AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

MONDAY, APRIL 25, 2016

2:30 P.M. - STATE CAPITOL ROOM 444

ITEMS TO BE HEARD

ITEMS TO BE HEARD

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

ISSUE 1: DEPARTMENT OVERVIEW AND BUDGET

PANELISTS

- **Robert P. David**, Director, Office of Statewide Health Planning and Development
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

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.

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 Information Division (HID) collects and disseminates timely and accurate 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.

The Healthcare Workforce Development Division (HWDD) 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.

PROPOSED BUDGET

OSHPD's proposed budget is summarized in the table below. Overall expenditures are proposed to decrease by $2.3 million (1.4 percent).

OSHPD Budget
(Dollars in Thousands)

Fund Source	2014-15 Actual	2015-16 Projected	2016-17 Proposed	BY to CY $ Change	BY to CY % Change
Hospital Building Fund	52,750	61,344	60,872	($472)	-0.8%
Health Data & Planning Fund	34,348	35,631	33,912	($1,719)	-4.8%
Registered Nurse Education Fund	2,111	2,190	2,186	($4)	-0.2%
Health Facility Construction Loan Insurance Fund	6,514	5,084	5,029	($55)	-1.1%
Health Professions Education Fund	4,235	9,004	9,001	($3)	-0.03%
Federal Trust Fund	1,518	1,443	1,443	0	0%
Reimbursements	7,182	7,861	860	($7,001)	-89.1%
Mental Health Practitioner Education Fund	550	393	400	$7	1.8%
Vocational Nurse Education Fund	231	230	233	$3	1.3%
Mental Health Services Fund	26,668	37,602	44,570	$6,968	18.5%
Medically Underserved Account For Physicians, Health Professions Education Fund	3,607	2,315	2,303	($12)	-0.5%
TOTAL EXPENDITURES	**139,714**	**163,097**	**160,809**	**($2,288)**	**1.4%**
Positions	450.8	449.0	449.0	0	0%

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to provide an overview of the department and its proposed budget, and to provide updates on seismic safety of hospitals and the Investment in Mental Health Wellness funding.

Staff Recommendation: No action is recommended at this time.

ISSUE 2: SONG-BROWN HEALTH CARE WORKFORCE TRAINING PROGRAM UPDATE AND STAKEHOLDER PROPOSALS

PANELISTS

- **Stacie Walker**, Deputy Director of the Healthcare Workforce Development Division of the Office of Statewide Health Planning and Development
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Eduardo Garcia**, Associate Director, Government Relations, California Medical Association
- **Beth Malinowski**, Deputy Director of Government Affairs, California Primary Care Association
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

BACKGROUND

Song-Brown provides grants to support health professions training institutions that provide clinical training for Primary Care residents, Family Nurse Practitioners, Primary Care Physician Assistants, and Registered Nurse students. Residents and trainees are required to complete training in medically underserved areas, underserved communities, lower socio-economic neighborhoods, and/or rural communities (Health Professional Shortage Areas, Medically Underserved Areas, Medically Underserved Populations, Primary Care Shortage Areas, and Registered Nurse Shortage Areas).

According to OSHPD, Song-Brown-funded programs have led practitioners to be at the forefront of curricula development and clinical care for many contemporary challenges facing California's healthcare system such as homeless, refugee, and immigrant health. Various studies indicate that residents exposed to underserved areas during clinical training are more likely to remain in those areas after completing their training.

Funding is provided to family practice residency programs via capitation funding. Each training program funded by Song-Brown must meet the accreditation standards set forth by their specific discipline. Song-Brown funds do not replace existing resources but are used to support and augment primary care training. Family practice residency programs are funded in increments of $51,615 per capitation cycle ($17,205 per year for three years). The funding included in the 2014 Budget Act provides a higher level of support for *new* residency slots.

PROGRAM UPDATE

The 2014 budget included the following augmentations related to the Song-Brown Program:

1. ***Song-Brown Program – New Residency Slots***. As proposed by stakeholders, the 2014 Budget Act augmented OSHPD's budget by $4 million (California Health Data and Planning Fund) to fund new residency slots in the Song-Brown Health Care Workforce Training Program over the next three years. Adopted trailer bill language to specify criteria for this funding, including that priority shall be given to support new primary care physician slots and to physicians who have graduated from a California-based medical school.

2. ***Song-Brown Program Residency Program***. As proposed by the Governor, the 2014 Budget Act includes $2.84 million (California Health Data Planning Fund) per year for three years to expand the Song-Brown program. Adopted trailer bill language to expand the eligibility for Song-Brown residency program funding to teaching health centers and increased the number of primary care residents specializing in internal medicine, pediatrics, and obstetrics and gynecology. The 2014 Budget Act also included resources for one three-year limited-term position to develop and implement this program expansion.

STAKEHOLDER PROPOSALS

California Medical Association (CMA) Proposal:
The CMA requests $100 million to increase medical residency slots, both in traditional hospital residency programs, and in Teaching Health Center programs.

The intent of this proposal is to not only support traditional primary care residency programs operated by hospitals, but also to expand on relatively new but successful Teaching Health Center programs. California currently has six Teaching Health Centers (THCs) that are community-based primary care training programs committed to preparing physicians to serve the needs of the community. By moving primary care training into the community, THCs are on the leading edge of innovative educational programming dedicated to ensuring a relevant and sufficient supply of health workforce professionals.

Stakeholder are concerned that because of the relatively recent development of THCs, these programs may be disadvantaged during the Song-Brown grant award process. The Song-Brown program is required to prioritize funding to primary care residencies that have a track record of placing residents in underserved communities; due to the relatively recent development of THCs, this track record has not yet been established. The proponents of this proposal would like to work with the Legislature, OSHPD, and other key stakeholders to develop a mechanism to make this funding available to community health centers outside of the Song-Brown program.

Stakeholder provide the following data:

1. Primary care training programs are facing a $43 million fiscal cliff as significant federal and private foundation grants have recently expired or are set to expire this year.
   - $21 million California Endowment grant to the Song-Brown Program
   - $4 million California Health Data and Planning Fund appropriation to the Song-Brown Program
   - $18 million Health Resources and Services Administration (HRSA) funding for the Primary Care Residency Expansion to California

2. In addition, the federal Teaching Health Center program, which has already distributed more than $15 million to California primary care training programs, has cut grants by 40 percent and is set to expire in 2017.

Several areas of the state with the most critical primary care shortages could greatly benefit from a new residency program in their specific region (e.g., Humboldt, Tulare and Imperial counties), but current funding levels are inadequate to support that kind of investment. The amount of money needed to create a residency program can vary significantly depending on preexisting infrastructure. Consultants who work with hospitals and communities to build residency programs estimate the start-up costs to be $500,000 to $1 million before capital expenditures.

California Primary Care Association (CPCA) Proposal:
The CPCA requests $17.5 million for the following:

- Community clinics and health centers (CCHCs) to establish new teaching health center sites offering additional primary care residencies - $10 million annually

- California's six current Teaching Health Center Graduate Medical Education (THCGME) program sites to provide sustainability funding - $5.5 million annually

- Office of Statewide Health Planning and Development (OSHPD) for administration of the Teaching Health Center Primary Care Graduate – $1 million annually

- OSHPD to provide state matching funds for the National Health Service Corp State Loan Repayment Program (SLRP) – $1 million annually

Horizon 2030: Meeting California's Primary Care Workforce Needs (2016), a recently released report commissioned by CPCA, offers an analysis of California's primary care workforce today while detailing key opportunities to meet the workforce needs of tomorrow. With six out of nine California regions experiencing a primary care provider shortage, and a ratio of primary care physicians in Medicaid that is half the federal recommendation, California ranks 32nd in physician access. The report estimates that California will need 8,243 additional primary care physicians by 2030 and provides a stark reminder that the primary care workforce shortage has reached a critical point and will continue to devolve if California doesn't take immediate action.

To remedy current primary care shortages and avoid future shortfalls, it is estimated that the U.S. needs to add another 1,700 to 3,000 primary care residency slots. California currently has six Teaching Health Centers (THCs) that are community-based primary care training programs committed to preparing physicians to serve the needs of the community. Stakeholders argue that, by moving primary care training into the community, THCs are on the leading edge of innovative educational programming dedicated to ensuring a relevant and sufficient supply of health workforce professionals.

CPCA reports that preliminary evaluation results from *Teaching Health Centers: A Promising Approach for Building Primary Care Workforce for the 21st Century* (2015), demonstrate positive and promising results THCs are having across the country. Nearly all (91%) of THC graduates remain in primary care practice, compared to less than one-quarter (23%) of traditional graduate medical education graduates. Forty percent (40%) of THCGME graduates from THCs become primary care providers in nonprofit, community health centers working with underserved communities as compared to just 2% of traditional graduates.

Stakeholders also highlight the fact that the State Loan Repayment Program (SLRP) authorizes repayment of qualified education loans for those providers who commit to an initial 2-year, full-time or 4-year, half-time service agreement to provide direct patient care in primary, dental, or mental health in health professional shortage areas (HPSAs).

The SLRP is an important program to recruit healthcare professionals to communities in need but the Federal SLRP dollars require a state match. While other states provide this match themselves, California has shifted the cost onto the health centers. As a result, less than one third of the health centers in the state are currently listed as SLRP certified eligible sites. California receives $1 million in federal funding annually, but many small and medium size health centers cannot afford to provide matching funds and are precluded from SLRP participation.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to provide an update on the implementation of the increased resources that were included in the 2014 Budget Act for Song Brown and to respond to the following:

1. How many new residency slots were created with the 2014 funding?

2. How much is the subsidy provided for each new slot?

3. What does OSHPD anticipate will happen to these new residency slots after the three years of funding, if more state resources are not made available?

The Subcommittee also requests CMA and CPCA to present their proposals.

Staff Recommendation: Staff recommends no action at this time.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 3: DEPARTMENT OVERVIEW AND BUDGET

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

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.

PROPOSED 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. As summarized in the table below, the Governor's 2016-17 budget proposes $76.6 million, an increase of $2.5 million (3.4%) over current year spending, for the Department's overall budget.

DEPARTMENT OF MANAGED HEALTH CARE
(Dollars In Thousands)

Fund Source	2014-15 Actual	2015-16 Projected	2016-17 Proposed	BY to CY Change	% Change
Federal Trust Fund	$461	$589	$0	($589)	-100%
Managed Care Fund	$52,316	$70,862	$75,038	$4,176	5.9%
Reimbursements	$1,861	$2,640	$1,609	($1,031)	-39.1%
Total Expenditures	**$54,638**	**$74,091**	**$76,647**	**$2,556**	**3.4%**
Positions	324.4	304.1	305.6	1.5	0.5%

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to provide an overview of the department and its proposed budget and updates on any recent significant activities at the department.

Staff Recommendation: No action is recommended at this point in time.

ISSUE 4: END OF LIFE OPTIONS ACT (AB X2 15) BUDGET CHANGE PROPOSAL

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The DMHC requests two-year limited-term expenditure authority of $244,000 for 2016-17 and $244,000 for 2017-18 to meet the Department's operational needs in order to address the short-term workload resulting from the implementation of AB X2 15 (Chapter 1, Second Extraordinary Session, Statutes of 2015).

BACKGROUND

Existing state law authorizes adults to give an individual health care instruction and to appoint an attorney to make health care decisions for that individual in the event of that adult's incapacity in accordance to a power of attorney for health care and guarantees terminally ill individuals certain care. When a health care provider diagnoses a patient with a terminal disease, the provider is required to notify the patient of his or her right to comprehensive information and counseling regarding legal end of-life options, including: 1) hospice care at home or in a health care setting; 2) a prognosis with and without the continuation of disease-targeted treatment; 3) the patient's right to refuse or withdraw from life-sustaining treatment; and 4) the patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care. Health and Safety Code Section 1367.215 also requires timely coverage of pain management drugs for terminally ill individuals. Health and Safety Code Section 1368.1 requires a plan that denies an experimental treatment to a terminally ill individual to provide information on covered alternative treatments and on the plan's grievance process, as well as an opportunity for the enrollee to attend a conference to discuss the matter with the plan.

AB X2 15 adds Part 1.85 (commencing with Section 443) of Division 1 to the Health and Safety Code and enacts the End of Life Option Act (Act). The Act authorizes adult California residents who meet certain qualifications and who have been determined by their primary care physician to be suffering from a terminal disease to, under specified conditions and procedures, request and self-administer an aid-in-dying prescription drug for the purpose of ending their life. AB X2 15 also establishes the specified conditions

and procedures that must be followed under this new law. The provisions of AB X2 15 will sunset on January 1, 2026.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 5: FEDERAL MENTAL HEALTH PARITY ONGOING COMPLIANCE REVIEW BUDGET CHANGE PROPOSAL

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The DMHC requests $529,000 for 2016-17 and 2017-18 for clinical consulting services to assist the DMHC in revising current compliance filing instructions and forms, conducting review of commercial plans' classification of benefits and non-quantitative treatment limits, and resolving clinical issues arising in compliance filings with the Mental Health Parity and Addiction Equity Act (MHPAEA) and its Final Rules.

BACKGROUND

This request is for the resources required to perform initial compliance reviews on new plan offerings and to conduct ongoing clinical monitoring of MHPAEA compliance for all new commercial products offered by newly licensed plans and current licensees. The DMHC is committed to implementing sustained oversight activities to ensure compliance with the MHPAEA Final Rules and any subsequent Center for Medicare and Medicaid Services (CMS) rulemaking or guidance. Future oversight activities are needed to ensure MHPAEA compliance in all new products. New licensees will have to demonstrate their coverage complies with the financial, quantitative treatment limits (QTLs) and NQTLs, and disclosure requirements of MHPAEA; the Knox Keene Act; and regulations of the Covered California health benefits exchange. Current licensees proposing to add new products also will have to demonstrate that their new coverage complies with MHPAEA. Compliance review also must be conducted for plans that change the terms of their previously-approved MHPAEA compliance – their cost-sharing or treatment limits - due to a significant change in benefit design, cost-sharing structure, or enrollee utilization of the coverage.

In 2008, Congress enacted the MHPAEA, requiring only large group health plans that offer mental health and substance use disorder (MH/SUD) benefits to do so in a manner comparable to medical and surgical (M/S) benefits. After the enactment of the Affordable Care Act (ACA) in 2010, federal regulations and a state statute implementing essential health benefits (EHB) made MHPAEA also applicable to individual and small group health

insurance products. On November 13, 2013, federal regulators issued Final Rules for implementing parity, which laid out how health plans must conduct parity analyses to comply with MHPAEA. The Final Rules apply for all group products as employers renew or purchase coverage, as well as individual products.

Assessing compliance with the Final Rules requires an analysis that is significantly different and more complex than the analysis the DMHC currently conducts to enforce state mental health parity requirements. Under the California mental health parity law, the DMHC reviewed health plans' evidences of coverage (EOCs) for compliance with state law and the ACA, with a general focus on whether analogous benefits for specific severe mental illnesses and serious emotional disturbances in children are subject to the same cost-sharing and utilization management requirements as medical conditions.

