AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, FEBRUARY 7, 2022

2:30 PM, STATE CAPITOL, ROOM 447

We encourage the public to provide written testimony before the hearing. Please send your written testimony to: BudgetSub1@asm.ca.gov. Please note that any written testimony submitted to the committee is considered public comment and may be read into the record or reprinted. All are encouraged to watch the hearing from its live stream on the Assembly's website at https://assembly.ca.gov/todayevents.

The Capitol will be open for attendance of this hearing. Any member of the public attending a hearing in the Capitol will need to wear a mask at all times while in the building.

A moderated telephone line will be available to assist with public participation. The public may provide comment by calling the following toll-free number: ***877-692-8957, access code 131 54 47.***

ITEMS TO BE HEARD

LIST OF PANELISTS IN ORDER OF PRESENTATION

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
8860 DEPARTMENT OF FINANCE

ISSUE 1: COVID RESPONSE EARLY ACTION ITEMS WITHIN CDPH AND DHCS

PANEL 1 - PRESENTERS

- **Tomás Aragón**, Director, California Department of Public Health
- **Brandon Nunes**, Chief Deputy Director of Operations, California Department of Public Health
- **Susan Fanelli**, Chief Deputy Director of Policy and Programs, California Department of Public Health
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 1 – Q&A ONLY

- **Erica Pan**, Deputy Director, Center for Infectious Diseases, California Department of Public Health
- **Kathleen Jacobson**, Public Health Medical Administrator, Center for Infectious Diseases, California Department of Public Health
- **Elizabeth Basnett**, Acting Director, Emergency Medical Services Authority
- **Sonya Harris**, Senior Advisor, COVID-19 Vaccine Task Force, California Department of Public Health
- **Adam Dondro**, Deputy Secretary of Information Technology & Agency Information Officer, California Health and Human Services Agency
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Assistant Program Budget Manager, Department of Finance

- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

ISSUE 2: OFFICE OF HEALTH CARE AFFORDABILITY

PANEL 2 – PRESENTERS

- **Elizabeth Landsberg**, Director, Department of Health Care Access and Information
- **Ryan Buckley**, Chief Counsel, Department of Health Care Access and Information
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 2 – Q&A ONLY

- **Vishaal Pegany**, Assistant Secretary, California Health and Human Services Agency
- **Michael Valle**, Deputy Director, Department of Health Care Access and Information
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 3: HOSPITAL EQUITY REPORTING (AB 1204) – BUDGET CHANGE PROPOSAL

PANEL 3 – PRESENTERS

- **Michael Valle**, Deputy Director, Department of Health Care Access and Information

PANEL 3 – Q&A ONLY

- **Scott Christman**, Chief Deputy Director, Department of Health Care Access and Information
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 4: HEALTH CARE DEBT AND FAIR BILLING – DISCOUNT PAYMENT AND CHARITY CARE POLICIES ENFORCEMENT (AB 1020) – BUDGET CHANGE PROPOSAL

PANEL 4 – PRESENTERS

- **Ryan Buckley**, Chief Counsel, Department of Health Care Access and Information

PANEL 4 – Q&A ONLY

- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 5: SKILLED NURSING FACILITIES: ANNUAL CONSOLIDATED FINANCIAL REPORT (SB 650) – BUDGET CHANGE PROPOSAL

PANEL 5 – PRESENTERS

- **Michael Valle**, Deputy Director, Department of Health Care Access and Information

PANEL 5 – Q&A ONLY

- **Ty Christensen**, Health Program Audit Manager II, Department of Health Care Access and Information
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

4800 HEALTH BENEFITS EXCHANGE (COVERED CALIFORNIA)

ISSUE 6: AFFORDABILITY OPTIONS REPORT – OVERSIGHT

PANEL 6 – PRESENTERS

- **Katie Ravel**, Director, Policy, Eligibility and Research Division, Covered California
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 6 – Q&A ONLY

- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 7: CALRX AND MEDI-CAL RX – OVERSIGHT

PANEL 7 – PRESENTERS

- **Vishaal Pegany**, Assistant Secretary, California Health & Human Services Agency
- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL 7 – Q&A ONLY

- **René Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Assistant Program Budget Manager, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ITEMS TO BE HEARD

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
8860 DEPARTMENT OF FINANCE

OVERVIEW

This issue covers the California Department of Public Health (CDPH) and Department of Health Care Services (DHCS) components of the proposed early action package. Formally, this package of proposals will be reviewed and acted on outside of Subcommittee #1; nevertheless, this is an opportunity for the Subcommittee to thoroughly review just these components.

ISSUE 1: COVID RESPONSE EARLY ACTION ITEMS WITHIN CDPH AND DHCS

PANEL – PRESENTERS

- **Tomás Aragón**, Director, California Department of Public Health
- **Brandon Nunes**, Chief Deputy Director of Operations, California Department of Public Health
- **Susan Fanelli**, Chief Deputy Director of Policy and Programs, California Department of Public Health
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL – Q&A ONLY

- **Erica Pan**, Deputy Director, Center for Infectious Diseases, California Department of Public Health
- **Kathleen Jacobson**, Public Health Medical Administrator, Center for Infectious Diseases, California Department of Public Health
- **Elizabeth Basnett**, Acting Director, Emergency Medical Services Authority
- **Sonya Harris**, Senior Advisor, COVID-19 Vaccine Task Force, California Department of Public Health
- **Adam Dondro**, Deputy Secretary of Information Technology & Agency Information Officer, California Health and Human Services Agency

- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Katherine L. Clark**, Assistant Program Budget Manager, Department of Finance
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Assistant Program Budget Manager, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

The following COVID-related and non-COVID-related proposals are included in the early action bills:

COVID-Related Components:
$1,624,710,000 General Fund is included to cover CDPH COVID response costs that will be incurred in the second half of the current fiscal year (January – July of 2022), that were not assumed in the 2021 Budget Act. The administration anticipates that the state will be reimbursed for some of these costs by the Federal Emergency Management Agency (FEMA). These costs reflect the following ongoing and expanded response activities that have primarily resulted from the Omicron variant:

Vaccinations -- $399,132,000
This includes: boosters, appointment assistance, expanded vaccination work by community-based organizations, targeted public awareness and information, support for health care providers, mobile vaccine teams, pop-up vaccination clinics, supplies and administration.

Testing -- $599,173,000

This includes:

1. Over-the-counter antigen tests (approximately $200 million);
2. OptumServe testing sites – expansion to the current number;
3. Schools' testing vendors – expansion to hours of operation and broader community reach;
4. Community-Based Organizations – expansion to broader community reach;

5. Request for Innovations – production and manufacturing of point-of-care tests for COVID, flu, and other diseases, in order to ensure a secure pipeline for over-the-counter tests;
6. Lab processing time – exploring "release valves" to accelerate test processing times such as through UCLA and UCD labs;
7. Lab technology – exploring the test processing technology being used in labs with faster turn-around times; and
8. Vending machines – exploring the use of antigen test vending machines.

