hearings and stakeholder input, provisions to address the shortcomings of dental managed care were included in AB 1467 (Committee on Budget) Chapter 23, Statutes of 2012, budget. This bill included the following key provisions:

- *Sacramento Stakeholder Advisory Committee*. The bill allows Sacramento County to establish a stakeholder advisory committee to provide input on the delivery of oral health and dental care. It authorizes the advisory committee to provide input to the DHCS and to the Sacramento County Board of Supervisors. Requires DHCS and the Sacramento County Department of Health and Human Services advisory committee to meet with this advisory committee.

- *Beneficiary Dental Exception*. The bill authorizes the Director of DHCS to establish a beneficiary dental exception (BDE) process in which Medi-Cal beneficiaries who are mandatorily enrolled in dental health plans in Sacramento County can move to fee-for-service Denti-Cal. The BDE is to be available to beneficiaries in Sacramento who are unable to secure access to services through their managed care plan, within time-frames established within state contracts and state law.

- *Dental Plan Performance Measures*. The bill requires DHCS to establish a list of performance measures to ensure that dental health plans meet quality criteria. The bill requires DHCS to post on its website on a quarterly basis, beginning January 1, 2013, the list of performance measures and each plan's performance. The bill requires the performance measures to include: provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers.

The bill also requires DHCS to designate an external quality review organization to conduct external quality reviews for all dental health plan contracting.

- *Dental Plan Marketing and Information*. The bill requires each dental plan to submit its marketing plan; member services procedures, beneficiary informational materials, and provider compensation agreements to DHCS for review and approval.

- *Annual Reports*. The bill requires DHCS to submit annual reports to the Legislature, beginning March 15, 2013, on dental managed care in Sacramento and Los Angeles, including changes and improvements implemented to increase Medi-Cal beneficiary access to dental care. The bill also requires the Department of Managed Health Care (DMHC) to provide the Legislature, by January 1, 2013, its final report on surveys conducted and contractual requirements for the dental plans participating in Sacramento.

- *Amendments to Contracts*. Requires DHCS to amend contracts, upon enactment of the statute, with dental health plans to reflect and meet the requirements of this new statute.

Study on Fee-for-Service

In 2012, dental health plans contracted with Barbara Aved Associates (the author of the managed care study) to conduct research on Medi-Cal's fee-for-service dental care. The study found, in part, that: 1) 97 percent of non-participating dentists cited low reimbursement rates as the reason for not participating; 2) 90 percent of general dentists said it was somewhat or very difficult to find a pediatric dentists accepting Medi-Cal referrals; and, 3) 38 percent of general dentists and 69 percent of pediatric dentists who take Medi-Cal have 15 percent or less of their patient population in Medi-Cal. The author concludes that children in Medi-Cal are getting inadequate dental care, largely due to insufficient provider participation, reflecting low reimbursement rates. The author recommends: 1) streamlining the provider enrollment process; 2) increasing rates; 3) adopting more quality measures; 4) increasing monitoring of utilization data; and, 5) increasing public oral health education to families.

DHCS March 2013 Report

On April 5, 2013, DHCS submitted a follow-up report to the Legislature on their efforts to improve the Dental Managed Care program. The report cites a substantial increase in dental care utilization rates in the program, from 2011 to 2012. Specifically, DHCS finds an "Increase of plans' utilization rates in Sacramento County from 32.3 percent in 2011, to 43.7 percent in 2012, and in Los Angeles County from 24.6 percent in 2011, to 36.8 percent in 2012." The report lists the following actions that DHCS had taken at that time to improve dental managed care:

- DHCS implemented the Immediate Action Expectations (IAE), which has resulted in the submission of monthly reporting to DHCS to compile and publish reports to the public.

- Implementation of the Beneficiary Dental Exemption (BDE) process, has allowed the staff to assist and manage these special needs cases until the rendering provider completes the necessary services.

- Conducting stakeholder and all plan meetings, to collaborate on dental issues, have become a component in improving the program.

- Assembly Bill 1467 (Committee on Budget), Chapter 23, Statutes of 2012 was enacted July 1, 2012, to improve requirements of DMC and amend Welfare and Institutions (W&I) Codes.