In contrast, under MHPAEA the Final Rules reject a static approach of comparing specific MH/SUD benefits to M/S benefits, and instead require analysis of broader benefit classifications. Rather than a relatively simple comparison of the applicable terms and conditions, the Final Rules require extensive review of the health plans' processes and justifications for classifying benefits within the following six permissible classifications and two sub-classifications:

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network
    a. Outpatient Office Visits
    b. Outpatient Other Items and Services
4. Outpatient, Out-of-Network
    a. Outpatient Office Visits
    b. Outpatient Other Items and Services
5. Emergency Care
6. Prescription Drugs

After classifying all benefits into these categories, health plans must then determine parity for financial requirements (e.g., deductibles, copays, coinsurance), QTLs (e.g., number of visits, number of days of treatment), and NQTLs. The analyses of the health plans' methodology for determining compliance require extensive reviews that are beyond the DMHC's existing capacity and expertise. Moreover, the analyses required under the Final Rules are data-intensive and require information that health plans do not routinely file with the DMHC (e.g., methodologies to determine benefit classifications, projected plan claims, and rationale for application of NQTLs).

The evaluation of MHPAEA compliance in a plan product filing includes the following steps:

1. Prior to submission, the DMHC shall instruct the plan on how it must meet the necessary elements of federal compliance in the plan's description of its standards for classifying benefits and its methodology for calculating the predominant financial requirements that apply to substantially all the medical/surgical benefits in each classification;

2. Provide guidance on the data that plans must submit pursuant to the Final Rules detailing the benefits the plans cover, the cost-sharing charged for those benefits, the QTL and NQTL placed on the benefits, together with relevant supporting documentation such as utilization management criteria;

3. Analyze the way the plan classified its benefits for compliance with the Final Rules and clinical soundness;

4. Evaluate the soundness of the plan's financial calculations and QTLs based on estimated claims and whether its MH/SUD cost-sharing and day/visit limits, respectively, are in parity with those for M/S benefits;

5. Examine supporting utilization management, credentialing, and authorization policies and procedures to determine parity in NCTLs;

6. Analyze evidences of coverage to ensure they accurately disclose compliant MH/SUD cost-sharing, QTLs, and NQTLs, and clearly identify the MH/SUD treatments that are covered under the plan contract;

7. Issue comments on deficiencies in any of the aforementioned parity elements to the plans;

8. Teleconference with plans to answer questions and resolve legal issues;

9. Coordinate clinical, actuarial, legal, and administrative review of each filing; and

10. Document a plan's eventual compliance in reports and in briefing memos.

Compliance reviews consist of two components: 1) front-end reviews - the review of documentation submitted by plans to ensure compliance with MHPAEA, and 2) back-end reviews - onsite reviews to verify plans are operating in accordance with compliance filings.

In a FY 2014-15 May Revise MHPAEA BCP, the DMHC received approval for a one-time augmentation of $369,000 to contract with clinical consultants to conduct initial front-end compliance reviews of the 26 health plans subject to MHPAEA. The reviews include analyses of benefits classifications and NQTLs (limits such as the definition of medical necessity or medical management standards that affect access to, scope, and duration of benefits) to determine if health plans are meeting parity requirements under MHPAEA. The results will establish a baseline of information the DMHC will utilize in future compliance and enforcement activities.

The 2014 Budget Act authorized 5.0 permanent positions and $2.1 million dollars to help support sustained compliance oversight of the 26 health plans subject to MHPAEA in the individual, small group, and large group markets. One of these positions was designated to lead the DMHC's department-wide efforts, one position was allocated for Office of Plan Licensing (OPL) to conduct initial front-end compliance reviews, and three positions were

allocated to the Division of Plan Surveys (DPS). The DPS positions perform onsite medical surveys, or back-end reviews, to verify plans are operating consistently with their approved compliance filings once the initial compliance review is complete. The 2015 Budget Act authorized additional resources to further support onsite medical surveys of the plans affected by the MHPAEA. As a result, DMHC states that sufficient resources exist to support the back-end component of MHPAEA compliance reviews; however, existing resources will not be sufficient to perform the work attributed to the initial front-end reviews and associated actuarial duties.

The DMHC initiated monitoring of plan compliance with MHPAEA in the 2014-15 MHPAEA compliance project, which is anticipated to be completed during FY 2015-16. This project has been a focused review of one to fifteen standard individual and small group Exchange products and large group products to determine initial compliance within 26 plans' commercial coverage. One Attorney IV (the designated department-wide MHPAEA coordinator), one Attorney III, one Associate Governmental Program Analyst, and one Associate Life Actuary have been devoting time to this effort since 2014.

Based on the results of this project to date, the DMHC anticipates a significant increase in workload associated with the ongoing monitoring and review of 28 complex filings and 125 routine filings of commercial products to ensure compliance with MHPAEA.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 6: INFRASTRUCTURE AND SUPPORT SERVICES BUDGET CHANGE PROPOSAL

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The DMHC requests 2.0 permanent positions and $247,000 for 2016-17 and $234,000 for 2017-18 and ongoing to ensure the DMHC can address the administrative workload resulting from program expansions resulting from the implementation of the ACA and conforming state legislation.

BACKGROUND

The DMHC explains that, as a result of the enactment of the ACA and other legislation, the DMHC's programs have grown in excess of 25 percent over the past four years, with staffing levels increasing from 352.0 to 442.0. While BCPs were submitted to address the increased programmatic workload associated with the expansion of DMHC's oversight of managed health care plans, sufficient positions were not requested to address the correlated workload increases in support services. Of the 130 positions created in the past four years, one position was earmarked for the Office of Administrative Services (OAS). The DMHC states that the considerable expansion in a rapid timeframe has strained existing departmental resources in OAS as there have been no additional positions created to support department-wide efforts.

According to the DMHC, over the last two fiscal years the increase In workload resulting from program expansion far exceeded the department's capacity to complete the work using existing resources. In order to meet workload requirements resources were redirected from other areas and temporary help enlisted. Even with these resources, OAS still experienced difficulties completing assignments within designated timeframes. While OAS has prioritized certain less crucial tasks, the workload must be addressed.

OAS is responsible for supporting staff by providing a considerable array of personnel (i.e., recruitment, retention, training, benefits, leave, reasonable accommodation, discipline issues); accounting (i.e., travel expense claims, payroll warrants and checks); and facility (i.e., ergonomic evaluations, telecom and repair requests) services. In addition to employee services, OAS is responsible for ensuring that departmental resources are

utilized appropriately, in part by managing budget allotments against expenditures and projections. This also includes the coordination, review and approval of all related contracts, purchases, invoices, receipts, timesheets, duty statements, and classification justifications.

OAS has experienced growth in all facets of its operations since the implementation of the ACA. The DMHC reports that, in order to complete the increased workload, managers have had to work extra hours of overtime, retired annuitants have been heavily relied upon, and existing staff resources have been redirected when possible to support these efforts.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 7: LARGE GROUP RATE REVIEW (SB 546) BUDGET CHANGE PROPOSAL

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The DMHC requests 4.0 permanent positions and $682,000 for 2016-17 and $644,000 for 2017-18 and ongoing to address the increased workload resulting from the implementation of SB 546 (Leno, Chapter 801, Statutes of 2015). SB 546 establishes additional rate review requirements for the large group market.

This request includes $106,000 for FY 2016-17 and $100,000 for FY 2017-18 and ongoing for contractor costs. In FY 2016-17, contractor costs consist of $6,000 for transcription services and $100,000 for actuarial consulting. In FY 2017-18 and ongoing, the contractor costs are for actuarial consulting.

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) requires rate review of individual and small group rate filings, but exempts large group rate filings. Health plans set rates for large groups in one of two ways. For a "larger" large group - a group with more than 500 covered lives (and in some cases more than 1,000 lives) - a health plan may base rates entirely on the claims experience of that group. For a "smaller" large group - a large group with less than 500 covered lives - a health plan would set rates using a formula comprised of a standard risk for all large employers (e.g., the base rate), additional factors that affect the base rate that are specific to that employer group (e.g., geographic region, industry, etc.), and the claims experience of the specific employer group.

Under Section 2794 of the federal Public Health Service Act (PHSA), as added by the ACA, health plans must file a justification for an unreasonable premium rate increase, prior to implementation, and publicly disclose the information. As required by Section 154.101 of Title 45 of the Code of Federal Regulations, a rate increase is subject to review if it is 10 percent or more for a 12-month period (or a more stringent standard set by the state). However, under the May 23, 2011, Rate Increase Disclosure and Review Final Rule (Final Rule), this requirement applies only to non-grandfathered individual and small group contracts and does not apply to large group contracts. The U.S. Department of

Health and Human Services (HHS), the federal agency implementing the ACA's rate review requirements, determined large group rate review unnecessary because large groups are sophisticated purchasers and the premiums for most large groups are experience rated, based on the group's own claims experience.

In 2010, SB 1163 (Leno, Chapter 661, Statutes of 2010) implemented the ACA's rate review provisions in California. These provisions require health plans to file individual and small group rate changes 60 days prior to implementation and submit justification for an unreasonable rate increase, as defined by the ACA. SB 1163 went beyond federal law by requiring plans to file any rate change for unreasonable rate increases for large group contracts 60 days prior to implementation. However, the Final Rule, which was published after SB 1163 was enacted, does not apply to the large group market nor does it contain a definition for unreasonable rate increase that applies to large group contracts.

Also related to California's rate review is SB 1182 (Leno, Chapter 577, Statutes of 2014). Under SB 1182, health plans and health insurers must annually provide de-identified claims data at no charge to a large group purchaser that requests the information and meets specified conditions. This data is restricted to: (1) large group purchasers with an enrollment of more than 1,000 covered lives, with at least 500 covered lives enrolled with the plan or insurer providing the claims data, or (2) multi-employer trusts with an enrollment of more than 500 covered lives, with at least 250 covered lives enrolled in the plan providing the claims data. The threshold is set at 1,000 and 500 covered lives because there must be a sufficient number of covered lives to de-identify the claims information to protect the confidential medical information of individuals.

SB 546 establishes additional rate review requirements for the large group market. These requirements include:

- Effective on or before October 1, 2016, and annually thereafter, health plans must file the following information aggregated for the specific health plan's entire large group market:
    - Weighted average increase for all large group benefit designs during the preceding calendar year;
    - Number and percentage of rate changes, as specified;
    - Factors affecting the base rate and actuarial basis for those factors, as specified;
    - Plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category;
    - Amount of the projected trend separately attributable to the use of services, price inflation, fees, and risk for annual policy trends by aggregate benefit category;
    - Comparison of the aggregate per member per month costs over the prior five year period by specific category;

- Changes in enrollee cost sharing, changes in enrollee benefits, and quality improvement efforts over the prior year; and

- Number of products covered by the information that incurred the excise tax. (The excise tax, otherwise known as the "Cadillac tax," refers to the requirement in the ACA that, effective for tax years after December 31, 2017, imposes a 40 percent federal tax on the aggregate cost of employer-sponsored coverage exceeding a statutory limit; $10,200 for individual coverage and $27,500 for self and spouse or family coverage.)

- DMHC must conduct an annual public meeting regarding large group rates within three months of posting the aggregate information on DMHC's website to allow a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market.

- Health plans must provide a written notice to a large group 60 days prior to a premium rate or change in coverage that includes the following:

  - Whether the proposed rate is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange (Covered California) for the most recent calendar year for which the rates are final;

  - Whether the proposed rate is greater than the average rate negotiated by CalPERS for the most recent calendar year for which the rates are final; and

  - Whether the rate change includes any portion of the excise tax paid by the health plan.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 8: LIMITATIONS ON COST SHARING: FAMILY COVERAGE (AB 1305) BUDGET CHANGE PROPOSAL

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The DMHC requests limited-term expenditure authority of $196,000 for 2016-17 and $188,000 for 2017-18 to meet the Department's operational needs to implement AB 1305 (Bonta, Chapter 641, Statutes of 2015).

BACKGROUND

The Knox Keene Act requires non-grandfathered health plan contracts issued on or after January 1, 2015 in the small group market to include the annual out-of-pocket limit on Essential Health Benefits (EHB) described in the Affordable Care Act (ACA) and subsequent rules, regulations, or guidance. The Knox Keene Act also aligns the out-of-pocket cost limit for covered benefits that are EHB to this federal limit for non-grandfathered health plan contracts issued on or after January 1, 2015, in the large group market, to the extent that this limit does not conflict with federal law or guidance.

AB 1305 makes two changes to existing law: 1) For non-grandfathered family coverage, AB 1305 prohibits a health plan from imposing a maximum out-of-pocket limit for an individual within a family that is greater than the maximum out-of-pocket limit for individual coverage for that product; and 2) if a non-grandfathered health plan contract for family coverage includes a deductible, an individual within a family shall not have a deductible that is greater than the deductible for individual coverage for that product, except for a high deductible health plan (HDHP). The requirement would apply to non-grandfathered family coverage in the small group market beginning January 1, 2016, and in the large group market beginning January 1, 2017. This provision eliminates health plan contracts with aggregated family deductibles, in which an individual with a family HDHP must meet the family deductible before the plan covers any services, other than preventive services, for that individual.

In the case of HDHPs, the bill includes an exception to allow individuals to continue to qualify for Health Savings Accounts (HSA). Under federal law, an individual may qualify

for an HSA only if the individual is covered under an HDHP. A family HDHP is an HDHP covering an eligible individual and at least one other individual. As explained in Internal Revenue Service (IRS) Publication 969, if either the deductible for the family as a whole or the deductible for an individual family member is less than the minimum annual deductible for family coverage, the plan does not qualify as an HDHP. For calendar year 2015, the minimum annual deductible is $1,300 for self-only coverage and $2,600 for family coverage. Thus, in 2015, a family HDHP must have an individual deductible of at least $2,600 or the plan does not qualify as an HDHP. (Specific deductible amounts change in subsequent years.) A family HDHP with an individual deductible below $2,600 would cause individuals to lose HSA tax savings.

Accordingly, AB 1305 provides that, in the case of a health plan contract meeting the federal definition of an HDHP, the deductible shall be the greater of either of the following: 1) the deductible for individual coverage under the plan contract, or 2) the amount required under federal law to qualify for an HSA, as updated by the IRS annually as indexed for inflation. This language prevents, in the case of a family HDHP, the individual deductible from being lower than the amount required under federal law for an individual to qualify for an HSA.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 9: OUTPATIENT PRESCRIPTION DRUG FORMULARIES (AB 339) BUDGET CHANGE PROPOSAL

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The DMHC requests limited-term resources of $733,000 for 2016-17; $700,000 for 2017-18; $558,000 for 2018-19; and $558,000 for 2019-20 to meet the Department's operational needs in order to address the short-term workload resulting from the implementation of AB 339 (Gordon, Chapter 619, Statutes of 2015).