Test Kits for Schools

Outside of the early action funding, the administration has also begun purchasing 30 million additional test kits to be distributed to schools, utilizing $238 million in unexpected 2021 Budget Act savings in the DHCS budget, which will be reimbursed by FEMA. CDPH is responsible for the distribution of these test kits to schools, and the administration expects to have received the full supply by the middle of February.

Contact Tracing - $18,182,000

This includes establishment of a new Public Health Reserve Corps (PHRC) to employ, as volunteers, state employees as case investigators, contact tracers, outbreak investigators, and contact tracing school specialists for 90-day stints. PHRC Strike Teams will be called on to be deployed to support Local Health Jurisdictions at any time.

Surge Staffing -- $486,682,000

This includes funding for the state to help support surge capacity staffing in emergency rooms throughout the state.

Operational Support -- $56,556,000

To address ongoing public demand for information, these resources will support service agreements to answer phones, respond to text messages and web chats from the public.

Information Technology – $64,985,000

These resources are to maintain and operate technology infrastructure developed in response to COVID to support contact tracing, vaccine management and disease surveillance on a large scale. The pandemic lead to an exponential increase in the need for storage, serve compute, and network bandwidth, all of which needs to be maintained in order to respond to future public health emergencies or large-scale disasters.

Areas of Expenditure	2021 Budget Act	Incremental Budget Alignment	2021-22 Supplemental Appropriation**	2021-22 Projections as of 2022-23 Governor's Budget
Vaccinations	$ 149,600,000	$ -	**$ 399,132,000**	$ 548,732,000
Testing	$ 625,163,000	$ (395,000,000)	**$ 599,173,000**	$ 829,336,000
Contact Tracing	$ 2,408,000	$ -	**$ 18,182,000**	$ 20,590,000
Staffing	$ 209,286,000	$ -	**$ 486,682,000**	$ 695,968,000
Operations Support	$ 93,474,000	$ -	**$ 56,556,000**	$ 150,030,000
IT Pandemic Response	$ -	$ 220,000,000	**$ 64,985,000**	$ 284,985,000
Border Activities	$ 360,000,000*	$ -	**$ -**	$ 360,000,000
Control Section 11.91	$ -	$ 175,000,000	**$ -**	$ 175,000,000
TOTALS	***$ 1,439,931,000***	***$ -***	***$ 1,624,710,000***	***$ 3,064,641,000***

*Funds authorized in 2020-21 per Executive Order E20/21-274 for continuous appropriation without regard to fiscal year, pursuant to Government Code section 8690.6

**Includes an additional $386 million in testing, $8 million in staffing, and $6 million in IT pandemic response.

The California Hospital Association urges the Legislature's support for the Governor's proposed COVID response resources described here, but also requests an augmentation to the surge staffing resources, stating:

> "Of particular significance is the additional $478 million, plus an omicron supplement of $8 million (for a total of $486 million), in the current year for hospital and medical surge activities. These need to be adopted and augmented to allow the state to deploy additional ambulance patient offload time (APOT) teams soon and over the next months to ensure all patients get the emergency care they need. These hospital and medical surge funds will enable CDPH, in partnership with the California Emergency Medical Services Authority (EMSA), to continue to deploy critical personnel to hospitals. With these proposed and additional resources, more APOT teams could be deployed to hospitals to decompress emergency departments and improve patient access to emergency care."

Non-COVID-Related Components:

CDPH

There are two CDPH items unrelated to COVID in SB 115. Specifically, this bill:

1. Implements AB 45 (Aguiar-Curry, Chapter 576, Statutes of 2021), which requires CDPH to regulate hemp products. This bill had an urgency clause, but no appropriation, thereby requiring immediate implementation without any resources. The early action bill includes $1.6 million and 11 positions for the current year to implement AB 45.

2. Provides an exemption from the Public Contracts Code for the California Reducing Disparities Project, which was funded in the 2021 Budget Act in order to continue the existing Phase 2 contracts. The current contracts expire in April and it would not be possible to continue them without this exemption.

DHCS/MHSOAC

This bill contains one provision under DHCS, which is an amendment to control section 11.96, to swap Federal State Fiscal Relief Fund (SFRF) funds (included in the 2021 Budget Act) with Mental Health Services Fund (MHSF, Proposition 63) dollars, so that the Mental Health Services Oversight and Accountability Commission (MHSOAC) will receive MHSF instead of either federal funds or General Fund. The administration explains that the 2021 Budget Act projected receipt of more federal relief funds than were actually received, and therefore this temporary gap in federal funds is being backfilled with General Fund for various programs. For the MHSOAC specifically, MHSF is being used instead of General Fund (and General Fund is backfilling the MHSF) in order to create consistency and administrative efficiencies at the MHSOAC. This $100 million swap in funds appears in SB 115 under a DHCS item (4260-112-0001) because DHCS is the MHSF administrator. This amendment also shifts $15 million from local assistance to state operations, to allow for sufficient staff support for the Mental Health Student Services Program at the MHSOAC.

The following explanation of the need for these fund swaps can be found on page 158 of the Governor's Budget Summary:

> "States that lost revenue due to the pandemic, as calculated pursuant to interim U.S. Treasury regulations, are permitted to use an amount of SFRF equivalent to their lost revenue to fund government services. At the 2021 Budget Act, Finance estimated the state's revenue loss to be $9.2 billion. As of the Budget, Finance re-evaluated the methodology to calculate California's revenue loss and now estimates the revenue loss to be $11.2 billion, or about $2 billion more than the 2021 Budget Act estimate.
>
> To maximize funding flexibility and streamline federal reporting activities, the Administration proposes shifting $1.8 billion of programs funded by the SFRF to either the General Fund or other state funds. This proposal results in no net General Fund costs, since this shift would be offset with a like amount of savings resulting from the additional $2 billion in revenue replacement funding. The proposal also will not change total funding levels for any of the impacted programs."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH and DOF to present these components of the early action package and respond to any questions of the Subcommittee members.

Staff Recommendation: No action is recommended as this is an oversight issue.

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

ISSUE 2: OFFICE OF HEALTH CARE AFFORDABILITY

PANEL – PRESENTERS

- **Elizabeth Landsberg**, Director, Department of Health Care Access and Information
- **Ryan Buckley**, Chief Counsel, Department of Health Care Access and Information
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL – Q&A ONLY

- **Vishaal Pegany**, Assistant Secretary, California Health and Human Services Agency
- **Michael Valle**, Deputy Director, Department of Health Care Access and Information
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

The Governor's budget includes proposed trailer bill, and a re-appropriation of resources that were included in the 2021 Budget Act, to establish an Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI).