- Since IAE was implemented in March and April of 2012, the dental plans have realized higher utilization increases in the second half of the year. Utilization is expected to continue to increase in 2013.

- The dental managed care (DMC) Contract procurement process was changed from a Request for Application to a Request for Proposal, which allowed DHCS to award contracts to plans demonstrating an ability to meet DHCS' goals and objectives, resulting in improved delivery of services in DMC.

- DMHC in conjunction with DHCS conducted non-routine surveys on most of the Sacramento County dental plans, and noted Knox-Keene deficiencies and contract findings

2012 Hearings

A series of legislative hearings in 2012 found a lack of oversight of the Dental Managed Care programs in Sacramento and Los Angeles counties by DHCS, resulting in significant underutilization by pediatric beneficiaries. On March 8, 2012, the Assembly Select Committee on Workforce and Access to Care convened a meeting to examine the state of the dental safety net, followed by a Senate Budget Hearing on March 22, 2012, that directly examined the Sacramento GMC Program.

As a result, 2012 budget trailer bill provided for the beneficiary dental exemption process, which allows beneficiaries who are not receiving adequate or timely access to care to opt out of the managed care program, requires DHCS to establish performance measures and benchmarks for dental health plans, requires DHCS to utilize dental health plan performance data for contracting purposes, and requires the establishment of contract incentives and disincentives, along with enacting other oversight mechanisms.

2014 Denti-Cal Audit

On December 11, 2014, the California State Auditor issued a report titled *"California Department of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care".* The report showed that insufficient dental providers willing to participate in Medi-Cal, low reimbursement rates, and a failure to adequately monitor the program, led to limited access to care and low utilization rates for Medi-Cal beneficiaries across the State. In fiscal year 2013, nearly 56 percent of the 5.1 million children enrolled in Medi-Cal did not receive dental care through the program.

While DHCS had not formally established criteria to measure the adequacy of the beneficiaries' access to dental services, a 1:2,000 provider-to-beneficiary ratio was used to meet the requests made by the State Auditor for the report. The Audit found that 16 counties either had no active providers or did not have providers willing to accept new Medi-Cal patients, and 16 other counties had an insufficient number of providers to meet the 1:2,000 provider-to-beneficiary ratio.

Studies published by CMS, the National Academy for State Health Policy, and the National Bureau of Economic Research identify low reimbursement rates as a barrier to securing provider participation and thus children's access to dental care. California has not increased its reimbursement rates for Medi-Cal fee-for-service dental services since fiscal year 2000-01, and California's dental reimbursement rates are lower than national and regional averages. California's reimbursement rates for the 10 fee-for-service procedures most frequently authorized for payment under the program in 2012 averaged $21.60 or 35 percent of the national average of $61.96. The audit finds that DHCS has not complied with state law requiring it to annually review reimbursement rates to ensure reasonable access of Medi-Cal beneficiaries to dental services.

Dental Transformation Initiative (DTI)

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

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

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

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

with continuity of care levels *below, equal to, or above* the statewide continuity of care baseline (and other factors) as follows:

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

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

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

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

Outreach to Children and Providers

Through the 2014 Budget Act, DHCS implemented an outreach effort to increase pediatric utilization by identifying beneficiaries aged 0-3, during their birth months, who have not had a dental visit during the past 12 months, and mailed parents/legal guardians a letter that: 1) encourages them to take their children to see a dental provider; and 2) provides educational information about the importance of early dental visits.

In 2015, DHCS completed a pediatric dental outreach campaign for 12-month non-utilizing beneficiaries age 0-3 statewide. Over 580,000 mailers with letters and brochures were sent to heads of household, followed by robodialer outbound calls. DHCS found an increase in utilization at nine (9) and fifteen (15) months after the effort. Utilization rates started at zero (0) for these beneficiaries, increased to 21.22% after 9 months, and increased to 29% after 15 months. For the period ending October 23, 2015, there were 652,875 eligible beneficiaries in the study, and 21.22% (138,514) had received services within the previous 12 months. For the period ending April 23, 2016, there were 652,875 eligible beneficiaries in the study, and 29.00% (189,306) had received services within the previous 12 months. DHCS is finalizing its 2017 Provider and Beneficiary Outreach Plans and both 2016 and 2017 plans will be posted on their website "soon."