This request includes $196,000 in contracted consulting costs for FY 2016-17, FY 2017-18, FY 2018-19, and FY 2019-20 to assist DMHC offices with developing implementation standards and identifying health plan clinical standard deficiencies during the survey process.

BACKGROUND

AB 339 builds on federal guidance and existing general anti-discrimination provisions with more robust, specific, and enforceable parameters for drug benefit designs. AB 339 aligns with Covered California's current approach to address the high out-of-pocket costs for medically necessary drugs and incorporates a sunset date of 2020 for the out-of-pocket cost limitations and drug tiering provisions. AB 339 addresses the competing challenges of providing access to medically necessary drugs for consumers without severely hampering health plans' ability to contain costs through drug price negotiations. Moreover, AB 339 aligns with and incorporates new federal standards regarding the prescription drug Essential Health Benefits, including the requirements regarding pharmacy and therapeutics committees, formulary transparency, and reasonable access to retail pharmacies (rather than mail-order pharmacies). Adding these provisions to California law ensures they will be enforceable by the DMHC.

Additional provisions of AB 339 include:

- Requires health care service plan contracts (other than Medi-Cal managed care contracts) to cover medically necessary prescription drugs, including medically

necessary single-tablet antiretroviral drug regimens for AIDS/HIV, except as specified.

- Limits cost sharing for a 30-day supply of a prescription to no more than $250 (or $500 for a bronze-level plan or its actuarial equivalent for large group), except that an applicable deductible must be satisfied, as specified.

- Specifies formulary tier definitions for certain non-grandfathered individual or small group products.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 10: PROVIDER DIRECTORIES (SB 137) BUDGET CHANGE PROPOSAL

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The DMHC requests 8.0 permanent positions and $1,436,000 for FY 2016-17; $1,366,000 for FY 2017-18; and $1,181,000 for FY 2018-19 and ongoing to address the increased workload resulting from the implementation of SB 137 (Chapter 649, Statutes of 2015).

This request includes $153,000 for FY 2016-17; $153,000 for FY 2017-18; and $77,000 for FY 2018-19 and ongoing for the Office of Enforcement's (OE) expert witness and deposition costs for enforcement trials.

This request also includes limited-term expenditure authority of $89,000 for FY 2016-17 and FY 2017-18, enabling DMHC's Office of Technology and Innovation (OTI) to address short-term IT-related setup activities.

BACKGROUND

Existing slate law requires health care service plans (health plans) to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area. Since 2001, when AB 938 (Cohn, Chapter 817, Statutes of 2001) was enacted, state law has also included requirements related to health plans' provider directories. With the enactment of the Patient Protection and Affordable Care Act (ACA), the accuracy of provider directories has never been more important as the ACA has enabled hundreds of thousands of individuals who formerly lacked health coverage to obtain health coverage for the first time. Since the ACA requires health plans to cover individuals who formerly could not obtain coverage due to their health problems, health plans have focused on other ways to control costs. One way health plans have attempted to control costs is to develop products with 'narrow networks,' which have fewer provider options, but still achieve network adequacy. Consequently, there may be even greater variation in a health plan's provider networks than in the past, with some networks having more limited provider options than others.

Understandable and accurate provider networks enable consumers to make important decisions and are fundamental components to allow enrollees timely access to health care services. SB 137, effective July 1, 2016, amends the Health and Safety Code to expand upon existing provider directory requirements by establishing clear and specific requirements for publishing and maintaining health plans' provider directories, including content, updating and reporting standards. To achieve this, SB 137 includes the applicable controls and requirements, and provides the DMHC and California Department of Insurance (CDI) with the responsibility to develop uniform provider directory standards that health plans and providers must follow. SB 137 also gives the DMHC the authority to enforce the law and take action if a health plan or provider is found to be non-compliant.

The requirements of SB 137 apply to all full service and specialty health plans including Medi-Cal managed care plans and includes the following provisions:

- Health plans must require their contracting providers, when they are no longer accepting patients, to direct potential enrollees to the health plan for additional assistance in finding a different provider and to inform the DMHC of the possible inaccurate information in the directory.

- Health plans must publish and maintain provider directories on their public website, with information on contracting providers that deliver health care services to the health plan's enrollees.

- Health plans must reimburse enrollees for any amount beyond what the enrollee would have paid for in-network services, if the enrollee reasonably relied on the provider directory.

- Mandates specific requirements and timelines for health plans to actively investigate reports of inaccuracies in their directories and sets forth triggers for when a provider must be removed from the directory.

SB 137 requires the DMHC to create uniform standards for provider directories on or before December 31, 2016. Because these standards are expected to require health plans to make significant system changes, the provisions requiring regulatory guidance will go into effect by July 31, 2017, or 12 months after the provider directory standards are developed, whichever occurs later. One of the significant standards will include the process for referring a patient to hospitals and other providers and the way information is presented in the directories.

In order to address the concern of compliance with the new authority to delay payment, SB 137 requires the DMHC to include a review of the health plan's compliance with this provision in its routine financial examinations of the health plans, which occur every three to five years.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 11: VISION SERVICES (AB 684) BUDGET CHANGE PROPOSAL

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The DMHC requests 2.0 permanent positions and $308,000 for 2016-17 and $292,000 for 2017-18 and ongoing to address the increased workload resulting from the implementation of AB 684 (Chapter 405, Statutes of 2015).

BACKGROUND

AB 684 authorizes the establishment of landlord-tenant relationships between a registered dispensing optician (RDO), an optometrist, and an optical company, as long as the lease agreement includes specified conditions. Additionally, AB 684 authorizes an RDO or optical company to operate, own, or have an ownership interest in a health care service plan (health plan) licensed under the Knox Keene Health Care Service Plan Act of 1975 (Knox Keene Act), as amended, if the health plan does not directly employ optometrists who provide services to enrollees. This legislation establishes a three-year period for the transition from direct employment of optometrists to lease arrangements.

Optometrists are health care providers licensed under the California State Board of Optometry (Board of Optometry) who perform eye examinations and write prescriptions for eyeglasses and contact lenses. After receiving a prescription, consumers may get their prescriptions filled by optometrists and ophthalmologists (medical doctors) who sell eyewear as part of their practice, or consumers may get their prescriptions filled by RDOs. RDOs are technicians licensed under the Medical Board of California (Medical Board) who fit consumers with glasses and contact lenses.

AB 684 resolves long-standing legal disputes between optometrists and optical chain stores. Existing California law has strict prohibitions on relationships between optometrists and RDOs. California's Business and Professions Code Section 655 currently prohibits optometrists and RDOs from having any financial interest or landlord-tenant relationship with each other and prohibits an optometrist from having any financial interest or landlord-tenant relationship with entities engaged in the manufacture or sale of lenses, frames, and other optical products. Business and Professions Code Section

2556 currently prohibits RDOs from advertising the services of an optometrist or ophthalmologist. It also prohibits an RDO from directly or indirectly employing, or maintaining on or near the premises used for optical dispensing, an optometrist or ophthalmologist. These Business and Professions Code prohibitions are intended to ensure that optometrists professional decisions are not influenced by commercial interests.

National optical chain stores, such as LensCrafters, operate under a "co-location" business model where consumers can obtain an eye examination from an optometrist located at, or near, a retail store where eyeglasses or contact lenses may be purchased. In the 1980s, the parent companies of these optical stores created affiliate companies which obtained Knox Keene licenses to provide optometric services. Health and Safety Code Section 1395 provides that a health plan licensed under the Knox Keene Act may employ, or contract with, health professionals licensed under the Business and Professions Code, and that a Knox Keene licensee may directly own and operate, through its professional employees or contracted licensed professionals, offices and subsidiary corporations to provide health care services to the plan's enrollees. Thus, optical store companies obtained Knox Keene licenses as a shield against Business and Professions Code Sections 655 and 2556. However, after years of legal challenges, California courts definitively ruled that a Knox Keene license does not exempt optometrists and RDOs from these Business and Professions Code prohibitions, and federal courts ruled that these prohibitions do not violate federal law. Although unsuccessful, these challenges resulted in a moratorium on enforcement of these Business and Professions Code prohibitions from 2006 until 2013.

In the past year, the DMHC has discovered that a number of Knox Keene Act licensed vision plans are currently operating in a manner that would violate the above referenced Business and Professions Code Sections. AB 684 allows these vision plans to continue to operate as health plans with little or no modifications to their current business models, thereby preserving the model of vision coverage that millions of Californians have come to rely upon with no reduction in consumer protections.

At present, the DMHC regulates three specialized vision plans that operate under a "co-location" business model. However, the "co-location" vision plan model does not completely fit the description of a Knox Keene health plan, which the Health and Safety Code defines as an entity that provides health care services in exchange for a prepaid and periodic charge. The three Knox Keene vision plans that operate under the "co-location" model assume little or no risk, and primarily serve individuals rather than groups.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 12: COORDINATED CARE INITIATIVE AND OMBUDSMAN PROGRAM SPRING FINANCE LETTER

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The DMHC requests to extend limited-term expenditure authority set to expire June 30, 2016, in the amount of $1,460,000 for FY 2016-17 and $522,000 for FY 2017-18 to address the continuation of workload associated with transitioning dual eligible enrollees in participating counties into managed health care and providing consumer assistance through the Ombudsman Program - both of which are components of the Coordinated Care Initiative (CCI) - through December 31, 2017.

This request includes $165,000 for consulting services in FY 2016-17 to complete triennial medical plan surveys. This request also includes $800,000 in FY 2016-17 and $400,000 in FY 2017-18 for consulting services to provide consumer assistance to individuals enrolled in Cal MediConnect plans.

This proposal will be funded by a combination of special funds and reimbursement from the Department of Health Care Services (DHCS); who is currently receiving federal grant funds for these efforts. DHCS will reimburse the DMHC for 50 percent of costs associated with the California Dual Eligible Demonstration Project, now called Cal MediConnect Program, and 100 percent of consulting services costs incurred to operationalize the Ombudsman Program. The DMHC is requesting reimbursement authority of $1,070,000 for FY 2016-17 and $432,000 for FY 2017-18.

BACKGROUND

In California, the federal Medicaid program is administered by the DHCS as the California Medical Assistance Program, or Medi-Cal. Medi-Cal provides health care coverage through two basic types of arrangements - fee-for-service and managed care. The DHCS and the DMHC share oversight responsibility for most Medi-Cal Managed Care plans. The DHCS administers the contracts with Medi-Cal Managed Care plans to provide health care services to Medi-Cal beneficiaries pursuant to specified contract terms and is responsible for monitoring plan compliance with Medi-Cal requirements.

The DMHC regulates the licensed health care service plans pursuant to the Knox Keene Health Care Service Plan Act (Knox Keene Act) by overseeing the operational and financial solvency requirements of licensed plans according to the Knox Keene Act's statutes and associated regulations.

Chapter 438, Statutes of 2012 (AB 1468) and Chapter 717, Statutes of 2012 (AB 1496) authorized the CCI as a three-year demonstration project in eight counties. The goal of the CCI is to provide better health outcomes and program satisfaction for Medi-Cal beneficiaries, particularly Seniors and Persons with Disabilities (SPD). Overall, CCI includes the following components:

- Integration of "dual eligible", e.g., individuals who are eligible for, and receive services under, both the Medicare and Medi-Cal programs, into managed health care plans;

- Expanded responsibility for coordination of all health and long-term care services by Medi-Cal managed care plans;

- Transition of Healthy Families Program enrollees to Medi-Cal managed care; and

- Expansion of Medi-Cal managed care statewide.

The Cal MediConnect Program provides dual eligible beneficiaries in participating California counties a full continuum of acute care, primary care, institutional care, and long-term care services and supports (LTSS), including home-based and community-based services, integrated into a single benefit package. These services are delivered through DMHC-licensed health care service plans, pursuant to contracts between the plans, Centers for Medicare and Medicaid Services (CMS), and the DHCS, Participating health plans receive a monthly capitation payment and employ patient-centered care models and care coordination teams to facilitate delivery of all appropriate services, with the goal of improving health outcomes and keeping beneficiaries in their homes and communities whenever possible.

The DMHC plays a major role in the Cal MediConnect Program. AB 1468 required the DHCS to enter into an Interagency Agreement with the DMHC to perform certain oversight and readiness review activities, including:

• Provide consumer assistance to beneficiaries;
• Conduct medical plan surveys;
• Conduct financial audits;
• Conduct financial solvency audits; and
• Conduct reviews of the adequacy of provider networks of participating health plans.

In a FY 2012-13 May Revise Proposal, the DMHC received a one-time augmentation of $1,097,000 and 13.0 limited-term positions to address new workload attributable to the evaluation of plan readiness and oversight of health plans providing managed health care services. The 13.0 limited-term positions were approved as follows:

- Help Center, 8.0 (Consumer Assistance and Plan Readiness through medical plan surveys)
- Office of Plan Licensing, 1.0 (Licensing activities and Network Adequacy)
- Office of Financial Review, 4.0 (Plan Readiness for Financial Examinations)

In a FY 2013-14 BCP, the DMHC was granted an extension of the aforementioned 13.0 limited-term positions plus 3.5 new limited-term positions in the Help Center until June 30, 2016. An additional $334,000 was provided for consulting services to perform triennial medical plan surveys and financial audits. In FY 2013-14, two of the CCI positions designated for the Office of Financial Review were taken pursuant to Government Code Section 12439, reducing authorized positions to 14.5. Subsequent to approval of the FY 2013-14 BCP, DHCS received a federal grant under the "Support for Demonstration Ombudsman Program" to provide consumer assistance. In April 2014, the existing CCI Interagency Agreement between DHCS and DMHC was amended to include consumer assistance activities related to Ombudsman for the counties participating in the Cal MediConnect Program. Funding and position authority have never been provided specifically for Ombudsman activities.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 13: HEALTH INSURANCE PREMIUM RATE REVIEW CYCLE II GRANT REAPPROPRIATION SPRING FINANCE LETTER

PANELISTS

- **Marta Green**, Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips**, Deputy Director Of Legislative Affairs, Department of Managed Health Care
- **Jennifer Clark**, Chief Financial Officer, Department of Managed Health Care
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Jamey Matalka**, Principal Program Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The DMHC requests approval to reappropriate $100,000 in federal funds that were received as a part of the Health Insurance Premium Rate Review Cycle II Grant.

BACKGROUND

In the context of the original purpose of this federal grant, the DMHC found it extremely challenging to hire the required positions, and therefore could not expend the funds. The DMHC has received federal approval to instead use these funds to enter into a contract with consumer advocacy organizations to provide input on rate review. In general, the DMHC states that these resources will enable the department to complete the work started on July 1, 2012, including the following: collecting premium rate data, improving rate filing requirements, enhancing the rate review process, reporting data to the United States Department of Health and Human Services, and expanding consumer participation in the rate review process.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

4560 MENTAL HEALTH OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 14: EVALUATION MASTER PLAN AND INVOLUNTARY COMMITMENT CARE REAPPROPRIATIONS SPRING FINANCE LETTER

PANELISTS

- **Toby Ewing**, Executive Director, Commission
- **Norma Pate**, Deputy Director, Administrative and Legislative Services, Commission
- **Lawana Welch**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Commission requests reappropriation of $2.5 million MHSF in unexpended FY 2015-16 funds for continued support of the Commission's Evaluation Master Plan. Additionally, the Commission requests reappropriation of $315,000 MHSF in unexpended FY 2013-14 funds to complete the development of consensus guidelines and best practices for involuntary commitment care and provide applicable training.