As of the writing of this agenda, the administration had not yet provided the proposed trailer bill to the legislature. Nevertheless, it can be reasonably assumed that it will be similar to the administration's OHCA proposal last year, which included the following:

1. *Set Health Care Cost Targets*: The Director shall establish a statewide health care cost target and will also set targets by health care sector and geographic region, which may include by payer, provider, insurance market or line of business. These targets will be based on the recommended targets set by the Health Care Affordability Advisory Board public hearings and public comments prior to formally adopting the targets.

2. *Increase Cost Transparency through Annual Report and Public Meeting*: The Program shall collect and analyze data from existing and emerging public and private data sources to publicly report total health care spending and factors contributing to health care cost growth, including in the pharmaceutical sector. The Program shall publish an Annual Report and conduct public hearings to inform the Health Care Affordability Advisory Board, policymakers including the Governor and Legislature, and the broader public about performance against the cost target, cost trends and actionable recommendations for mitigating cost growth.

3. *Enforcement of the Cost Target*: The Program, through a progressive enforcement mechanism, shall oversee the state's progress towards the health care cost target by providing technical assistance, requiring public testimony, requiring submission of corrective action plans, monitoring progress within corrective action plans, and assessing civil penalties, including escalating civil penalties for noncompliance.

4. *Promote and Measure Quality and Health Equity*: In consultation with other state departments, external quality improvement organizations and forums, payers, physicians and other providers, the Program shall utilize HCAI data, as well as data collected by other departments, and adopt a priority set of standard quality measures for evaluating the spending of health care service plans, health insurers, hospitals, and physician organizations, with consideration for minimizing administrative burden and duplication.

5. *Advance and Monitor Adoption of Alternative Payment Models (APM):* The Program shall promote the shift from payments based on fee-for-service to those rewarding high quality and cost-efficient care. In furtherance of this goal, the Program shall set statewide goals for the adoption of APMs and measure the state's progress. In addition, the Program shall develop standards for APMs that may be used by payers and providers during contracting.

6. *Advance Standards for Health Care Workforce Stability and Training Needs*: The Program shall monitor the effects of cost targets on health care workforce stability, high-quality jobs, and training needs of health care workers. To assist health care entities in implementing cost-reducing strategies that advance the stability of the health care workforce, and without exacerbating existing health care workforce shortages, the Program shall develop standards in consultation with the Health Care Affordability Advisory Board.

7. *Address Consolidation and Market Power*: The Program shall monitor cost trends, including conducting research and studies, on the health care market including, but not limited to, consolidation and market power on competition, prices, access, and quality. In collaboration with the Attorney General, Department of Managed Health Care and California Department of Insurance, as appropriate, the Program shall promote competitive health care markets by examining mergers, acquisitions,

or corporate affiliations that entail a material change to ownership, operations or governance structure involving health care service plans, health insurers, hospitals or hospital systems, physician organizations and/or pharmacy benefit managers, and other health care entities. The review of proposed material changes by the Program is not intended to supplant the role of the Attorney General but provide increased bandwidth for examining these market issues through dedicated staff performing rigorous data analysis.

Should the administration release the 2022 proposed trailer bill for this proposal in sufficient time, staff will provide the Subcommittee with a more detailed analysis of it prior to the hearing on February 7th.

BACKGROUND

Massachusetts, Rhode Island, Delaware, and Oregon have implemented health care cost targets, with the goal that transparency-based, public reporting can reduce cost growth and better data and analytics can inform cost containment efforts. For all four states, a program for a health care cost target requires collecting data on total health care expenditures (all claims and non-claims based payments to providers, cost-sharing paid by consumers, and administrative costs and profits) and performing data analysis on cost trends by dimensions such as service category, payer, and provider. Given that the goal is an affordable high-value system, not just a low-cost system, each state program also simultaneously monitors performance on quality of care measures.

All Payer Claims Database

AB 80 (2020 budget trailer bill) provided the Office of Statewide Health Planning and Development (OSHPD, now HCAI) the authority to establish the Health Care Payments Database (HPD), often referred to as an All Payer Claims Database. The HPD will be a large research database derived from individual health care payment transactions. Similar to other states that have already implemented an HPD, this database will be used to analyze total health care expenditures and allow for deeper data dives on cost drivers and high cost service categories, such as diabetes treatment and specialty drug prices.

The proposal for an Office of Health Care Affordability builds on efforts in other states to reduce costs, such as the Massachusetts Health Policy Commission (HPC), which was established in 2012 with the charge of setting a health care cost target, monitoring health care spending and providing data-driven policy recommendations regarding health care delivery and payment system reform.

2020 Budget Proposal

The administration included a proposal to establish OHCA in the 2020 Governor's Budget, but that proposal was not pursued due to the pandemic.

2021 Budget Proposal

The Governor again proposed to establish OCHA in his proposed January 2021 budget with both trailer bill and a Budget Change Proposal (BCP), which requested 58 positions and $11.2 million in 2021-22, 106 positions and $24.5 million in 2022-23, 123 positions and $27.3 million in 2023-24, and annually thereafter from the California Health Data and Planning Fund to establish the Health Care Affordability Program.

For 2021-22, fifty-eight (58) key staff positions were requested to establish the Program. For subsequent years, the phase-in of staffing was expected to grow to 106 staff positions in 2022-23 and 123 staff positions in 2023-24.

This request also included $1,650,000 in 2021-22, $1,150,000 in 2022-23, and $900,000 in 2023-24 and annually thereafter in information technology costs. It also included $1,300,000 in 2021-22, $3,350,000 in 2022-23, and $2,850,000 in 2023-24 and annually thereafter in contracting resources.

This BCP was approved and the resources were included in the 2021 Budget Act, however the proposed trailer bill was not approved last year. Therefore, new trailer bill, and a re-appropriation of these resources, are included in the Governor's 2022 proposed budget.

AB 1130 (Wood, 2021)

In 2021, AB 1130 (Wood) contained the same proposal as the administration's proposed trailer bill. AB 1130 is a 2-year bill and is currently in the Senate Health Committee.

Stakeholder Support

There is substantial stakeholder support for this proposal by labor, health-related advocacy organizations, and others due to the significant impacts of the high costs of health care on Californians. Supporters of this proposal generally believe that the proposed Office holds the most potential for ensuring that the benefits of reform actually reach consumers, employers, workers, and taxpayers.

Concerns Raised By Hospitals

The California Hospital Association and the California Children's Hospital Association shared their concerns that the following principles are followed in creation of the OHCA:

1. **"All-in**: Every sector of health care must play a role in the work to hold cost growth in check. No health care entity should be held to a special standard or different level of accountability. The state also must recognize that underfunding of health care via Medi-Cal and Medicare means that commercial insurance premiums and other out-of-pocket costs go up to cover that shortfall.

2. **Preserve access and quality**: Cost targets should be based on a per capita basis and address the rate of growth, not cut existing health care spending levels. All

providers should also work toward the same targets, not separate targets (or sectors). Creating different targets among providers can result in high-risk patients getting shuffled to providers seeking to avoid tripping cost growth targets.