Utilization Data

In April 2015, DHCS worked collaboratively with stakeholders to establish measures for assessing beneficiary utilization, as recommended by the California State Auditor (CSA). The final measures are reported by DHCS and made publicly available through the Denti-Cal website on a quarterly basis. The measures are stratified by county, age and ethnicity to provide insight into utilization across regions and demographics. The

measures are based on 90 day continuous eligibility within the FFS delivery system, with the exception of the Usual Source of Care measure which requires two years of continuous enrollment. DHCS provided the following dental utilization data for both fee-for-service and managed care:

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

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

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

Fee-for-Service vs. Managed Care

For many years, stakeholders and advocates have attempted to compare the fee-for-service and managed care delivery systems within Denti-Cal to determine if one system is clearly superior to the other in terms of utilization rates, access, quality of care, and value for the state's dollar. According to the utilization data in the above chart, utilization rates are higher across all four years and for all age groups in FFS as compared to managed care. Given that the state pays a capitation to the managed care plans for all patients enrolled in those plans, regardless of whether or not these patients actually receive care, it is easy to understand the basis for favoring the FFS system.

However, arguably, managed care provides an opportunity to ensure greater accountability by holding the plans accountable for meeting timely access standards, network adequacy requirements, providing complex case management, a focus on prevention, and higher rates to providers. Some of the dental managed care plans

provide enhanced benefits to their enrollees, such as transportation to appointments. Managed care, whether in dental or medical care, has a built-in incentive to reduce the cost of care by supporting and promoting good preventive care. FFS lacks this incentive and instead incentivizes excess care. Liberty Dental, for example, has developed the "Early Smiles" program which brings preventive care, screenings, and referrals to kids in schools, much like the state's soon-to-be re-established Dental Disease Prevention Program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the Denti-Cal Program and respond to the following:

1. Please detail which Audit recommendations have been completed and which have not been completed.

2. Please provide an update on improvements to pediatric dental care, both managed care and fee-for-service, since the reports and audits described above.

3. Please describe the access monitoring done by DHCS for pediatric and adult dental care. What defines adequate access?

4. Please provide an overview and update of the DTI.

5. Some stakeholders speculate that the Administration intends to eliminate dental managed care, possibly as a component of the upcoming 2017 May Revise. Please comment on the quality of, and access to, care in managed care as compared to FFS.

6. What impact does DHCS believe the new federal Managed Care Rule, and specifically the new medical loss ratio, will have on dental provider rates?

The Subcommittee requests Assemblymember Caballero and the various stakeholders on the second panel to present their proposals.

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

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 8: OVERVIEW OF ORAL HEALTH PROGRAMS, UPDATE ON DENTAL DISEASE PREVENTION PROGRAM, AND PROPOSITION 56 TOBACCO TAX REVENUE BUDGET CHANGE PROPOSAL

PANELISTS

- **Jayanth Kumar**, **DDS,** State Dental Director, Department of Public Health
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The California Department of Public Health (CDPH) requests expenditure authority of $223.5 million for Fiscal Year (FY) 2017-18 and ongoing (subject to revenue levels), and 57 positions to implement the requirements of the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) for Public Health's oral health, tobacco law enforcement, and tobacco prevention programs. This request also includes a reduction of $3.7 million General Fund for the oral health program. This proposal includes the following three components:

- CDPH Tobacco Control Branch (TCB) requests an increase of 26.0 permanent positions and $178.5 million expenditure authority (the Subcommittee heard this component of the proposal on March 6, 2017); and

- CDPH Food and Drug Branch (FDB) requests an increase of 20.0 permanent positions and $7.5 million expenditure authority (the Subcommittee heard this component of the proposal on March 20, 2017);

- CDPH Oral Health Program (OHP) requests an increase of 11.0 permanent positions and $37.5 million expenditure authority. (*The Subcommittee is discussing this component of the proposal today in this Issue of the agenda*.)

Specifically, this proposal is for $37.5 million in 2017-18 and $30 million annually thereafter to CDPH OHP to create a comprehensive public health infrastructure to support oral health education, prevention, surveillance, and treatment of dental disease. The OHP will also focus on providing oral health interventions for those Californians most in need as directed by Proposition 56.