BACKGROUND

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). The passage of the MHSA initiated, at the state and local levels, the concept of transparent and collaborative processes being implemented to determine the mental health needs, priorities, and services for California mental health consumers. The Act created the Mental Health Services Oversight and Accountability Commission to provide broad oversight and leadership In the community mental health system statewide.

Involuntary Commitment Care Guidelines. The Budget Act of 2013 Included an additional $400,000 one-time MHSF to develop consensus guidelines and best practices for involuntary commitment care and to provide applicable training. The Budget further directed that the funds be provided to a statewide and technical assistance entity as contained In Section 4061(a)(5) of the Welfare and Institutions Code. Consistent with that provision, the Commission contracted with the California Institute for Behavioral Health Solutions (CIBHS) to develop the guidelines and implement appropriate training.

Unforeseen circumstances have delayed completion of that contract. The Commission is requesting reappropriation of $315,000 to extend the duration of the existing contract with CIBHS to fulfill the goals of the original appropriation.

Evaluation Master Plan Implementation. Welfare and Institutions Code Sect. 5881 specifies that, subject to the availability of funds, the Commission shall engage in evaluation activities to help the counties and the Department of Health Care Services ensure that county-level systems of care are serving their target populations; that timely

performance data related to client outcome and cost avoidance are being collected, analyzed, and reported; that system of care components are implemented as intended; and to provide information documenting needs for future planning.

In recognition of these goals, the 2013 Budget included approval of additional resources for the Commission to implement a broad strategy of ongoing research and evaluation (the Evaluation Master Plan). These resources included ongoing approval for additional permanent staff positions to conduct evaluation activities and monitor contracts. The Master Plan identified an initial, five-year strategy to utilize new staffing and contracting resources to improve the State's technical capacity to evaluate mental health program outcomes and to support statewide and county-level goals to assess and improve mental health program performance. The Budget Act of 2015 included $2.7 million to support new research and evaluation activities, primarily through contracts with external entities. During the past year, the Commission has experienced significant turnover in key staff leadership positions, which has delayed development and implementation of new research and evaluation contracts.

The Commission is requesting reappropriation of $2.5 million MHSF to continue implementation of the goals of the Evaluation Master Plan. This reappropriation authority would provide the Commission with additional time to meet the 2015-16 goals of the Master Plan in consultation with state and local agencies and mental health providers.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the MHSOAC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 15: MENTAL HEALTH ADVOCACY CONTRACTS SPRING FINANCE LETTER

PANELISTS

- **Toby Ewing**, Executive Director, Commission
- **Norma Pate**, Deputy Director, Administrative and Legislative Services, Commission
- **Lawana Welch**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Budget Act of 2015 included an appropriation of $1 million Mental Health Services Fund (MHSF) for competitive bid contracts to support mental health advocacy on behalf of youth, veterans, and racial and ethnic minorities. This request is for these funds to be ongoing.

Additionally, the Commission is requesting $200,000 MHSF ongoing to support a mental health advocacy contract on behalf of the lesbian, gay, transgender, questioning (LGBTQ) population.

BACKGROUND

The Mental Health Services Oversight and Accountability Commission (Commission) oversees the activities of statewide stakeholder advocacy contracts funded under Welfare and Institution (W&I) Code Section 5892(d). These contracts, currently held by NAMI California, United Advocates for Children and Families (UACF), California Youth Empowerment Network (CAYEN), and California Association of Mental Health Peer Run Organizations (CAMHPRO) are focused on supporting the mental health needs of clients, consumers, children and youth, and transition aged youth and their families through education, advocacy, and outreach efforts.

These contracts, originally awarded on a sole source basis, were transferred to the Commission after the dissolution of the Department of Mental Health in 2011. Historically, the amount allocated for stakeholder contracts has been a total of $1,954,000 per year, distributed between the following four populations: clients/consumers, children and youth, transition aged youth, and families of clients/consumers.

The Budget Act of 2015 included an additional $1 million MHSF, subject to availability of funds within the 5-percent administrative cap, to support mental health advocacy on behalf of youth, veterans, and racial and ethnic minorities to be awarded through a competitive process.

On January 28, 2016, the Commission adopted language for an additional contract to support mental health advocacy on behalf of LGBTQ. The Commission is requesting an additional $200,000 per year ongoing funds to support this effort.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the MHSOAC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 16: STAKEHOLDER PROPOSAL ON ADVOCACY CONTRACTS

PANELISTS

- **Rusty Selix**, Representative, Mental Health America
- **Toby Ewing**, Executive Director, Commission
- **Norma Pate**, Deputy Director, Administrative and Legislative Services, Commission
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

Mental Health America (MHA) of California proposes $1.536 million in additional Mental Health Services Act (Proposition 63) State Administration funding to support advocacy contracts entered into by the MHSOAC.

BACKGROUND

The Mental Health Services Oversight and Accountability Commission (MHSOAC) was created in Section 5845 of the Welfare and Institutions Code as part of Proposition 63 of 2004 (the Mental Health Services Act) to provide oversight accountability and recommendations and guidance to the Legislature, state agencies and counties in administering the act and related mental health funds. Subdivision (c) of Section 5846 states that the Commission shall ensure that the perspective and participation of members and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations."

Accordingly the Commission provides contracts to organizations representing various constituencies of consumers and family members to enable those organizations to effectively analyze issues, participate in policy discussions and effectively provide their perspective in policy development.

However, MHA reports that the funding levels provided to these groups varies widely. At a recent meeting there was discussion about the desirability to bring all of the organizations' funding to the same level since they all need to have the same ability to analyze issues and participate in decisions. Presently the National Alliance for Mental Illness (NAMI) generally representing the views of parents of adults with mental illness has the highest contract at $670,000 annually. The other currently funded groups have contracts ranging from $400,000 to $560,000.

These groups are United Advocates for Children and Families (UACF) –representing parents of children with serious emotional disturbances, California Youth Empowerment Network (CAYEN) -representing transition age youth, California Mental Health Peer Run Organizations (CAMHPRO) – representing adults with severe mental illnesses and the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) – representing underserved racial and ethnic communities.

As described in the prior issue in this agenda, last year the Legislature authorized a new contract with a group to represent Veterans and the MHSOAC now has a budget proposal to add a contract with a group to represent LGBTQ populations.

The legislature also indicated last year that all of these contracts would be subject to competitive bidding starting with the 2016-17 fiscal year. Currently $2.95 million is budgeted for these contracts.

MHA states that an augmentation of $1.536 million will be sufficient funds to bring all groups to the same level as NAMI.

MHA proposes that the funds be allocated to the Commission with discretion to award increased contracts based upon each organization that is a successful bidder demonstrating what the additional funds would be used for and ensuring appropriate added public policy value from the additional funding.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Rusty Selix to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 17: DEPARTMENT OVERVIEW AND BUDGET

PANELISTS

- **Howard Backer,** MD, MPH, FACEP (Director), Director, California Emergency Medical Services Authority
- **Dan Smiley,** Chief Deputy Director, California Emergency Medical Services Authority
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

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.

PROPOSED BUDGET

The department's proposed budget is summarized in the table below. Overall expenditures are proposed to increase by $619,000 (1.7%). The primary source of funding for this department is federal funds, which is included in the line below labeled "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	2014-15 Actual	2015-16 Projected	2016-17 Proposed	BY to CY Change	% Change
General Fund	**$8,025**	**$8,482**	**$8,725**	**$243**	**2.9%**
Federal Trust Fund	$2,622	$5,944	$6,035	$91	1.5%
Reimbursements	$11,534	$16,894	$17,355	$461	2/7%
Special Funds	$3,663	$4,208	$4,032	($176)	-4.2%
Total Expenditures	**$25,844**	**$35,528**	**$36,147**	**$619**	**1.7%**
Positions	67.3	66.9	66.9	0$	0%

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA to provide an overview of the department and its proposed budget, and respond to the following:

Please describe any involvement that EMSA had in responding to the terrorist attack in San Bernardino.

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

ISSUE 18: MEMBER PROPOSAL: ARROWHEAD REGIONAL MEDICAL CENTER SPECIAL MEDICAL RESPONSE TEAM

PANELISTS

- **Cheryl Brown**, Member, California State Assembly
- **Howard Backer,** MD, MPH, FACEP (Director), Director, California Emergency Medical Services Authority
- **Dan Smiley,** Chief Deputy Director, California Emergency Medical Services Authority
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Meredith Wurden**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

Assemblymember Cheryl Brown proposes $500,000 to fund a Special Medical Response Team at Arrowhead Regional Medical Center (ARMC) in the City of Colton.

The ARMC is a 456-bed university affiliated teaching hospital operated by the County of San Bernardino. The ARMC was instrumental in providing care to victims of the terrorist attack that occurred in San Bernardino on December 2, 2016. After the terrorist attack, the ARMC did an analysis of their field medical response and are looking to make improvements and increase their effectiveness in this regard.

One recommendation that has been put forward is to create a Special Medical Response Team (SMRT) comprised of emergency physicians, Registered Nurses, and other medical personnel who work in trauma centers and possess the skills to rapidly respond to events such as a large scale terrorist attack. This proposal would fund regular training for the SMRT team, emergency management staff, law enforcement, and state and federal agencies.

This proposal is predicated on the notion that a SMRT Team at ARMC would serve as a model, or pilot program, for the rest of the state. The author states that, "Having dedicated special medical response teams that are trained to triage, screen, and treat victims effectively in the field will help increase survival rates during natural disasters and man-made tragedies."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Brown to present this proposal, and requests EMSA to describe related activities at EMSA.

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 19: MEMBER PROPOSAL: SAN LEANDRO HOSPITAL FUNDING

PANELISTS

- **Rob Bonta**, Member, California State Assembly
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

Assemblymember Rob Bonta requests $2 million for San Leandro Hospital (SLH) to help financially stabilize the hospital.

BACKGROUND

Bonta explains that SLH is a safety net hospital and this funding will ensure that SLH stays open, providing additional time to improve operations. Bonta points out that the state requires seismic renovations of the SLH rehabilitation facility at a projected cost of $24 million.

SLH is a 93-bed facility that employs 450 people, and is operated by Alameda Health Systems. SLH serves primarily patients who are either uninsured or covered by Medicare or Medi-Cal. The hospital has experienced severe financial challenges for quite a few years and nearly closed in 2009. Community efforts have helped to keep the hospital open, including $1 million contributions each year from both the City of San Leandro and Alameda County. However, these contributions will expire at the end of 2016. This request for $2 million is intended to offset the loss of these funds.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Bonta to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 20: MEMBER PROPOSAL: SCHOOL HEALTH CENTER TECHNICAL ASSISTANCE

PANELISTS

- **Sebastian Ridley-Thomas**, Member, California State Assembly
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

Assemblymember Sebastian Ridley-Thomas and the California School Based Health Alliance request a one-time appropriation of $600,000 for two limited-term positions at the Department of Health Care Services to provide technical assistance and analysis associated with the development and expansion of school-based health centers.

BACKGROUND

The author of this proposal explains that children from lower socioeconomic backgrounds have poorer health outcomes, and even with the expansion of health insurance coverage through the Affordable Care Act and Medi-Cal, children from California's most distressed neighborhoods experience significant barriers to accessing preventive health care and have high rates of emergency room visits, obesity, asthma, mental and behavioral health disorders, and exposure to violence and trauma.

Stakeholders provide that school-based health centers offer an innovative solution to improve health outcomes for children by offering high quality services in a convenient and welcoming environment. School-based health centers play an important role in the safety net serving more than 250,000 children in grades K-12 throughout the state. They have demonstrated that they improve access to care and attract harder-to-reach populations, especially African-Americans and young men of color. Children who use school-based health centers are likely to use primary care more consistently and are less likely to visit the emergency room or be hospitalized.

Therefore, supporters of this proposal state that appropriating funds to the Department of Health Care Services for the School-Based Health and Education Partnership Program (formerly the Public School Health Center Support Program) will allow the state to provide technical assistance to school-based health centers that would help to facilitate and encourage the establishment, sustainability, and expansion of these health care facilities.

In 2006, Governor Schwarzenegger signed AB 2560 (Ridley-Thomas, the school Health Centers Act, which created the Public School Health Center Support Program to facilitate the development of school-based health centers. However, although the bill was signed and the program exists in law, it has never been funded.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Ridley-Thomas to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 21: MEMBER PROPOSAL: CAREGIVER RESOURCE CENTERS

PANELISTS

- **Cheryl Brown**, Member, California State Assembly
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

Assemblymember Cheryl Brown requests $7.1 million for Caregiver Resource Centers.

BACKGROUND

The CRCs are legislatively mandated to assist families who provide care for loved ones with Alzheimer's disease, stroke, Parkinson's disease, traumatic brain injury, Huntington's disease, multiple sclerosis and other cognitive disorders that occur after the age of 18. DHCS oversees state funding for the CRCs which experienced a 72 percent funding reduction in 2009-10. During the fiscal crisis, the CRCs total allocation was reduced from $10.5 million to $2.9 million. The 2015 Budget Act includes an increase of $2 million bringing the current funding level to $4.9 million General Fund.

Legislation in 1984 proposed to establish CRCs in 11 regions of the state. Signed by Governor George Deukmejian on September 30, 1984, the Comprehensive Act for Family Caregivers of Brain-Impaired Adults (Welfare & Institutions Code Section 4362) established the statewide California Caregiver Resource Center system under the then-California Department of Mental Health. The CRCs are legislatively mandated to assist families who provide care for loved ones with Alzheimer's disease, stroke, Parkinson's disease, traumatic brain injury, Huntington's disease, multiple sclerosis and other cognitive disorders that occur after the age of 18.

The CRC system in California was the first of its kind in the nation, and was viewed as a model for the development of similar services now available in all fifty states. State funding for CRCs was reduced by 74 percent in 2009. State funding qualifies for a 3:1 federal-state match. While eligibility for CRC services is not means-tested, CRC services are unique and generally not available elsewhere, even for people of middle or high-income who have health insurance. Moreover, individuals pay fees on a sliding scale. As a result of budget reductions to California's CRCs, particularly in 2009, all 11 CRCs maintain waiting lists for various services; the LA CRC has a waiting list of over 900 people just for respite services.

Each CRC serves as a point of entry to services available to caregiving families in every county of California. While each center tailors its services to its geographic area, all CRCs have a core component of programs that provide information, education & support for

caregivers. CRCs operate in: Burbank, Chico, Citrus Heights, Colton, Fresno, Fullerton, San Diego, San Francisco, Santa Barbara, Santa Cruz, and Santa Rosa. Core Services include:

- *Specialized Information*: CRCs provide advice and assistance on caregiving issues and stress, diagnoses and community resources.