3. **Supportive, not punitive**: Any enforcement processes should be collaborative and productive. The office should not default into accelerating enforcement actions and should afford reasonable opportunities for any health care entity that fails to meet a target to correct their actions or justify why they did not meet a target (e.g., new labor contracts, medical technology, high-cost drugs, required capital investments).

4. **Data-driven**: Decisions must be informed by data and analysis — not predetermined requirements that impose sector or geographic-based targets."

The Association of California Health Care Districts has an "oppose unless amended" position on this proposal, and provided the following explanation:

> "ACHD is particularly concerned with the development of cost targets and growth restrictions without adequate data and a thorough stakeholder process to set such targets. Additionally, we are concerned that cost targets that take a one size fits-all approach and may not always be achievable, especially for our small rural, critical access facilities where access to care is already a challenge. We encourage efforts to address cost concerns be thoughtful, deliberate and data driven with engagement for all segments of the health care system including all types of providers, insurers, and consumer organizations. Healthcare districts operate stand-alone facilities, serving primarily rural and urban underserved communities, and are often the only provider in their community. Healthcare districts often lack the resources of larger health systems and have significant concerns at the adverse and disproportionate effects these targets may have on their ability to deliver care."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests HCAI present this proposal and respond to the following:

1. What are the most significant (if any) differences between this year's and last year's proposed trailer bill?
2. Please respond to the concerns raised by hospitals, and any other stakeholder concerns the administration is aware of at this time.
3. Please explain how the OHCA will ensure that the proposed cost targets do not have a negative impact on either access to, or quality of, care.

Staff Recommendation: Hold this item open to allow for further review, analysis, and discussions with stakeholders.

ISSUE 3: HOSPITAL EQUITY REPORTING (AB 1204) – BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Michael Valle**, Deputy Director, Department of Health Care Access and Information

PANEL – Q&A ONLY

- **Scott Christman**, Chief Deputy Director, Department of Health Care Access and Information
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

HCAI requests 2.0 positions and $366,000 in 2022-23, 4.0 positions and $1,073,000 in 2023-24, 5.0 positions and $1,223,000 in 2024-25, and 5.0 positions and $861,000 in 2025-26 and annually thereafter from the California Health Data and Planning Fund to implement the Hospital Equity Reporting requirements pursuant to AB 1204 (Wicks, Chapter 751, Statutes of 2021).

BACKGROUND

AB 1204 creates the Medical Equity Disclosure Act requiring hospitals to file an annual equity report with HCAI and to also post it on their websites. The equity report would include measures on patient access, quality, and outcomes by race, ethnicity, language, disability status, sexual orientation, gender identity, and payor. The first equity reports are due by September 30, 2025, or, if later, 12 months after the release of the federal Centers for Medicare and Medicaid Services' (CMS) health equity quality measures for their proposed rules for other Medicare prospective payment systems. The report will also include a plan to prioritize and address disparities for vulnerable populations identified in the data and as specified by the Advisory Committee.

In addition to the new data collection, HCAI is required to convene a Health Care Equity Measures Advisory Committee (Advisory Committee), to provide recommendations on the development of measures and on the measurable objectives and specific timeframes

for hospitals to develop their plans to prioritize and address disparities for vulnerable populations identified in the data.

Lastly, this bill expands the definition of vulnerable populations for reporting of community benefits by private not-for-profit hospitals to include underrepresented racial and ethnic groups as well as socially disadvantaged groups as defined.

HCAI requests 2.0 full time positions in FY 2022-23, expanding to 5.0 full time positions in FY 2025 26 and ongoing thereafter to implement the requirements of AB 1204. Given the first reports are not due until 2025, HCAI is staggering the hiring to reflect the needs of the program as follows:

In FY 2022-23 and ongoing 2.0 PYs would consist of:

- Health Program Specialist I in the Enterprise Data Operations Branch
- PY Research Scientist II within the Administrative Data Group

In FY 2023 –24 and ongoing 3.0 more PYs would be added:

- Associate Governmental Program Analyst in the Enterprise Data Operations Branch
- PY Information Technology Specialist I to support the Program in data application changes, engineering, and maintenance
- Associate Governmental Program Analyst in the Enterprise Data Operations Branch

HCAI also requests in FY 2023-24 and FY 2024-25, $360,000 to contract for IT consulting to modify existing data capture, storage and management solutions. The consultant scope will include task and schedule planning, data analysis and related design work, technical integration of new data fields, testing (including regression testing) and modifications to reports as needed for compliance.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests HCAI present this budget change proposal, and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open for additional time for review and analysis.

ISSUE 4: HEALTH CARE DEBT AND FAIR BILLING – DISCOUNT PAYMENT AND CHARITY CARE POLICIES ENFORCEMENT (AB 1020) – BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Ryan Buckley**, Chief Counsel, Department of Health Care Access and Information

PANEL – Q&A ONLY

- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

HCAI requests 16 positions and $3.9 million ($1.9 million General Fund) in expenditure authority in Fiscal Year (FY) 2022-23, 18 positions and $3.6 million ($1.8 General Fund) in 2023-24, and $3.6 million ($1.8 General Fund) annually thereafter to support program services associated with the implementation of AB 1020 (Friedman, Chapter 473, Statutes of 2021).

BACKGROUND

Since 2008, HCAI has collected Hospital Fair Pricing Policies, procedures, and application forms. These documents spell out when and how a patient qualifies for discounted or free care. Each document is submitted to HCAI through a web-based application. Each document is reviewed by a Health Program Auditor for compliance with minimum statutory requirements, and then released to the public via the web-based application's internet web page.

AB 1020 expands HCAI's existing data collection effort by creating new notice requirements for hospital discount payment and charity care policies, limitations on the sale of patient debt, and penalties for violations. HCAI is required to promulgate regulations for the enforcement of Article 1 (Hospital Fair Pricing Policies, §§ 127400 — 127446) of Chapter 2.5, Part 2, Division 107 of the Health and Safety Code by, and the Director of HCAI to commence enforcement on, January 1, 2024. The regulations shall establish a process for receipt of complaints, criteria for determining penalty amounts, and an appeals process for administrative penalties.

AB 1020:

- Creates new requirements that prohibit hospitals from selling patient debt unless specified conditions are met;
- Extends adverse credit reporting and commencement of civil action from 150 to 180 days after initial billing and requires debt collectors to certify that the patient has been screened for public health coverage programs and financial assistance before filing a lawsuit;
- Raises the income level for financial assistance from 350 percent of the federal poverty level (FPL) to 400 percent FPL; and
- Allows patients to file complaints with HCAI, which triggers a series of actions that HCAI must take to investigate that complaint. If a violation is determined, HCAI is to assess a penalty of up to $40,000, which increases over time based on the Consumer Price Index for medical care. It also provides for an appeals process for hospitals to appeal a determination made by HCAI.