- This funding for OHP will be provided in lieu of the General Fund approved in the 2014-15 Budget Act for the Dental Director ($454,000 state operations) and the $3.2 million approved in the 2016-17 Budget Act for the Children's

Dental Disease Prevention Program ($320,000 state operations and $2.88 million local assistance).

BACKGROUND

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

The mission of the OHP is to promote oral health by reducing the prevalence of dental decay and tooth loss, periodontal disease, and other chronic diseases through prevention, education, and organized community efforts. As of 2006, 54 percent of kindergarten children and 71 percent of third graders in the state had tooth decay. Tooth decay is the most common chronic health condition in children. In addition, low-income and minority children suffer disproportionately from dental caries, also known as tooth decay. In 2012, only 67 percent of adults age 18 and over had visited a dentist or dental clinic in the previous year. A three-year aggregate comparison of Medicaid reimbursement for in-patient emergency department treatment ($6,498) versus preventive treatment ($660) revealed that, on average, the cost to manage symptoms related to dental caries on an in-patient basis is approximately 10 times more than the cost to provide dental care for these same patients in a dental office. Medical studies have also shown that the smoking of cigarettes and use of other tobacco products affects oral health by causing dental disease, including gum disease and bone loss, cancers of the mouth and throat, and severe tooth wear.1,2

1 U.S. Department of Health and Human Services. The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General. Atlanta, OA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014.

2 Tomar SL, Asma S. Smoking-attributable periodontitis in the United States: Findings from NHANES III. National Health and Nutrition Examination Survey. J Periodontol. 2000 May;71(5): 743-51

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

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

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

California Children's Dental Disease Prevention Program

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

Community Water Fluoridation Program

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

Integrating Oral Health Into Maternal, Child, and Adolescent Programs

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

Oral Health Workforce

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

Perinatal and Infant Oral Health Quality Improvement Project

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

Surveillance and Epidemiology

Proposition 56 Proposal

Beginning April 1, 2017, the 2016 Tobacco Tax Act increases the excise tax on cigarettes by $2.00 per pack (based on a pack of 20 cigarettes) and imposes an equivalent excise tax on other tobacco products. A portion of the 2016 Tobacco Tax Act revenues will be transferred into three newly created funds: the State Dental Program Account (Fund 3307), the Tobacco Law Enforcement Account (Fund 3308), and the Tobacco Prevention and Control Programs Account (Fund 3309).

The Proposition specifies allocations to various entities, including $6 million annually for Public Health to provide enforcement related activities and $30 million annually for Public Health's state dental program. Proposition 56 requires 82 percent of the remaining funds be transferred to the Department of Health Care Services. Of the remaining 18 percent, 13 percent is for the Department of Public Health and the Department of Education for tobacco prevention, and 5 percent to the University of California for medical research.

These resources will expand the OHP, resulting in increased capacity for CDPH and local jurisdictions to implement the California State Oral Health Plan. The OHP will

determine the projected outcomes through input from stakeholders including local jurisdictions and Denti-Cal, with an emphasis on the goals, objectives, strategies and activities included in the State Oral Health Plan, Healthy People 2020 Oral Health Objectives, Denti-Cal and Maternal and Child Health Services Block Grant performance measures, and the California Wellness Plan.

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

Stakeholder Concerns

Oral health stakeholders have expressed concerns based on their communication with DPH that has created the impression that DPH does not have the flexibility it needs, with regard to the distribution of Proposition 56 funds to local health jurisdictions, to ensure that the funds can be available for multi-year contracts and multi-year projects. If accurate, the restriction to single-year projects would greatly limit the ability of local health jurisdictions to be as effective as possible in their use of the fund.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH provide an overview of the Oral Health Program at CDPH, specifically provide an update on the implementation of the re-establishment of the California Children's Dental Disease Prevention Program (funded through the 2016 Budget Act), and present the Proposition 56 Budget Change Proposal (specific to oral health funding). Please also respond to the following:

1) Please respond to stakeholder concerns with regard to DPH's ability to distribute the Proposition 56 funds quickly, allowing for the funds to be used for multi-year projects.

2) Where are the virtual dental homes that exist today (including those funded through the HRSA grant)?

3) Please describe DPH's latest thinking and planning on how the Dental Disease Prevention Program might be implemented, and particularly how you think it might be different from how it was implemented when it existed several years ago.

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