- *Family Consultation & Care Planning*: Individual sessions and telephone consultations with trained staff to assess needs of individuals who are incapacitated and their families, and to explore courses of action and care options for caregivers.

- *Respite Care*: In-home support to assist families caring at home for an adult with a disabling condition.

- *Short-term Counseling*: family, individual and group sessions with licensed counselors to offer emotional support to caregivers coping with the strain of the caregiving role.

- *Support Groups*: Monthly meetings in a supportive atmosphere to share experiences and ideas to ease the stress of caregiving.

- *Education*: Special workshops on topics such as diagnosis, treatment, long-term care planning and stress management to help caregivers cope with day-to-day concerns.

- *Legal & Financial Consultation*: Personal consultations with experienced attorneys regarding powers of attorney, estate and financial planning, conservatorships, and other matters.

The CRCs have in past years served 15,000 families annually. Due to the cuts in funding, an estimated 73% fewer new caregivers entering the program were able to access:

- Depression screening reduction of 76%
- Care planning and consultation reduction of 81%
- Counseling reduction of 76%
- Education/training reduction of 78%
- Support Groups reduction of 59%
- Legal reduction of 85%
- Respite
  - In-home reduction of 98%
  - Adult Day Care reduction of 100% (elimination of this service)

Prior to the budget reductions:

- CRCs had 120 staff (FTE) serving every county in California; CRC staffs have been reduced to 36 or 70% statewide.

- There were 24 offices which have been reduced to 14 or 42%; CRCs no longer have a presence in rural areas.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Brown to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 22: LATINO LEGISLATIVE CAUCUS PROPOSAL: MEDI-CAL DATA COLLECTION

PANELISTS

- **Joaquin** Arambula, Member, Latino Legislative Caucus, California State Assembly
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The California Latino Legislative Caucus requests $200,000 to align Medi-Cal's health plan data collection and reporting requirements for race/ethnicity, language (REL), and sexual orientation and gender identity (SOGI) data with Covered California's proposed 2017 Qualified Health Plan standards.

BACKGROUND

This requirement will allow Medi-Cal to begin to identify, track, and address health disparities at the plan level and ensure alignment across both Medi-Cal and Covered California's markets, which both serve high numbers of low-income communities of color in California.

Currently, communities of color are overrepresented in Medi-Cal, at 78% of Medi-Cal managed care enrollment. The Caucus states that this provides Medi-Cal with a tremendous opportunity to use its power as the country's largest Medicaid program, and the state's largest insurer, to drive changes toward the identification and reduction of health disparities. The Caucus also states that for many health policymakers the assumption has been that a focus on overall health quality would be inclusive of disparities reduction efforts, but this is not the case. The Caucus believes that in order for California to make meaningful progress on the elimination of health disparities, Medi-Cal must first track REL and SOGI data, and then hold plans and providers accountable for making meaningful progress on disparities where appropriate. Currently, the Department of Health Care Services' plan quality monitoring efforts do not include reporting on disparities, and often, one of the reasons cited is a lack of reliable data at the plan and provider levels.

The Centers for Medicare and Medicaid Services (CMS) recently recommended its agencies evaluate disparities impacts and integrate equity solutions across all CMS programs, which would include California's Medi-Cal program. Similarly, the Caucus believes that the state should seek to align its efforts to evaluate disparities and integrate equity solutions across its large purchasers, starting with Medi-Cal and Covered California.

Currently, Covered California's draft QHP model contract includes a proposed requirement for all plans to track and trend quality measures by race, ethnicity, and gender, for the plan's entire population, and to achieve a goal of 85% self-reported racial/ethnic identity reporting by the end of 2019. While plans are in the process of working with providers to collect this data at each patient encounter, the plans will also provide proxy identification for race and ethnicity through zip code and surname analysis where self-reported data is not available. Because Covered California's requirement would extend to each plan's entire book of business, several of our Medi-Cal plans will already have to meet this requirement.

SEIU California and the California Pan Ethnic Health Network (CPEHN) are in strong support of this proposal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Arambula to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 23: STAKEHOLDER PROPOSALS ON MEDI-CAL ISSUES

PANELISTS

- **Sharon Rapport**, Associate Director, California Policy, Corporation for Supportive Housing
- **Christina Romero**, Legislative Director, Planned Parenthood Affiliates of California
- **Darin White**, DPT, California Physical Therapy Association
- **Fred Main**, Clear Advocacy
- **Barbara Glaser**, Senior Legislative Advocate, California Hospital Association
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSALS

The Corporation for Supportive Housing and Housing California

Proposal

The Corporation for Supportive Housing (CSH) and Housing California request $60 million one-time to create a Medi-Cal Housing Program. This budget item would leverage use of federal and county funding to match services with rental assistance to end chronic homelessness for between 900 to 1,000 Californians. A $60 million General Fund allocation would grant counties funds to pay for rental subsidies to categorically-eligible Medi-Cal beneficiaries experiencing chronic homelessness. Eligible counties would be using Whole Person Care pilots to provide services to homeless beneficiaries or partnering with managed care health plans participating in the Health Home Program.

Counties could use the dollars to fund rental assistance for people who are homeless or formerly homeless now living in supportive housing, provided these individuals and families receive services under the Whole Person Care pilots or the Health Home Program. Counties could use funding for up to 9 months of interim housing, where people still homeless could live safely while waiting for permanent housing, or for supportive housing. Counties could structure 5- to 15-year rent assistance periods

Under both the Whole Person Care pilots and Health Home Program, lead administering entities must report data on decreased use of acute care, such as emergency department visits, inpatient admissions, and inpatient days. As a program fostering local-State-federal partnership in ending homelessness, all three entities would be responsible for funding aspects of the program. Counties and DHCS would report data that would form the basis for ongoing appropriations.

Background

Stakeholders provided the following data to the Subcommittee that draws the connection between housing and health, and health care costs:

- Homeless individuals cost our public systems an average of $2,897 per month, two-thirds incurred through the health system.

- People who are homeless have longer hospital stays than housed people with the same conditions.

- Medi-Cal beneficiaries participating in foundation-funded frequent user programs reduced Medi-Cal hospital costs by $3,841 per beneficiary after one year and $7,519 per beneficiary per year after two years, over and above the costs of these programs. However, when programs funded services only, and failed to connect participants to stable housing, inpatient costs actually increased among homeless participants.

- A Seattle study showed homeless people with significant alcohol use disorders connected to supportive housing incurred $2,449 less in Medicaid costs per person, per month, than control group participants after six months, beyond the costs of the program.

- Two randomized studies published in the Journal of the American Medical Association (JAMA) demonstrated chronically homeless people who moved into supportive housing decreased hospital days by a third within a year and 46% after 18 months, and decreased nursing home days by over 60% within a year compared to people in the control groups who remained homeless.

In March 2015, the Department of Health Care Services (DHCS) proposed using Medi-Cal to fund rental assistance and services promoting housing stability—the combination known as "supportive housing"—to address the health needs of beneficiaries experiencing homelessness and multiple barriers to housing stability, DHCS acknowledged decades of research demonstrating that supportive housing decreases Medicaid costs among homeless beneficiaries. The Federal Centers for Medicare & Medicaid Services (CMS) approved a final 1115 Medicaid Waiver that included the Whole Person Care pilot program. The pilot program:

- Is intended to address the "whole needs" of high users of multiple systems (health, behavioral health, and social services needs);

- Allows counties to tap into federal funds of $1.5 billion over 5 years to pay for

    1. Services to outreach to and engage chronically homeless people, who are generally distrustful of health systems,
    2. Services that help chronically homeless people to find and access available permanent housing, and
    3. Services that help people who have been chronically homeless remain stably housed;

4. Creates “housing pools” for counties to coordinate existing housing resources in the community; and
5. Requires counties to match federal investment.

DHCS is also working to implement a new Health Home Program, a Medi-Cal benefit that would fund services akin to services the Whole Person Care pilots are intended to fund. The Health Home benefit will allow counties to sustain Whole Person Care services beyond the 5 years of the Whole Person Care pilots.

Under both the Whole Person Care pilots and the Health Home Program, lead entities are required to report outcomes, such as decreases in emergency department visits, inpatient admissions, and inpatient days. DHCS has also indicated health home providers will have to report the number of participants who were initially homeless, but living in permanent housing during the reporting period.

Though CMS rejected using federal Medicaid dollars to pay for rental assistance in the final 1115 Medicaid Waiver, the special terms and conditions that guide the Whole Person Care pilots acknowledge State dollars could fund rental assistance, and match that assistance with Whole Person Care services. New York, as an example, currently uses State-funded Medicaid dollars to pay for rental assistance based on estimates of costs saved by moving high-cost beneficiaries into supportive housing.

Planned Parenthood Affiliates of California

Proposal

Planned Parenthood Affiliates of California (PPACA) proposes trailer bill language that would revise the Medi-Cal and Family PACT reimbursement formula for drugs and supplies dispensed by requiring the clinic-dispensing fee to be the difference between the actual acquisition cost of a drug or supply and the Medi-Cal reimbursement rate.

Background

PPACA explains that clinics that dispense medication onsite provide the added benefit of a “one stop shop” that allows patients to leave their health care provider with mediation in hand. This convenience has led to improved access to health care and to better patient health outcomes. Existing law allows these community clinics to receive a dispensing fee in addition to the purchasing cost of the medications they dispense to Medi-Cal and Family PACT patients. However, PPACA states that the current billing system the clinics must use is overly complex, and leads to numerous billing errors that require staff time for both clinics and the state to fix. These errors can take months to resolve and deny the clinics Medi-Cal reimbursement to which they are entitled.

California Physical Therapy Association

Proposal

The California Physical Therapy (CPT) Association proposes trailer bill language to authorize Medi-Cal reimbursements to physical therapists for electromyography and nerve conduction studies (EMG/NCS).

Background

In 1978, a bill was passed and signed into law that permits physical therapists (PTs) to perform EMG/NCS. The California Physical Therapy Board was given the authority to administer an annual examination to certify PTs to perform EMG/NCS. PTs have been performing EMG/NCS throughout the United States for over 50 years and are considered qualified providers of EMG/NCS by all major insurance providers, including Medicare, according to the CPT Association. However, in 2004, budget trailer bill was proposed by the administration, to curb fraud, that limits reimbursement for EMG/NCS only to physicians with residency training in neurology and physical medicine (physiatry).

The CPT Association explains that many PTs practicing EMG/NCS travel to rural hospitals and clinics that service a large population of individuals with Medi-Cal insurance, yet are not able to provide this service to Medi-Cal beneficiaries due to the absence of reimbursement. Hospitals that provided the service prior to 2004 to Medi-Cal beneficiaries stopped providing it. The CPT Association states that patients who previously could walk to the hospital or clinic in their rural community now are forced to travel long distances to urban areas where medical specialties in neurology and physiatry are available to provide EMG/NCS.

In general, EMG/NCS is a covered benefit in Medi-Cal, through other types of providers, and it is within the legal scope of practice for PTs, and therefore PTs argue that it should be a reimbursable service for them to provide to Medi-Cal beneficiaries.

California Birth Center Association

Proposal

Stakeholders claim that birth centers are financially unsustainable due to Medi-Cal payment practices. Hence, they propose the following changes:

1. Full restoration of the Medi-Cal payments for code Z7615 that were reduced by sequestration. In 2014 reimbursement for services provided in birth centers was reduced by the 10% for sequestration. In 2015, the sequestration was restored for others, (retroactive to July 2014) but not for birth centers.

2. Fair reimbursement for the facility use and professional services in instances of “observation” of a client in our center. They request sufficient reimbursement for observation and triage of mothers when there is a need for evaluation or observation, such as, decreased fetal movement, possible rupture of membranes, false labor, etc. Most moms evaluated in a birth center are likely to remain in the birth center for their birth. Without proper reimbursement for cost saving care, birth centers could be forced to send women to hospitals to be evaluated. This will

reduce the savings and advantages Medi-Cal receives from birth center births. Care in birth centers is highly individualized and highly staff intensive. This is a key element of the resulting high quality, high value care.

3. Increase Medi-Cal payment codes for birth centers to reward the care that generates birth center cost savings. Current rates make it difficult for birth centers to pay their overhead and meet the mandate of their licenses:

    - HCPCS code Z7500 (reimbursement: $23.77), is the only available code for facility reimbursement, (in event of observation) in Birth Centers. Expenses incurred, include bed linen processing, lights needed to evaluate the patient, supplies used, bathroom facility, general/professional liability insurance, cleaning/sanitizing the space. It also does not cover the costs of the staff (not the midwife) needed when a patient comes in for observation/evaluation but is not admitted.

    - Birth centers request a code for "decreased fetal movement needing non-stress test". This condition requires both a NST and evaluation of amniotic fluid that requires ultrasound. There needs to be identification of code 76815 for the evaluation of amniotic fluid during this encounter.

    - Codes (99234-99236) cover the professional services of the midwife. Reimbursement rate for these codes is $74.70-$124.60. Medicare reimbursement for these same codes is $225.00-$250.00. They propose Medi-Cal reimbursement match Medicare rates.

4. Newborn Facility Fee: Currently facility services for care provided for the newborn is not being reimbursed at all. Facility costs cannot be sustained without adequate reimbursement. Once born, the baby is a new and unique patient requiring evaluation and management. While California recognizes 99461 for newborn care given by the provider, it does not include the facility costs. A facility fee is needed in that it requires different equipment and furnishings for a newborn (heat source, suction equipment, neonatal resuscitation equipment, infant scale, medications, etc). There is code 99477 that is a facility fee for initial day for a newborn and they propose that the department allow this code for Birth Centers for newborn care as it more adequately reflects the services needed and provided.

Background

Birth centers provided the following background to the Subcommittee:

The free-standing birth center is an accepted and medically sound, cost effective alternative to having a hospital birth for those women who wish a more personal and drug-free birthing experience. It is a home-like facility with a program of care designed in the wellness model of pregnancy and birth. Birth centers are guided by principles of prevention, sensitivity, safety, appropriate medical intervention and cost effectiveness. Birth centers provide family-centered care for healthy women before, during and after normal pregnancy, labor, and birth. The women who deliver at birth centers are Nulliparous or Multiparous (first time moms or moms who have previously given birth)

Term (37 to 42 weeks gestation) Singleton (one baby) and Vertex (fetal head down as opposed to breech or any other abnormal position).

Birth Centers have the distinction of providing high quality, high value services cost effectively. Many studies over the last 3 decades repeatedly demonstrate excellent outcomes for mothers and babies with substantial savings to payers. The savings accrue in the short and long term due to low rates of cesarean section and reduced interventions that drive up costs and increase complications that negatively impact the health of mothers and babies.

CMS calculated that the average savings to states in the US was over $1,100 per birth center birth. Maternity costs in California are higher than average but based on the CMS estimate, if 50 birth centers delivered only 20 Medi-Cal babies a month the savings to Medi-Cal would be over 1.1 million per month.