HCAI requests a total of 18.0 positions to implement the provisions of this bill as follows:

In FY 2022-23 and ongoing 16.0 PYs

- Staff Services Manager II (1.0)
- Associate Governmental Program Analyst (1.0)
- Staff Services Analyst (1.0)
- Associate Health Program Advisors (4.0)
- Assistant Chief Counsel (1.0)
- Attorneys III (2.0)
- Attorneys (2.0)
- PY Information Technology Specialist I (2.0)
- PY Information Technology Associate (1.0)
- Associate Governmental Program Analyst (1.0)

In FY 2023-24 and ongoing 2.0 additional PYs would be added:

- Accounting Officer Specialists (2.0)

Information Technology Resources:

Information Technology resources are needed in FY 2022-23, including $750,000 to contract for business analysis, system software engineering, and continuous operation to engineer and maintain technology systems to support the program, with ongoing costs of $250,000 in FY 2023-24 and ongoing.

Additional Contract Resources:

Additional contract resources are needed in FY 2022-23 and ongoing, including $25,000 to contract for the written translation and verbal interpreter services necessary to prepare forms and materials in multiple languages, support review of patient complaints, and provide meaningful access for limited English proficiency consumers.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests HCAI present this budget change proposal, provide a justification for the significant number of new positions being requested, and respond to any other questions raised by the Subcommittee.

Staff Recommendation: Hold open to allow for additional review and analysis.

ISSUE 5: SKILLED NURSING FACILITIES: ANNUAL CONSOLIDATED FINANCIAL REPORT (SB 650) – BUDGET CHANGE PROPOSAL

PANEL – PRESENTERS

- **Michael Valle**, Deputy Director, Department of Health Care Access and Information

PANEL – Q&A ONLY

- **Ty Christensen**, Health Program Audit Manager II, Department of Health Care Access and Information
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

HCAI requests 4.0 positions and $1,433,000 expenditure authority in Fiscal Year (FY) 2022-23, and 6.0 positions and $1,209,000 expenditure authority in FY 2023-24, and $955,000 expenditure authority ongoing from the California Health Data and Planning Fund to implement SB 650 (Stern, Chapter 493, Statutes of 2021).

BACKGROUND

HCAI is currently required to develop and maintain uniform systems of accounting and reporting for licensed skilled nursing facilities (SNFs). Each of the approximately 1,100 SNFs licensed by the California Department of Public Health are required to submit to HCAI a Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report (Cost Report) within four months of the facility's fiscal year end. The report contains a balance sheet, statement of income, statement of cash flows, statement detailing patient revenue by payer, as well as many supporting detailed worksheets.

HCAI collects and reviews financial report data submitted by individual SNFs. Annual reports are prepared by SNFs using HCAI-approved software and uploaded directly to HCAI's electronic reporting and auditing system. Reports are reviewed for completeness, accuracy, and compliance with HCAI's uniform systems of accounting and reporting. Copies are made available on HCAI's website, as well as in downloadable data sets.

SB 650 requires organizations that operate, conduct, own, manage, or maintain one or more SNFs to prepare and file with HCAI a consolidated financial report which includes the same set of financial statements currently submitted individually by each SNF. Each consolidated report must be reviewed by a Certified Public Accountant, or if an audited consolidated financial report already exists, that audited version must be submitted. The consolidated report must also detail the same financial statements for each operating entity, license holder, and related party.

The bill states that HCAI would not be required to determine if the consolidated report, including individual financial statements for each SNF, is accurate. However, HCAI is required to audit the current individual SNF financial statements submitted according to current law, including the related party profit and loss statements. With the new reports submitted after review by a CPA, HCAI would be required to act on this information, identifying any inconsistencies, and including those inquiries in HCAI's current desk audit of individual SNF financial reports.

HCAI requests a total of 6.0 positions to implement the provisions of this bill as follows:

In Fiscal Year 2022-23 and ongoing 4.0 PYs including:

- Health Program Auditor IV to design and maintain the accounting, reporting, and auditing system for related entity and consolidated reporting, including development and maintenance of program regulations (1.0 PY).
- Health Program Auditor III will be required to establish audit procedures and lead the staff level auditors in the review of submitted reports to determine completeness (1.0 PY).
- Staff Services Analyst is required to assist in the creation and maintenance of regulations, identify entities required to report, establish and maintain secure system accounts, and produce compliance records and reports (1.0 PY).
- Information Technology Specialist to support the program in data application changes, engineering, maintenance, and continuous operations (1.0 PY).

In Fiscal Year 2023-24 and ongoing 2.0 additional PYs would be added:

- Health Program Auditor II is required to review submitted reports for completeness and compliance with the established reporting requirements (2.0 PY).

Information Technology Resources:
Information Technology contracting resources are requested in Fiscal Year 2022-23 of $750,000 and in Fiscal Year 2023-24 of $250,000 to modify existing data capture, storage and management solutions. Consultant scope will include: task and schedule planning,

data analysis and related design work, technical integration of new data fields, testing (including regression testing) and modifications to reports as needed for compliance.

STAFF COMMENTS/QUESTIONS

As described above, HCAI currently receives financial reports from SNFs, and will be receiving additional financial reports from SNFs and related companies and organizations as a result of SB 650. However, while HCAI collects this significant supply of financial data, and makes this data and information available to the public, HCAI does not perform any analysis of the information themselves. Particularly in light of the pandemic, and the significant loss of life in SNFs due to COVID, there is a very robust policy discussion underway in California on how to improve the quality of care and safety in SNFs. Many experts on long-term care and patient advocates contend that increased staffing leads to increased quality of care in SNFs, yet California's SNF industry argues that while they would like to increase the staffing levels, they cannot afford to in light of their primary source of revenue being low Medi-Cal rates. In fact, Medi-Cal rates only cover 95 percent of SNF labor costs. Advocates typically assert that, despite low Medi-Cal rates, SNFs are highly profitable and therefore can afford to offer higher wages and hire more staff if they so desired.

While academic researchers and advocates likely obtain and analyze the financial information that SNFs report to HCAI, the legislature might consider it valuable to have the state itself analyze this data in order to advance the state's understanding of the fiscal condition of this industry. Such an analysis could help shape both policy and budget decisions, ultimately improving the quality of care in SNFs.

The Subcommittee requests HCAI present this budget change proposal, respond to the staff comments above, and answer any other questions raised by the Subcommittee.

Staff Recommendation: Hold open to allow for additional review and analysis.