A report compiled by Truven Health Analytics (2013) on the cost of childbirth in the US, found that both commercial and Medicaid payers paid approximately 50% more for cesarean than vaginal births and that for both types of births, commercial payers paid approximately 100% more than Medicaid. This demonstrates that if the national cesarean rate were the 15% recommended by the World Health Organization rather than the current 32.8% savings would be over five billion dollars per year.

FACT: Birth Centers have cesarean section rates of less than 10% while hospitals caring for the same groups of low risk women, have rates two to 3 times higher. The Pacific Business Group Health Report finds that hospitals in California have a 27.4 % rate of cesarean section among NSTV women (Nulliparous, Singleton, Term, Vertex)—the very women who should have low rates. Many California hospitals have over a 50% rate of cesarean section. Women who have their first babies by cesarean section will most likely have all their babies by cesarean section, making them higher risk for morbidity and mortality.

CMS and the ACA acknowledge birth centers as an innovative solution to improving outcomes and reducing the cost of childbearing care in the US. The women who utilize birth centers have high levels of satisfaction with their care, and their babies are more likely to breastfed for extended time-periods resulting in fewer health issues in childhood and adulthood.

California Hospital Association

Proposal

The California Hospital Association (CHA) proposes trailer bill language to extend the sunset on the hospital quality assurance fee from January 1, 2017 to January 1, 2018.

Background

Federal Medicaid regulations allow states to assess “health care–related taxes” on certain health care providers and use the tax revenues as the nonfederal share of Medicaid payments. Since 2009, the Legislature has imposed a health care–related tax, the hospital QAF, on certain private hospitals. The hospital QAF benefits the hospital industry

through the use of fee revenue to draw down federal funds that are generally provided to hospitals through various financing mechanisms. Most of the revenues collected through the fee provide the nonfederal share of: 1) certain increases to capitation payments that Medi–Cal managed care plans are required to pass along entirely to private and public hospitals; and 2) certain supplemental payments to private hospitals. A certain portion of the fee revenue offsets General Fund costs for providing children's health care coverage, thereby achieving General Fund savings. In 2015–16, General Fund savings from the fee are estimated to be $815 million.

The current hospital QAF sunsets on January 1, 2017. The Governor's budget does not propose extending the fee. A November 2016 ballot measure, however, would permanently extend the fee if passed. An extension of the fee requires both legislative (or voter) approval and subsequent approval from the federal government to draw down federal funds.

The Legislative Analyst (LAO) recommends the Legislature extend the hospital QAF because this fee is both a benefit to the General Fund and to the hospital industry. Further, LAO recommends the Legislature extend the fee this legislative session to provide greater assurance that the fee's benefit in drawing down federal funds is maximized by preventing a lapse in the fee being operative. LAO states that while there is a ballot initiative that would make the fee permanent, a delay in authorizing the fee could result in General Fund costs of at least the low hundreds of millions of dollars.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 24: ELECTRONICS RECORDS STAFFING-MONITORING AND OVERSIGHT BUDGET CHANGE PROPOSAL

PANELISTS

- **Karen Johnson**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, DOF
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Department of Health Care Services (DHCS), Information Management Division (IMD), Office of Health Information Technology (OHIT) requests three-year limited-term resources of $403,000 ($41,000 General Fund (GF) and $362,000 Federal Trust Fund (FTF)) to provide extensive data analysis, policy analysis, enrollment and eligibility support, and pre and post-payment audits and investigations for program eligible managed care and fee for service providers.

The requested resources are needed to provide continuous support and compliance oversight of the program as required by CMS. CMS has approved 90 percent federal funding participation (FFP) for the resources requested in this Budget Change Proposal (BCP).

BACKGROUND

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorizes the outlay of federal money estimated to be approximately $4,5 billion for California and $45 billion nationally for Medicare and Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade and meaningfully use electronic health records (EHR) in accordance with the Act's requirements. The goal of HITECH is to improve the quality, safety, and efficiency of health care through "meaningful use" (MU) of EHRs. HITECH has resulted in a significant increase in provider adoption and use of EHR systems, leading to desired health care improvement, and an overall improvement in public health. The use of EHR technology includes the use of electronic prescribing (e-prescribing), submission of clinical quality measures, reporting to immunization and disease registries, and exchanging health information among Medi-Cal providers, hospitals and DHCS to improve the quality of patient care.

The HITECH Act authorizes state Medicaid programs to directly administer Medicaid HER Incentive Programs. The state's Medi-Cal EHR incentive Program is integral to patient safety and quality of care by incentivizing Medi-Cal providers to adopt, implement, or upgrade and use EHRs in a meaningful way. On October 26, 2009, DHCS submitted a

funding request to CMS that was approved for $2.8 million to establish OHIT and to provide funding for a consulting contract to begin the State Medicaid Health Information Technology Plan (SMHP) process. In November 2009, DHCS contracted with The Lewin Group and McKinsey & Company to complete the initial assessments and planning deliverables. The result of this effort was a preliminary Landscape Assessment of eligible hospitals (EHs) and eligible providers (EPs) in the state as well as a proposed incentive program Implementation Plan, The implementation Plan included the requested resources necessary for a successful Medi-Cal EHR Incentive Program.

The department completed and received CMS approval of the SMHP and Implementation Advance Planning Document (I-APD) on September 30, 2011, and authorization to implement the EHR Incentive Program, which occurred on October 3, 2011. This request outlines the incentive program, resource levels necessary for operations support, data analysis, policy analysis, procedure development, education and outreach to providers and beneficiaries, enrollment and eligibility, payment of incentives to providers for adoption, and coordination of efforts with a number of state and public entities. These entities include state health departments, the California Office of Health information Integrity, Medi-Cal Managed Care Plans, Regional Extension Centers (REC) and REC-like entities in the state, provider associations and patient advocates, as well as other entities.

The Implementation Plan developed by the consultants, identified the need for the resources requested in this proposal. In addition, a comprehensive Project Workbook was developed with the assistance and input of a wide array of program stakeholders, which identified the need for additional resources to implement the recommended projects this request seeks to complete. In FY 2013-14, OHIT received approval, through BCP - 0HIT13-01, for 11.0 limited-term positions: 8.0 positions expired on June 30, 2015 and 3.0 positions are expiring on June 30, 2016. Of the 8.0 positions which expired on June 30, 2015, 6.0 were made permanent and 2.0 were extended for two years through 2015-16 BCP IMD15-01. OHIT was initially unsuccessful in securing the state's 10% match from outside entities for Enhanced FFP. Delays of the vendor to design, develop, and implement the required Web Portal for acceptance of provider enrollment applications due to frequent policy and technological changes in the CMS requirements for the incentive program also contributed to the delay and the need for continued resources. Significant CMS policy changes occurred in 2013, twice in 2014, 2015 and are currently being developed for 2016 and 2017; many of which could result in technological changes.

The Web Portal has been partially implemented, but has deficiencies in the State Administrative Module (SAM) - the reporting system that allows OHIT to electronically review and approve applications and release incentive payments in a timely manner. The vendor and DHCS continue working on essential functions of the SAM, including ad hoc and standard reporting capabilities, application audit and appeal tracking and payment processing. As a result of the delays due to CMS changes, the deficiencies in the administrative module, and the expansion of the program over time, OHIT staff has been tasked with handling an overwhelming number of applications. OHIT has prioritized work necessary to enable timely payments to providers. In addition, staff continues to support ongoing operations, provider education and outreach and the continuous development of

policies and procedures to further advance the Medi-Cal EHR Incentive Program.

The Medi-Cal EHR Incentive Program is a multi-year program that began on October 3, 2011 for Eligible Hospitals, November 15, 2011 for Groups/Clinics, and January 3, 2012 for Eligible Providers. The Medi-Cal EHR Incentive Program is currently scheduled to operate through December 31, 2021. Phase 1 of SAM was released in May 2012 and partially updated in September 2012. Since the implementation of the Medi-Cal EHR Incentive Program, DHCS OHIT has authorized more than 20,000 incentive payments to over 17,000 providers and 260 hospitals. This has resulted in more than $1 billion in 100% FFP incentive payments made to date. DHCS expects to distribute between $100 and $200 million per year for the remainder of the program. Recently updated landscape assessment data indicate there are likely another 15,000 providers who are, or will become eligible for the program. DHCS has estimated approximately $2 billion will be distributed to providers and hospitals over the course of the program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 25: HIPPA COMPLIANCE AND MONITORING BUDGET CHANGE PROPOSAL

PANELISTS

- **Karen Johnson**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, DOF
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Department of Health Care Services (DHCS), Office of Health Insurance Portability and Accountability Act (HIPAA) Compliance requests the conversion of 8.0 limited-term positions to permanent effective July 1, 2016. The requested expenditure authority for this conversion is $1,202,000 ($240,000 General Fund (GF) and $962,000 Federal Trust Fund (FTF). The positions are necessary to continue existing efforts, maintain compliance with current federal and state regulations, address new HIPAA rules, provide support for growth in the Capitation Payment Management System (CAPMAN). and continue to strengthen oversight of privacy and security protections for members served by DHCS programs.

BACKGROUND

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 have been updated repeatedly since their inception. The most recent changes demonstrate that HIPAA will continue to evolve as technology, policy capabilities, and standards are developed and refined in the health care environment, DHCS must respond to HIPAA changes with an ongoing process to evaluate and implement the latest industry standards for the safe and secure exchange of electronic health care information. DHCS has developed and maintained staffing levels to respond to HIPAA through a series of eight Budget Change Proposals (BCPs) or Spring Finance Letters (SFLs) that have continued to extend formerly approved limited-term positions since HIPAA efforts began at DHCS in 2000. HIPAA will continue to advance and grow in order to make health administration more efficient, secure, and standardized. DHCS needs an ongoing organization, with sufficient permanent staff and resources, to successfully lead and coordinate these efforts.

Recent federal directives have highlighted the need for permanent HIPAA resources, particularly in the areas of Medicaid Information Technology Architecture (MITA), new healthcare standards and operating rules, and capitation program system development, maintenance, and operations.

MITA. The Centers for Medicare & Medicaid Services (CMS) introduced MITA in 2005 as an initiative to guide states to improve the operation of their Medicaid programs through the implementation of an enterprise framework of business, information, and technical standards. On April 14, 2011, CMS significantly elevated the importance of MITA by issuing new final regulations under sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act. The final regulations contained new standards and conditions that must be met by states in order for Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for the enhanced (90%) federal financial participation. To enable conformance to MITA. DHCS is required to submit an annual State self-assessment (SS-A) which includes a "Road Map" that outlines DHCS' progression and new initiatives that will lead to a higher level of MITA maturity. On April 14, 2015, CMS released proposed regulations that further strengthen MITA and place additional requirements on State Medicaid Agencies, including: use of updated standards and additional conditions in order to obtain federal funds for Medicaid information technology; demonstrated progress toward seamless coordination and interoperability with other federal and state agencies; improved performance testing and demonstrated results; a requirement for mitigation plans for all major systems functionalities; and documentation that will enable re-use of software developed with federal funds.

New Health Care Standards and Operating Rules. The Patient Protection and Affordable Care Act (ACA), signed into law on March 23, 2010, contained several significant and still to be implemented HIPAA-related changes, including more frequent updates to HIPAA regulations, new operating rules, new transaction standards, new health plan certification requirements, and considerably higher penalties for noncompliance. Collectively, compliance with the new and existing HIPAA regulations requires significant efforts within DHCS to assess impacts, design and adapt policies and regulations, define business rules, test changes with providers and other business partners, and remediate information technology systems

Growth in CAPMAN. The DHCS Office of HIPAA Compliance (OHC) is responsible for the management of the CAPMAN system, which supports federal regulations that require the State of California to maintain member benefit enrollment and accounting for all capitated payments made to managed health care plans. This is a very large and extremely complex IT system responsible for approximately 83% of all Medi-Cal payments per month. CAPMAN replaced a manual process to calculate and pay managed care plans in July 2011. Since the initial implementation of CAPMAN, Medi-Cal managed care has experienced phenomenal growth. This growth is attributed to two components: 1) Medi-Cal expansion emanating from the Affordable Care Act; and 2) moving Medi-Cal members from fee-for-service to managed care. When the system was developed there were approximately 3.5 million Medi-Cal members in managed care. Currently there are over 9 million Medi-Cal members in managed care, representing an increase of 257%, In addition to the growth in members, the complexity of payment methodologies has increased, and will continue to increase, as DHCS includes additional services in the premium (e.g., long term care services and support). HIPAA compliance solutions vary greatly by rule, health care program, and systems impacted. Often times, entire systems, policies, and processes are modified. In some cases, addressing HIPAA requires full system replacements or automating a manual process. HIPAA permits any

existing rule to be updated to adopt new standards or best practices. HIPAA will continue to evolve in order to make health administration more efficient, secure, and standardized.

Since the first series of HIPAA federal regulations were released, DHCS has developed and maintained limited-term staffing through a series of BCPs and/or SFLs, with the understanding that HIPAA was a finite project. In the FY 2013-14, OHC received approval, through the BCP OHC 13-01, for 2.0 3-year limited-term positions that are expiring on June 30, 2016. In FY 2014-15, through BCP OHC 14-01, OHC extended 6.0 2-yearlimited-term positions that are set to expire on June 30, 2016. However, due to the changing nature of HIPAA, constantly changing technologies and the ever-present need to protect patient confidentiality, HIPAA has grown to become a permanent undertaking and the need for additional permanent staff, as requested on this proposal to convert the approved limited-term positions to permanent, reflects that change.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 26: ROBERT F. KENNEDY FARM WORKERS MEDICAL PLAN (SB 145) BUDGET CHANGE PROPOSAL

PANELISTS

- **Karen Johnson**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, DOF
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Department of Health Care Services (DHCS), Third Party Liability and Recovery Division (TPLRD), requests five-year limited-term funding of $220,000 (General Fund) to implement provisions of Senate Bill (SB) 145 (Chapter 712, Statutes of 2015). An additional $100,000 is requested for a one-time system upgrade. Funding is 100 percent GF because SB 145 did not provide or indicate a source of funding.

SB 145 requires DHCS to reimburse the Robert F. Kennedy Farm Workers (RFK) Medical Plan up to $3,000,000 annually for claim payments that exceed $70,000 on behalf of an eligible employee or dependent for a single episode of care, until January 1, 2021.

BACKGROUND

RFK Medical Plan is a non-governmental, self-funded, self-insured health plan that is subject to collective bargaining agreements between the United Farm Workers (UFW) and multiple agricultural employers. The Affordable Care Act (ACA) bans annual and lifetime limits to plan coverage. The ACA allows for multi-employer plans with collective bargaining agreements to maintain a "grandfathered" status for some provisions, but not the annual and lifetime limits. Due to these prohibitions, RFK Medical Plan has stated that it will not be financially viable to continue without a subsidy. SB 145 requires DHCS to review claims submitted by RFK Medical Plan and reimburse the plan.