4800 HEALTH BENEFITS EXCHANGE (COVERED CALIFORNIA)

ISSUE 6: AFFORDABILITY OPTIONS REPORT – OVERSIGHT

PANEL – PRESENTERS

- **Katie Ravel**, Director, Policy, Eligibility and Research Division, Covered California
- **Luke Koushmaro**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL – Q&A ONLY

- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Adam Dorsey**, Program Budget Manager, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

AFFORDABILITY OPTIONS REPORT – OVERSIGHT

American Rescue Plan

In March 2021, President Biden signed the American Rescue Plan (ARP), which makes a significant investment in advance premium tax credits (APTC) to improve affordability for consumers seeking health care coverage in health benefit exchanges, including Covered California. For the 2021 and 2022 plan years, the ARP removes the income eligibility cap on APTC premium subsidies, which previously limited subsidies to individuals at or below 400 percent of the FPL. The ARP provides subsidies so that no individual at any income level will have to pay more than 8.5 percent of their income for a silver plan in an ACA marketplace, such as Covered California. In addition, no individual with income below 150 percent of the FPL, or any individual that receives unemployment insurance payments at any point in 2021, will pay any premiums at all for silver level coverage.

As a result of the more generous subsidies provided by the ARP, the three-year state premium subsidy program implemented by the 2019 Budget Act was subsumed by the new federal subsidies. The state subsidy program was designed to limit individuals between 400 and 600 percent of the FPL to spending between 9.68 percent and 18 percent of income on premiums. Because the ARP caps premiums at 8.5 percent for all income levels, no state premium subsidy is necessary to reach the required contribution levels included in the state premium subsidy design. As a result, the 2021 Budget Act reverted General Fund expenditure authority of $405.6 million in 2021-22 to reflect

savings in the state subsidy program resulting from the more generous federal premium subsidies.

Build Back Better Act

Pending federal legislation, the Build Back Better Act, would permanently extend the generous federal premium subsidies implemented by the ARP and set to expire in the 2023 coverage year. Permanent extension of the federal ARP subsidies would continue to subsume the state's previously enacted state subsidy program, allowing those resources to be devoted to additional support to make coverage more affordable such as yet more generous premium subsidies, or subsidies to reduce or eliminate deductibles, co-pays, or other cost-sharing. If the ARP subsidies are not extended, the state would likely need to consider implementation of a replacement subsidy program to prevent a drastic increase in premiums year-over-year and a concomitant reduction in take-up of coverage in the exchange. Covered California estimates failure to extend the ARP subsidies would result in a loss of $1.6 billion annually in premium support to California consumers.

In addition to the extension of premium subsidies, the Build Back Better Act also includes $10 billion annually for three years for states to implement programs to reduce consumer cost-sharing. While these funds would only be available for three years, passage of Build Back Better would represent a substantial investment in reducing deductibles, co-pays, and other cost-sharing.

Health Care Affordability Reserve Fund and Marketplace Affordability Report

The 2021 Budget Act also included trailer bill language to establish the Health Care Affordability Reserve Fund, as well as a transfer of General Fund resources of $333.4 million, which is the revenue the Administration estimates the state will receive from the individual mandate penalty. The reserve fund was meant to provide available resources to support state subsidies if the more generous federal subsidies are not extended beyond the 2022 coverage year, or if the state implements future health care affordability measures.

In addition to establishing the fund, the trailer bill language required Covered California to prepare a report by January 1, 2022, with options for utilizing the Health Care Affordability Reserve Fund to further improve affordability or cost-sharing requirements, including timelines and system requirements for implementation.

Bringing Care Within Reach

In January 2022, Covered California released its report, titled "Bringing Care Within Reach – Promoting California Marketplace Affordability and Improving Access to Care in 2023 and Beyond." The report included options for use by policy makers under three potential scenarios:

1. ***American Rescue Plan premium subsidies expire after 2022*** – In this scenario, the state would need to evaluate options to backfill the loss in federal premium support to avoid drastic increases in consumer premium costs.

2. ***American Rescue Plan premium subsidies are extended with federal cost-sharing support*** – In this scenario, the state would continue to benefit from generous ARP subsidies and significant additional federal resources would be available to support cost-sharing reduction subsidies for three years.

3. ***American Rescue Plan premium subsidies are extended without federal cost-sharing support*** – In this scenario, the state would need to consider utilizing its own funds to implement a cost-sharing reduction subsidy program.

In general, the report focuses on scenarios 2 and 3 in which the ARP premium subsidies are extended with or without federal cost-sharing support, respectively. The report acknowledges that if ARP subsidies are not extended, the loss of $1.6 billion in federal premium support would require the state to consider revisiting its investment in state premium subsidies to mitigate a drastic increase in consumer costs and a significant drop in affordability and uptake of coverage in the exchange.

The report provides various options for cost-sharing reduction subsidies and estimates three levels of cost estimates for each option based on the level of plan switching that occurs due to changes in cost-sharing provisions. The report provides an illustration of seven options, four of which could be supported by the $333.4 million in the Health Care Affordability Reserve Fund, and three of which could be supported with additional federally-funded cost-sharing reduction subsidies, such as those contained in the Build Back Better Act. However, despite the presentation of the options in the report in this format, it is important to note there is no legal or other barrier that would prevent the state from making a larger General Fund investment than the $333.4 million in the Fund, particularly considering that California was committed to investing $547.2 million in 2021-22 for its state premium subsidy program prior to approval of the American Rescue Plan. The options presented in the report are as follows:

- Option 1: Actuarial Value (AV) 95/90/85/80 with no deductibles ($475 million to $626 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 600 percent of the federal poverty level (FPL). Coverage generosity would be increased with new cost-sharing reduction (CSR) plan actuarial values set to 95, 90, 85 and 80. All individuals above 150 percent of FPL would be upgraded from their existing plans. As modeled, all deductibles would be eliminated under this option. This is the only modeled option that incorporates CSR enhancements above 400 percent of FPL.

- Option 2: AV 95/90/85 with no deductibles ($463 million to $604 million). In this option, CSR support would be expanded to all enrollees up to 400 percent of the FPL. Coverage generosity would be increased with new CSR plan actuarial values set to 95, 90 and 85. All individuals above 150 percent of FPL would be upgraded from their existing plans. As modeled, all deductibles would be eliminated under this option.

- Option 3: Affordable Care Act cost-sharing reduction plan upgrade with no deductibles and Gold AV for individuals between 300 and 400 percent of the FPL ($386 million to $489 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to a Silver 94 plan with no deductibles, and individuals between 200 and 300 percent of the FPL would be upgraded from a Silver 73 to a Silver 87 plan with no deductibles. Individuals between 300 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

- Option 4: Affordable Care Act cost-sharing reduction plan upgrade with no deductibles and Gold AV for individuals between 250 and 400 percent of the FPL ($362 million to $452 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to an existing Silver 94 plan, and individuals between 200 and 250 percent of the FPL would be upgraded from a Silver 73 to an existing Silver 87 plan. Individuals between 250 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

- Option 5: Affordable Care Act cost-sharing reduction plan upgrade for individuals between 150 and 250 percent of the FPL ($278 million to $322 million). In this option, eligibility for CSR plans would remain at 250 percent of the FPL, but individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to an existing Silver 94 plan, and individuals between 200 and 250 percent of the FPL would be upgraded from a Silver 73 to an existing Silver 87 plan. Deductibles would not be eliminated in this option, which would potentially prevent the need for benefit-design changes in 2023.