TPLRD is responsible for enabling the Medi-Cal program to comply with State and Federal laws and regulations relating to the legal liability of third parties for health care services to beneficiaries, and for taking all reasonable measures to allow the Medi-Cal program to be the payer of last resort. Functions include recouping amounts Medi-Cal has paid when a beneficiary has Medicare or other health insurance, collections from the estates of deceased beneficiaries, recouping provider overpayments, and placing liens against casualty insurance or workers' compensation settlements, judgments, or awards. In addition, TPLRD collects Working Disabled Program premiums and fees imposed on intermediate care facilities, skilled nursing facilities, and hospitals for quality assurance.

TPLRD's Special Collection and Process Innovation Section is responsible for consultative and analytical work for a wide variety of Medicaid recovery and collections programs. The Section is responsible for requesting and analyzing eligibility and service data to determine claim amounts, supporting litigation and collection activities, responding to customer inquiries, and developing new collection processes. DHCS is proposing to implement SB 145 requirements within the TPLRD; because this would be a new program, there is no workload history.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 27: HEALTH HOMES PROGRAM ACTIVITIES BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Scott Ogus**, Finance Budget Analyst, Department of Finance
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD), requests three-year limited-term expenditure authority of $1,031,000 ($516,000 Federal Fund / $515,000 Special Deposit Fund), in support of the Health Homes Program (HHP), beginning July 1, 2016. Included in the request is three-year, limited-term contract funding for a total of $775,000 (50% Federal Fund/50% Special Deposit Fund): Year 1 $275,000, Year 2 $275,000, and Year 3 $225,000.

BACKGROUND

Health Homes Optional Medicaid Benefit Program (HHP)
Assembly Bill (AB) 361 (Mitchell) (Chapter 642, Statutes of 2013, Welfare & Institutions Code (WIC) 14127 et seq.) authorizes DHCS to implement the Affordable Care Act (ACA) Section 2703 optional Medicaid HHP Services benefit for members with chronic conditions with the goal of Improved health outcomes from Medi-Cal's most vulnerable beneficiaries. The HHP will provide enhanced care coordination benefits. The authorization to implement is permissive, is not time-limited, and may be based on DHCS's determination of program fiscal and operational viability. DHCS began further analysis and development work on AB 361 in the Spring of 2014. The earliest possible program implementation will be in 2016. Under ACA Section 2703, states may adopt the HHP benefit and receive a 90% federal match for program services for two years. After two years, the federal match converts to 50%. There is no deadline to submit a State Plan Amendment (SPA) for a HHP or to receive the two years of 90% federal funding. Eligible individuals must have one or more chronic conditions. HHP services must be provided by a designated HHP provider, a team of health care professionals operating with such a provider, or a health team, defined in 42 United States Code (USC) Section 256a-1 as a community-based interdisciplinary, interprofessional team, HHP services include comprehensive care coordination and patient and family support.

AB 361 specifies that DHCS may only implement the HHP if prior and ongoing projections show no additional General Fund monies will be used to fund the program's administration, evaluation, and services. DHCS may use General Fund monies to operate the program if ongoing General Fund costs for the Medi-Cal program do not result in a

net increase. In January 2013, The California Endowment (TCE), Board of Directors approved a $25 million commitment in each of the first two years to provide the 10% non-federal match for program services. TCE has not only agreed to provide funding for program services, but also funding for state operations activities (at a 50% FF /50% SDF rate). In addition, TCE is currently providing the non-federal matching funds for an ongoing $500,000 Title XIX grant from CMS for ACA Section 2703 Health Homes planning, received in 2011.

The California Health Care Foundation (CHCF) is fully funding the Center for Health Care Strategies (CHCS) to assist DHCS with technical assistance on national health home best practices, CMS policy, and a roadmap for program development and decision points.

Senate Bill 75 (Chapter 18, Statutes of 2015) Section 51 established the Health Home Program Account in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds to be used for HHP implementation. Per Senate Bill 75 (Chapter 18, Statutes of 2015) Section 52: "The sum of fifty million dollars ($50,000,000) is appropriated from the Health Home Program Account to the State Department of Health Care Services for the purposes of implementing the Health Home Program established pursuant to Article 3.9 (commencing with Section 14127) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code. Notwithstanding Section 16304 of the Government Code, this appropriation shall be available for encumbrance or expenditure until June 30, 2020."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 28: OUTREACH AND ENROLLMENT EXTENSION BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Guadalupe Manriquez**, Finance Budget Analyst, DOF
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Department of Health Care Services (DHCS), Medi-Cal Eligibility Division (MCED) requests two-year limited-term special fund resources of $435,000 ($217,000 Special Deposit Fund/$218,000 Federal Fund) for the Outreach and Enrollment (O&E) Unit within MCED. The requested resources will address the workload performed by existing limited term positons that will expire on June 30, 2016.

BACKGROUND

These resources are needed to support the implementation, maintenance and oversight of the Medi-Cal outreach, enrollment, and renewal assistance work that must be carried out to meet the requirements specified in Assembly Bill (AB) 82, Chapter 23, Statutes of 2013, Sections 70 and 71, and Senate Bill (SB) 18, Chapter 551, Statutes of 2014 as extended by Senate Bill (SB) 75, Chapter 18, Statutes of 2015. The resources will be used to address workload related to collaborating with the counties, the County Medical Services Program (CMSP) Governing Board and community-based organizations in conducting outreach and enrollment activities for hard to reach populations that may be eligible for Medi-Cal, as well as renewal assistance for current Medi-Cal beneficiaries.

DHCS' mission is to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care. The Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111 -152), commonly referred to as the ACA, changed the application and renewal process for the Medi-Cal program and implemented new coverage groups based on an income methodology referred to as Modified Adjusted Gross Income (MAGI). The ACA also mandated Medi-Cal application and renewal simplifications for individuals seeking and retaining coverage; however, Medi-Cal also continues to maintain policies and procedures based on rules that are unchanged by ACA and have been in place for several decades, generally referred to as non-MAGI. The existence of new eligibility groups subject to new eligibility rules while retaining existing Medi-Cal rules and coverage groups has resulted in challenges for individuals seeking and retaining coverage for which they were otherwise eligible. One new aspect of MAGI income methodology that has caused Medi-Cal applicants and beneficiaries some confusion is the need to provide information

concerning their income, tax filing status, and tax dependent status. These are questions that were not historically asked of Medi-Cal applicants or beneficiaries.

The following state legislation created the Outreach and Enrollment and Renewal Assistance Programs, funded by The California Endowment (TCE), for the purpose of providing outreach and assistance to uninsured Californians seeking coverage, and retaining eligible individuals with in-person application and renewal assistance:

- Pursuant to AB 82, Section 70, funding in the amount of $28 million ($14 million Special Deposit Fund and $14 million Federal Funds) to the Outreach and Enrollment and Renewal Assistance Funds (Funds) for the purpose of providing payments to application assisters as compensation for their efforts in assisting individuals apply and become eligible for Medi-Cal.

- Pursuant to AB 82, Section 71, funding in the amount of $25 million ($12.5 million Special Deposit Fund and $12.5 million Federal Funds) to the funds for the purpose of outreach to, and enrollment of, targeted Medi-Cal populations. DHCS provides counties with specified grant amount and requires the funded entitles to partner with a network of community-based organizations to reach underserved communities.

- Pursuant to SB 18, funding in the amount of $12 million ($6 million Special Deposit Fund and $6 million Federal Funds) for the purpose of providing Medi-Cal renewal assistance to existing Medi-Cal beneficiaries.

- Pursuant to Section 5 of SB 101, Chapter 361, Statutes of 2013, DHCS is authorized to use the funds available to cover the administrative costs.

Covered California had an Interagency Agreement with DHCS, that provides funding for the payments to Certified Enrollment Entities (CEEs) and Certified Insurance Agents (CIAs) for in-person enrollment assistance for individuals who enroll in Medi-Cal and for costs to administer the application assistance program. Beginning July 1, 2015, Covered California implemented a new payment model for the CIAs and will no longer be providing application assistance payments to CEEs and CIAs for applications with Medi-Cal eligible individuals received after June 30, 2015. Covered California currently holds contracts with more than 900 CEEs and nearly 15,000 CIAs. Because DHCS does not have resources to contract with individual CEEs and CIAs and has not fully expended the funds for application assistance for Medi-Cal eligible individuals, the remaining funds for the application assistance program will be transferred to the county outreach and enrollment grants and will be allocated to counties in a manner determined by DHCS.

Based on current enrollment trends, DHCS estimates it will pay out an additional $7.3 million through June 30, 2015. Approximately $2.5 million (9%) in remaining funding will be transferred to the county outreach and enrollment grants. These figures represent a portion of the total combined $28 million received from TCE and matching federal funds, which would provide additional funding for county outreach and enrollment grants

currently performed by counties and community-based organizations (CBOs). In addition, recent legislation, SB 75, has further extended the timeframe for which DHCS may continue the two programs, from June 30, 2016 to June 30, 2018.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 29: HEALTH REALIGNMENT (AB 85) BUDGET CHANGE PROPOSAL

PANELISTS

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

PROPOSAL

The Department of Health Care Services (DHCS) requests one permanent position and expenditure authority of $845,000 ($423,000 General Fund (GF) and $422,000 Federal Fund (FF)), of which $734,000 would be three year limited-term, to address the ongoing administration of Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013), as amended by Senate Bill (SB) 98 (Chapter 358, Statutes of 2013).

BACKGROUND

With the implementation of Health Care Reform in January 2014, it was assumed counties would have fewer costs associated with providing care for low income populations since the State was assuming responsibility for the administration of Health Care Reform, It was further expected that State costs would increase, while county costs would decrease. To address this shift, Assembly Bill (AB) 85 laid out a process by which transfer amounts were identified, and county health realignment funds were redirected from counties to the Department of Social Services (CDSS) to offset the cost of CDSS programs.

All counties were affected by this process and each county elected a one-time option to either accept a reduction of 60%, or show that a lesser reduction would be appropriate based on cost experience of the uninsured programs in their counties using a formula developed by the State and the counties. DHCS is required to use the formula to calculate an annual redirection amount, and to perform interim and final reconciliations of data. For the counties that elected the formula option, statute requires these calculations occur annually until 2023 or until the interim redirection calculation is within 10 percent of the final reconciliation amount and the final reconciliations for two years in a row are within 5 percent of each other. DHCS SNFD administers this workload.

Additionally, AB 85 placed specific member enrollment requirements on managed care plans to ensure continuity of care and post ACA monitoring. The bill requires DHCS to work with managed care plans to ensure Designated Public Hospitals (DPH) are paid at least cost for their new Medi-Cal eligible population. These requirements added workload to MCQMD and CRDD.

Health and Safety Code section 100171 (section 100171) requires the Director of DHCS to provide a hearing process to adjudicate disputes from a variety of DHCS programs, and AB 85 allowed counties to appeal their final reconciliations. OLS attorneys and analysts represent DHCS in virtually all Office of Administrative Hearings and Appeals (OAHA) cases. Workload related to AB 85 appeals is expected to continue along with final reconciliations. SB 98 made technical corrections to provide clarification and ease the implementation to fully implement AB 85.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 30: FEDERALLY QUALIFIED HEALTH CENTERS PILOT (SB 147) BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Scott Ogus**, Finance Budget Analyst, DOF
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Department of Health Care Services (DHCS), Deputy Director's Office, requests three-year, limited-term expenditure authority of $240,000, to support the implementation, administration, and evaluation of an alternative payment methodology (APM) pilot for select California Federally Qualified Health Centers (FQHCs). pursuant to the requirements of Chapter 760. Statutes of 2015 (SB 147). One-time contract authority of $300,000 is requested in FY 2017-18, to prepare an evaluation of the pilot. The contract will be funded 50 percent Federal Funds (FF) and 50 percent reimbursement from a foundation. FY 2016- 17 expenditure authority requested: $240,000 (50% General Fund (GF)/ 50% FF). FY 2017- 18 expenditure authority requested: $540,000 ($120,000 GF/ $270,000 FF/ $150,000 reimbursement).

BACKGROUND

In recent years, FQHCs have been working to find new, more patient-centered and efficient ways to provide services, in order to meet the needs of a growing Medi-Cal patient population. There has been considerable interest across the health care delivery system to test payment and delivery reform that promotes value over volume and ultimately delivers better health outcomes for Medicaid beneficiaries. California is seeking this pilot to take steps toward delivery of high quality, cost effective care. The pilot would help FQHCs achieve the Triple Aim goals contained in the Affordable Care Act.

Currently, FQHCs are reimbursed through a federally mandated bundled prospective payment system (PPS) based on face-to-face visits with a limited number of health professionals. Under the pilot, the payor of FQHC services would transition from the state to Medi-Cal managed care plans. The pilot would assure clinics are reimbursed at no less than the PPS rate, as prescribed under federal regulations, while incenting delivery system and practice transformation at FQHCs through flexibilities available under a full capitation payment structure. The objective of the pilot is to transition the delivery of care at FQHCs from its current volume-based system to one that better aligns the financing and delivery of health care services.

This pilot, as well as the expenditures allocated to them, is based on an entirely new concept that has no existing DHCS resources assigned to it. By granting these resources, DHCS, will be able to perform the necessary monitoring, calculations, administration, and oversight of these new programs (and the populations affected by them) as outlined in the FQHC APM pilot.

In 1989, the U.S. Congress established FQHCs as a new provider type. FQHCs are public or tax-exempt entities which receive a direct grant from the federal government under Section 330 of the Public Health Service Act, or are determined by the federal Department of Health and Human Services to meet the requirements for receiving such grants. Federal law defines the services to be provided by FQHCs for Medicaid purposes and included special payment provisions to ensure that they would be reimbursed for 100% of their reasonable costs associated with furnishing these services. One of the legislative purposes in doing so was to ensure that federal grant funds are not used to subsidize health center or program services to Medicaid beneficiaries. State Medicaid programs must pay for covered services provided by FQHCs. There are over 820 FQHC locations (FQHCs may have more than one clinic location) in California.

Federal Medicaid payments to FQHCs are governed by state (Medi-Cal in California) and federal law. In December 2000, Congress required states to change their FQHC payment methodology from a retrospective to PPS. This federal law change established (for existing FQHCs) a per-visit baseline payment rate equal to 100 percent of the center's average costs per visit incurred during 1999 and 2000 which were reasonable and related to the cost of furnishing such services. States are required to pay FQHCs a per-visit rate, which is equal to the baseline PPS payment rate, increased each year by the Medicare Economic Index (MEI), and adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC during that fiscal year. Under PPS, State Medicaid agencies are required to pay centers their PPS per-visit rate (or an APM, discussed below) for each face-to-face encounter between a Medicaid beneficiary and one of the FQHCs billable providers for a covered service.

For MCP patients, DHCS is required to reimburse an FQHC for the difference between its per-visit PPS rate and the payment made by the plan. This payment is known as a "wrap around" payment. The MCP wrap-around rate was established to comply with federal and state regulation to reimburse a provider for the difference between their PPS rate and their MCP reimbursement.

FQHCs and Rural Health Clinics (RHCs) are both reimbursed under the PPS system. The average ($178.14) and median ($157.24) PPS rate paid to an FQHC and RHC in 2014-15 is considerably higher than the most common primary care visit reimbursement rates in Medi-Cal, but it also includes additional services not included in a primary care visit. Because FQHCs are required to receive an MEI adjustment to their rates under federal law, and because of their role in providing primary care access to the Medi-Cal population, FQHCs have been exempted from the Medi-Cal rate reductions.

SB 147 calls for a pilot project using an APM where FQHCs would receive per-member per month (PMPM) payments from the health plan, and would no longer receive a "wrap around" payment from DHCS. CMS has indicated a state may accept an FQHCs written

assertion that the amount paid under the APM results In payment that at least equals the amount to which the FQHC is entitled under the PPS.

The proposed APM pilot project will comply with federal APM requirements and DHCS shall file a State Plan Amendment (SPA) and seek any federal approvals as necessary for the implementation of this article. The SPA will specify that DHCS and each participating FQHC voluntarily agrees to the APM.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 31: DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM MONITORING SPRING FINANCE LETTER

PANELISTS

- **Karen Baylor**, Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Budget Analyst, DOF
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Department of Health Care Services (DHCS), Substance Use Disorder Program, Policy, and Fiscal Division (SUD PPFD), requests 8.0 permanent, full-time positions and $946,000 ($473,000 General Fund (GF)/$473,000 Federal Fund (FF)). The resources will be phased in over two fiscal years as follows:

- FY 2016-17 5.0 positions at $624,000 ($312,000 GF/$312,000 FF)

- FY 2017-18 3.0 positions at $322,000 ($161,000 GF/$161,000 FF)

BACKGROUND

The resources are needed to support fiscal oversight and programmatic monitoring requirements of the 1115 Demonstration Waiver Amendment for the Drug Medi-Cal Organized Delivery System (DMC-ODS). The DMC-ODS will demonstrate how organized substance use disorder care increases treatment benefits to DMC beneficiaries while decreasing other system health care costs. With the Centers for Medicare and Medicaid Services (CMS) approval, DHCS is required to implement all of the provisions outlined in the Special Terms and Conditions (STCs), federal managed care requirements and the State and County contracts.

The purpose of the DMC-ODS waiver is to create a continuum of care model that will provide an Organized Delivery System of SUD services modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services. The continuum of care model enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance use disorder treatment, and coordinates with other systems of health care. The DMC-ODS waiver, an amendment to DHCS' Bridge to Reform Waiver, was approved by CMS on August 13, 2015 for five and a half years. Currently, the services under DMC include outpatient, intensive outpatient, perinatal residential and methadone treatment. Counties must contract with any willing DMC certified service provider; otherwise the state must

enter into a direct contract with the treatment provider. Currently DMC is a fragmented system without a true continuum of care for Medi-Cal beneficiaries with substance use disorders.

At the beginning of 2014, DHCS began the stakeholder engagement process to solicit input to improve the DMC system. Stakeholders emphasized the need to broaden the services offered, address program integrity issues, and expand the benefit package of SUD treatment services given the federal restrictions on residential treatment services. An Expression of Interest survey was sent to all counties to gauge how many planned to opt-in during their regional phase of implementation. Fifty-three of the 58 counties expressed an interest to opt-in to the DMC-ODS waiver once approved by CMS.

The implementation of the DMC-ODS is occurring in regional phases modeled after the California Behavioral Health Director's Association boundaries for each region. Additionally, this approach gives DHCS and counties the opportunity to learn from each implementation phase and improve their submission for the next.

As of March 2016, seven counties have submitted their implementation plans (IPs) for DHCS and CMS review and approval. DHCS anticipates the experience gained from the initial IP reviews will Improve subsequent phase implementations.

Counties must submit to DHCS a plan on their implementation of the DMC-CDS. DHCS and CMS are reviewing IPs concurrently with a target of 60 days to approve or send back for adjustments. County IPs will ensure providers are appropriately certified for the contracted services, implementing at least two evidenced based practices, trained in ASAM Criteria, and participating in efforts to promote culturally competent service delivery.

Counties are not eligible for reimbursement of services without approval of the IP, state contract, and reimbursement rates by CMS and DHCS. Currently for non-waiver counties, the standard statewide DMC service rates are developed by DHCS in accordance with the Welfare and Institutions Code, Sections 14021.51, 14021.6 and 14021.9. Once established, the statewide DMC reimbursement rates are coded into the DMC billing and payment systems (Short-Doyle and SMART) so that services provided to beneficiaries in all counties are reimbursed at the same rate. However, participating waiver counties will propose their own county-specific rates, with subsequent DHCS and CMS approval.

The Waiver's STCs include many quality assurance, monitoring, and reporting requirements for participating providers, counties and the State. These activities are to ensure accountability to CMS, as well as, continued program integrity monitoring efforts to prevent waste, abuse and fraud within the DMC services. Quality assurance activities are modeled after Specialty Mental Health requirements and ensure the federal and state provisions of the Waiver are properly implemented and oversight is maintained by DHCS. For example. It will remain the State's responsibility to monitor DMC treatment providers and county adherence to the State-County Contract through fiscal and cost reporting, collecting beneficiary treatment data, and on-site compliance reviews and licensure renewal.

Two divisions within DHCS are responsible for the implementation and ongoing business requirements of the waiver; Substance Use Disorders Compliance Division (CD) and Substance Use Disorders Program, Policy and Fiscal Division (PPFD). Both divisions have been working on planning and development activities similar in nature to existing responsibilities that must be in place prior to the approval of the first County IP. CD Is the entry point for county outreach and training; ASAM designation of residential treatment programs; technical assistance on, and DHCS review of, county IPs; and liaison with CMS on county IPs. Concurrently, PPFD has been working on, and will be responsible for, drafting policy for new waiver services; waiver contract language and execution activities; business requirements, testing and training for changes to the fiscal reimbursement systems; monitoring and program integrity training for counties; and review protocols for External Quality Review Organization (EQRO) annual reports.

Existing staff in PPFD have initiated the following activities in preparation for the waiver implementation:

- Participating in weekly workgroups related to new and expanded waiver services, rate setting, IT requirements, cost report requirements, and provider database requirements;

- Conducting preliminary research and work with the Office of Legal Services on waiver contract requirements and developing draft contract documents;

- Identifying global claim adjudication rules which need to be established for the development into the Short Doyle Medi-Cal (SDMC) system to clearly identify waiver claims and differentiate from current regular DMC claims;

- Identifying system changes needed to capture the requirement that every county participating in the waiver will be reimbursed at Individually-approved interim rates;

- Developing preliminary modalities, program codes, and service codes for cost reporting purposes;

- Analyzing and developing the different processes needed for cost settlement of waiver counties using an interim rate methodology as opposed to the established methodology of settling at the lower of the provider's allowable cost of rendering the services, the provider's usual and customary charge to the general public for similar services, or the state maximum allowance for the services provided;

- Developing policy documents for new waiver services and additional treatment
- modalities;

- Developing county monitoring instrument for waiver contracts and annual review protocols;

- Developing program integrity training for county personnel; and

- Reviewing protocols for quality assurance reports from counties and EQRO reports.

Many additional tasks must be accomplished prior to implementation of waiver services and then there will be ongoing functions required to maintain the waiver program and services, separate from non-waiver program activities.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 32: MENTAL HEALTH SERVICES ACT FUNDS REAPPROPRIATION SPRING FINANCE LETTER

PANELISTS

- **Karen Baylor**, Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Lawana Welch**, Finance Budget Analyst, DOF
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

The Department of Health Care Services, Mental Health Services Division, requests reappropriation of unexpended Mental Health Services Act (MHSA) funding from fiscal years (FY) 2013-14, 2014-15, and 2015-16. The reappropriated funds will support costs to procure contracts for 1) MHSA Data Quality Assurance, 2) MHSA Data Collection, and 3) MHSD Web Re-design, Currently, the Department is unable to provide timely and accurate information for data queries from stakeholders or legislative staff. The work done will provide a foundation for easy access, query, and dissemination of information. This proposal requires budget bill language to reappropriate unexpended prior year funding.

BACKGROUND

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), which added Welfare and Institutions Code (W&IC) Section 5892. The MHSA imposes a 1 percent income tax on individuals earning over $1 million and provides funding for mental health services to individuals severely affected by or at risk of serious mental illness. Per Welfare and Institutions Code (W&IC) Section 5892(d), up to 5 percent of Mental Health Services Fund revenues may be used for state administration. Allowable costs include administrative functions performed by a variety of state entities to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services.

The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures Senate Bill 1009 (Chapter 34, Statutes of 2012) transferred functions from the former Department of Mental Health (DMH), including functions related to administration of the MHSA program, to DHCS.

As part of this transfer, a number of IT systems, including the Data Collection and Reporting (DCR) system, were migrated from the former DMH to DHCS. DHCS planned to migrate these systems in two phases. Phase 1 was the transfer of the IT systems from DMH to DHCS. Phase 2 involves a business process reengineering effort to capture

system and process efficiencies. Phase I was successfully completed on July 2013.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 33: 1115 WAIVER RENEWAL "MEDI-CAL 2020" SPRING FINANCE LETTER

PANELISTS

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

PROPOSAL

The Department of Health Care Services (DHCS), requests a combination of two-year and five-year limited-term resources of $10,818,000 ($5,409,000 General Fund /$5,409,000 Federal Fund) to support the implementation of California's new 1115 waiver, "Medi-Cal 2020". Within the expenditure authority requested, $14,200,000 will be used for contractual services over the span of 5 years.

BACKGROUND

As California continues to be a leader in implementing the Affordable Care Act (ACA), operating the nation's largest Medicaid program, Medi-Ca! 2020 will build on the efforts of California's previous 1115 waiver, "Bridge to Reform (BTR)," expanding and sustaining the delivery of high quality, cost effective care over time. The renewal of the Medicaid Waiver is a fundamental component to California's ability to continue to successfully implement the ACA beyond the primary step of coverage expansion.

Because of the successes of the last 1115 waiver, California is in a position to focus its efforts on other critical components of health care reform such as expanding access, improving health quality, equity and outcomes, and controlling the cost of care through a shift toward paying for value and outcomes instead of volume. The Medi-Cal 2020 waiver partners with the Centers for Medicare and Medicaid Services (CMS) in continuing to test innovative strategies that better coordinate care and align incentives around Medi-Cal members taking a whole-person approach to care.

With the renewal of the 1115 waiver, the efforts of the Medi-Cal program will be a transformation of the current health care delivery system and payment structure for the continued success and viability of the Medi-Cal program. The positions requested, which span over multiple divisions, will be utilized to help implement and administrate the several proposed programs of Medi-Cal 2020:

- Dental Transformation Initiative Program
- Public Hospital Redesign & Incentives in Medi-Cal Program (PRIME)
    - Alternative Payment Methodology (APM) Benchmark for PRIME Entities
- Whole Person Care Pilots

- Global Payment Program for the Remaining Uninsured
- Other requirements as set forth in the Special Terms and Conditions (STCs)

These programs, as well as the resources allocated to them, are entirely new concepts that were not included in the BTR waiver and therefore have no existing DHCS employees assigned to them. By granting these positions, DHCS will be able to perform the necessary monitoring and oversight of these new programs (and the populations affected by them) as outlined in the 1115 Waiver Special Terms and Conditions (STCs). Without these resources, the Department will be unable to perform the calculations, administration, and oversight needed to meet the STCs and significant losses in federal funding will be sustained.

Along with these programs, Medi-Cal 2020 also requires several assessments, evaluations, and achievement of benchmarks which will require significant tracking and workload. These administrative requirements include:

- Independent Hospital Assessments (2016 and 2017)
- Independent Assessment of Access
  Global Payment Program Evaluations
- Hospital Redesign and Incentives in Medi-Cal Program (PRIME) Evaluations
- Other Waiver component evaluations

Pursuant to Section 1115 of the Social Security Act, the US Secretary of Health and Human Services has broad authority to allow experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statutes." DHCS is the single State agency authorized to administer California's Medicaid program, known as Medi-Cal. The BTR 1115 Waiver enabled California to implement an early expansion of Medicaid under the Affordable Care Act, as well as provide funding for health care delivery system reform and uncompensated care in designated public hospital systems. California's entire Medi-Cal managed care program, Community-Based Adults Services (CBAS) program, and Coordinated Care Initiative are also operated under the 1115 Waiver.

The BTR 1115 Waiver expired on October 31, 2015; however, CMS authorized an extension through December 31, 2015. California received approval for a renewal to be effective January 1, 2016 for 5 more years, resulting in $6.2 billion dollars of initial federal funding, through December 31, 2020.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 34: WORKER'S COMPENSATION INFORMATION SUNSET TRAILER BILL LANGUAGE

PANELISTS

- **Karen Johnson**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, DOF
- **Amber Didier**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

This proposal eliminates the sunset provision of the operative Labor Code (LC) Section 138.7 and indefinitely extends the Department of Industrial Relations (DIR) authority to supply work-related injury or claim data from the Workers' Compensation Information System (WCIS) to the Department of Health Care Services (DHCS). This proposal also repeals the LC Section 138.7 that would have become operative on January 1, 2017 if the WCIS provisions had sunset.

BACKGROUND

DHCS is responsible for enabling compliance with state and federal law related to the legal liability of third parties to pay for a Medi-Cal beneficiary's health care, so that the Medi-Cal program is the payer of last resort. DHCS contracts with outside vendors to process worker's compensation (WC) claims and to recover Medi-Cal costs from settlements arising from work-related injuries where a liable third party exists.

In 1981, Welfare and Institutions (W&I) Code Section 14124.81 et seq. directed the State to enter into two pilot project contracts for WC third party recoveries. Initial recoveries made under these contracts consisted entirely of reimbursements from contested cases; claims filed against an insurance carrier or employer who has not accepted liability for the injuries sustained. These cases are identified using data from the Workers' Compensation Appeals Board.

In 2010, DHCS learned that DIR also compiled data on non-contested WC cases (i.e., claims filed against an insurance carrier who has accepted liability for the injuries sustained) in the WCIS. AB 2780 (Solorio, Chapter 611, Statutes of 2010) was sponsored by Health Management Systems (a WC contractor) which amended Labor Code Section 138.7 to authorize DHCS to "obtain and use individually identifiable information, as defined for the purposes of seeking recovery of Medi-Cal costs incurred by the State for treatment provided to injured workers…" However, that bill included the sunset provision date of January 1, 2017 and revisions to LC 138.7 that would become operative on January 1, 2017 if the WCIS provisions sunset.

In May 2012, DHCS entered into an interagency agreement with DIR to secure a data transfer of the WCIS file in order to identify non-contested WC cases. In November 2014,

this interagency agreement was extended through June 30, 2019, and allows DHCS's WC contractor to create liens and recover from settlement awards for non-contested cases, which they otherwise would not have been able to do.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open.