- Option 6: Affordable Care Act cost-sharing reduction plans with no deductibles and Gold AV for individuals between 200 and 400 percent of the FPL ($128 million to $189 million). In this option, CSR support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 200 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

- Option 7: Affordable Care Act cost-sharing reduction plans with no deductibles ($37 million to– $55 million). In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. State funding would be used to eliminate all deductibles in existing CSR plans and upgrade the Silver base plan to a Silver 73 for individuals between 250 and 400 percent of the FPL.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Covered California present their report on affordability options, make any recommendations they are prepared to make, and answer any questions raised by the Subcommittee.

Staff Recommendation: Hold open to allow for additional discussion, analysis and consideration of these options, increased certainty around federal legislation, and the development of specific affordability proposals.

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 7: CALRX AND MEDI-CAL RX – OVERSIGHT

PANEL – PRESENTERS

- **Vishaal Pegany**, Assistant Secretary, California Health & Human Services Agency
- **Michelle Baass**, Director, Department of Health Care Services
- **Jacey Cooper**, State Medicaid Director & Chief Deputy Director of Health Care Programs, Department of Health Care Services

PANEL – Q&A ONLY

- **René Mollow**, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- **Aditya Voleti**, Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez**, Assistant Program Budget Manager, Department of Finance
- **Ben Johnson**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

CALRX AND MEDI-CAL RX – OVERSIGHT

The high cost of pharmaceuticals is often a significant component of any discussion on the high cost of health care generally. The administration has begun implementing two initiatives to help control the cost of pharmaceuticals for the State of California: CalRx and Medi-Cal Rx, both of which are described below.

CalRx

The California Health and Human Services Agency provided the following background and update on CalRx:

"Background

Senate Bill (SB) 852 (Pan, Chapter 207, Statutes of 2020) requires the California Health and Human Services Agency (CalHHS) to enter into partnerships to produce or distribute generic prescription drugs and at least one form of insulin, provided that a viable pathway

for manufacturing a more affordable form of insulin exists at a price that results in savings. Partnerships are broadly defined and include, but are not limited to, agreements for the procurement of generic prescription drugs by way of contracts or purchasing by a payer, state governmental agency, group purchasing organization, nonprofit organization, or other entity.

Implementation Progress

CalRx has followed a linear policy design and implementation strategy. We started from first principles, surveyed stakeholders, studied the broader landscape of generic manufacturing, and proceeded to engage potential partners to advance the State's goals for a Healthy California for All, where essential medicines are affordable for all who need them. Following summarizes the progress and direction of the CalRx initiative.

Identify Top Drugs (complete)

- As a first step, CalRx obtained the following project partners at universities: Johns Hopkins University and the UC Hastings Center for Innovation. CalRx developed an Memorandum of Understanding (MOU) that outlines the relationship and arrangements for data sharing, research, and consultation between project partners.

- **Stakeholder Survey and Selection Framework for Target Drug List:** Consistent with the requirements in SB 852, CalHHS conducted a broad survey of relevant stakeholders to prioritize the relative importance of certain public health and economic criteria in selecting target drugs. o The CalRx team asked approximately 40 stakeholders to rank selection criteria. Stakeholders included an array of state policy experts, consumer and labor advocates, public and private health plans, and providers. The majority of were California-based, but approximately 20% were based elsewhere in the U.S.
    - Criteria for the selection framework fell into two categories:
        - Economic Impact: high cost to payer, high consumer OOP spending, shortage risk, high price increases, high price per unit
        - Public Health Relevance: large target population, vulnerable target population, no therapeutic alternatives, treats high morbidity/mortality conditions, curative medication, treats communicable/infectious diseases
    - We asked respondents to ordinal rank the criteria (with 1 being the highest rank and 11 being the lowest rank). We then aggregated responses and used an algorithm to identify how much weight to give to each criteria.
    - All criteria merit consideration since the spread of criteria weights was relatively narrow (7.2% to 10.9%). Responses suggest CalRx should select drugs that **affect a large population** and have a **large absolute, total impact on costs.**

- Top three criteria included "absolute" factors: (1) Large Target Population, (2) Payer Cost, and (3) Consumer OOP Cost.
- "Relative" factors (i.e., high price increases) ranked among bottom three.

• We have identified preliminary target drugs based on the criteria weights from the survey along with utilization data from the public payers (Medi-Cal, Covered California, CalPERS).

Assess Legal, Policy, and Regulatory Factors (in progress)

• **Legal-Regulatory Barriers**: Patent, transactional, and other complex aspects of intellectual property law form the basis for generic drug development. Professor Robin Feldman from the UC Hastings Center for Innovation (C4i) at UC Hastings is assisting CalRx with freedom-to-operate analyses.

Address Strategic, Operational, and Market Issues (in progress)

• **RFP/Contract with a Manufacturing Consultant:** While university partners will advise CalRx with identifying potential target drugs, CalHHS also requires expertise to tackle strategic, operational, and market issues for getting drugs to patients.

• CalRx will contract a consultant with industry experience in these areas. We hope to complete a Request for Proposal and hire a consultant by early summer.

Enter into Manufacturing Partnerships (in progress and next steps)

Insulin: Currently, the majority of CalRx's attention is focused on exploring opportunities to bring interchangeable, low-cost insulin products to market with a CalRx or California-related label.

• **Future Opportunities and Challenges (next steps)** o **Small molecule drugs:** A biosimilar insulin partnership would lay the groundwork for future drug development projects, including for other shortage-prone, high-price, or specialty generics.

- **Engagement with other manufacturers:** CalHHS has explored the generic manufacturing space by having informational meetings with traditional pharmaceutical firms, non-profits, and start-ups.
- **Explore distributional models:** Some partners may include distribution in its strategy, but others will not. Equity challenges will complicate CalRx's proper distribution model as not all consumers use newer delivery models such as mail order pharmacy.
  - **Existing channels**: Utilize health plans, PBMs, wholesalers, and pharmacies to bring drugs to patients
  - **Direct-to-consumer**: Partner with third party mail-order or other direct-to-consumer services (vendors such as True Pill) to deliver drugs to patients.
  - *The expertise of the consultant will be instrumental in navigating these issues."*

Medi-Cal Rx

On January 7, 2019, Governor Gavin Newsom issued Executive Order N-01-19 (EO N-01-19) for achieving cost savings for drug purchases made by the state. A key component of EO N-01-19 requires that DHCS transition all Medi-Cal pharmacy services from Managed Care (MC) to Fee-for-Service (FFS).

Medi-Cal Rx includes all pharmacy services billed as a pharmacy claim, including but not limited to:

- Outpatient drugs (prescription and over-the-counter), including Physician-Administered Drugs (PADs)
- Enteral nutrition products
- Medical supplies

Medi-Cal Rx does not include pharmacy services billed as a medical (professional) or institutional claim.

Medi-Cal Rx did not change:

- The scope of the existing Medi-Cal pharmacy benefit.
- Providing pharmacy services as part of a bundled/all-inclusive billing structure in an inpatient or long-term care setting, regardless of delivery system.
- Existing Medi-Cal managed care pharmacy carve-outs (e.g., blood factor, HIV/AIDS drugs, antipsychotics, or drugs used to treat substance use disorder). Today, these are carved out from most Medi-Cal Managed Care Plans (MCPs) and, eventually, will be carved out of all MCPs.
- The State Fair Hearing process.

Medi-Cal Rx impacts all Medi-Cal MCPs, including the AIDS Healthcare Foundation.

Medi-Cal Rx does not apply to Programs of All-Inclusive Care for the Elderly (PACE) plans, Senior Care Action Network (SCAN), and Cal MediConnect health plans, or the Major Risk Medical Insurance Program (MRMIP).

Medi-Cal Rx went live in January of 2022, and has experienced some significant implementation challenges. DHCS provided the following implementation update:

"Medi-Cal Rx successfully launched on January 1, 2022. Pharmacy claims are being paid, prior authorizations are being processed, and Magellan's 24/7 call center is operating. As of January 24, Medi-Cal Rx has:

- Paid 7.1 million claims totaling approximately $762 million.
- Processed more than 61,945 prior authorizations.

- Answered 65,342 calls, including 17,194 live calls, 46,039 virtual hold call backs, and 2,109 voice mails returned. 100 percent of virtual hold calls (via call back feature) and voice mails have been returned.

DHCS has transitioned the Medi-Cal pharmacy benefit of more than 14 million Medi-Cal members to a single delivery system, and while we're confident the change will benefit members, we are aware of some initial implementation challenges and concerns that we are actively working to address.

Initial implementation challenges include excessive call center wait times, delays in prior authorization processing, some improper claims denials, and challenges with Magellan's data and reporting. DHCS is working diligently with Magellan to address these issues.

The call center has experienced high volumes of calls and at the same time experienced high absenteeism due to the current COVID-19 Omicron surge; this has resulted in longer than acceptable wait times (particularly during peak hours) and call abandonment rates.

- Average handle times for calls are high as call center staff are taking time to fully resolve issues, including longer handle times for bridging providers, pharmacies, and beneficiaries. This is also influenced by the fact that everyone is dealing with a new system/process – plans, providers, pharmacies, beneficiaries and thus it takes more time to handle.
- Callers have the option to wait for a live agent, request a call back, leave a voice mail, or call during off-peak hours.
- Magellan is developing a workforce plan for its call center, including bringing on-line an additional call center vendor, to decrease wait times and call abandonment rates.
- Additionally, DHCS has brought on-line its Medi-Cal call center to assist with calls.
- Furthermore, through these monitoring efforts we identified a system issue related to eligibility based on primary/secondary aid code prioritization for some populations that was triggering claim denials and/or PA requirements.
    - Based on the information gathered, DHCS and Magellan implemented a coding change that addressed the aid code issue, thus allowing claims to pay.

A high volume of prior authorizations (PAs) have been submitted in the first few weeks of Medi-Cal Rx, which has resulted in a backlog.

- To address the high volume of PAs, DHCS and Magellan have been monitoring the types of PAs submitted, as well as calls from pharmacies and prescribers related to the PA process to better understand the cause.

- As part of ongoing monitoring efforts, we found that some historical managed care plan beneficiary claim and PA data was not provided to Medi-Cal Rx, thus rules of the 180-day transition policy are not being applied in certain instances where it should be, thus triggering a PA submission requirement. The missing data appears to be related to data held by fully delegated provider groups (subcontracted to MCP), whose pharmacy claims and PA data was not part of what was submitted to Magellan in the lead up to implementation. DHCS is actively working with Magellan and the MCPs to determine the most effective way to identify and obtain this data.
- Additionally, various Drug Utilization Review (DUR) edits were causing claims to reject, or require PA inappropriately.
- Based on the information gathered, DHCS and Magellan have implemented fixes, including:
    - A coding change that addressed the aid code issue, thus allowing claims to pay.
    - An ability for a pharmacy to attest that they have prior paid claims, or approved PAs that would allow for the 180-day transition policy to override the need for a new PA.
    - Revising various Drug Utilization Review edits that were resulting in a claim denial or request for a PA. Instead of denying the claim or requiring a PA, the system provides the pharmacy with a message indicating the alert.
- As these adjustments are made, pharmacy providers are receiving fax blasts as well as electronic bulletins with information related to the changes. These bulletins are also being distributed via the Medi-Cal Rx subscription service.
- Magellan is developing a workforce plan for PAs, including bringing on additional resources to address the PA backlog.
- Additionally, DHCS has brought on-line its Pharmacy Benefit staff to process PAs.

DHCS and Magellan are committed to ensuring Medi-Cal beneficiaries receive the prescription drugs they need, when they need them; improving operational issues; and being accountable for contractual performance standards.

- Inquiries to date have mainly originated from the managed care plans, plan associations, the California Medical Association, and providers.
- Beneficiary issues are being handled immediately. Two areas of concern related to our beneficiaries that we have worked to address are:
    - Proper identification of beneficiary eligibility – initially some pharmacies were using the plan identification number rather than the beneficiary identification number to look up individuals. DHCS has worked with Magellan to develop provider education and guidance on which identification number to use. DHCS is also providing call center support through its fee-for-service call center, which is taking calls specific to

questions to Beneficiary Identification Card and Client Index Number validation.

  - Other Healthcare Coverage (OHC) – as Medi-Cal is the payer of last resort, DHCS has shared the process with Magellan on how OHC can be addressed using existing processes. This process is automated and online and can be cleared by either a beneficiary or provider (takes 24 hours to update the system once the request has been submitted).

- As we work to resolve issues, we are also working to ensure our providers are aware of the corrective action steps we have taken to address the issues – this information is communicated in multiple ways including email blasts, provider newsflashes, information on our website, and direct provider outreach.
- Magellan is also taking additional steps to strengthen their education and outreach to pharmacies and providers as we make corrections in the system to address issues.
- DHCS will ensure Magellan is held accountable for contractual performance standards such as call center performance metrics and timeliness of prior authorizations."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Health and Human Services Agency and DHCS to present overviews and implementation updates on CalRx and Medi-Cal Rx and respond to the following questions:

1. How is Magellan planning to resolve these concerns? What is DHCS's role in addressing these concerns?

2. Are there enough staff to help answer calls / emails when providers call in? How are these staff trained to make sure they can help answer questions being asked of them?

3. How soon do you expect these challenges to be resolved?

4. Is the administration considering augmenting the supplemental payment pool (SPP) as stakeholders have encouraged?

5. What is the administration doing to better understand the fiscal impact of Medi-Cal Rx on clinics and other providers?

6. Does the administration know the number of entities that would be eligible for SPP payments?

Staff Recommendation: No action recommended at this time as this is an oversight issue.