AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

WEDNESDAY, MARCH 2, 2016

3:00 P.M. - STATE CAPITOL ROOM 444

ITEMS TO BE HEARD

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4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: DEPARTMENT OVERVIEW

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Maricris Acon,** Department of Finance
- **Amber Didier,** Fiscal & Policy Analyst, Legislative Analyst's Office

PROPOSED BUDGET

Department of Health Care Services (DHCS) Budget

For 2016-17, the Governor's Budget proposes $87.7 billion for the support of DHCS programs (primarily Medi-Cal). Of this amount, approximately $600 million is budgeted for state operations, while the remaining is for local assistance. The proposed budget reflects nearly an 8 percent ($7.3 billion) decrease from the current year budget which reflects a reduction in Medi-Cal costs, specifically a reduction in managed care costs. The vast majority of DHCS's budget is for the Medi-Cal Program, for which the January budget proposes $85 billion ($19 billion General Fund), a $7.3 billion (7.9%) decrease from the current year, after a $1.4 billion (8.2%) General Fund increase.

DEPARTMENT OF HEALTH CARE SERVICES
(Dollars in Thousands)

Fund Source	2014-15 Actual	2015-16 Estimated	2016-17 Proposed	CY to BY Change	% Change
General Fund	**$17,443,508**	**$18,055,383**	**$19,556,037**	**$1,500,654**	**8.3%**
Federal Fund	$53,049,859	$61,266,825	$54,669,584	($6,597,241)	-10.8%
Special Funds/ Reimbursements	$11,714,355	$15,701,091	$13,480,475	($2,220,616)	-14.1%
Total Expenditures	**$82,207,722**	**$95,023,299**	**$87,706,096**	**($7,317,203)**	**-7.7%**
Positions	3,455.4	3,399.4	3,342.9	(56.5)	-1.7%

Resources Requests. DHCS is requesting approximately $6.7 million General Fund and 67 new positions, including the conversion of 18 existing limited-term positions to permanent, to support workload associated with, among other activities, all of the following:

1) Every Woman Counts Program
2) California Community Transitions Demonstration Project
3) Health Homes Program
4) Outreach and Enrollment
5) Dental Program Integrity

6) Federally Qualified Health Centers (SB 147, Hernandez, Chapter 760, Statutes of 2015)
7) Electronic Medical Records
8) Medi-Cal Eligibility Systems
9) Robert F. Kennedy Farm Workers Medical Plan (SB 145, Pan, Chapter 712, Statutes of 2015)
10) Specialty Mental Health Services Oversight
11) Foster Care Training on Psychotropic Medications
12) Residential Treatment Facilities (AB 848, Stone, Chapter 744, and AB 403, Stone, Chapter 773, Statutes of 2015)

BACKGROUND

DHCS's mission is to protect and improve the health of all Californians by operating and financing programs delivering personal health care services to eligible individuals. DHCS's programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost effective manner. DHCS programs include:

- ***Medi-Cal.*** The Medi-Cal program is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 13.5 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, low-income people with specific diseases, and childless adults up to 138 percent of the federal poverty level.

- ***Children's Medical Services (CMS).*** CMS coordinates and directs the delivery of health services to low-income and seriously ill children and adults with specific genetic diseases; its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Newborn Hearing Screening Program.

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations through the following programs: Indian Health Program; Rural Health Services Development Program; Seasonal Agricultural and Migratory Workers Program; State Office of Rural Health; Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program; Small Rural Hospital Improvement Program; and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services***. DHCS oversees the delivery of community mental health and substance use disorder services.

- ***Other Programs*.** DHCS oversees family planning services through the Family Planning Access Care and Treatment Program ("Family PACT"), cancer screening services to low-income under- or uninsured women, through the Every Woman Counts Program, and prostate cancer treatment services to low-income, uninsured men, through the Prostate Cancer Treatment Program ("IMPACT").

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the department, its various programs and functions, its basic organization, and the proposed budget for the department.

Staff Recommendation: This is an informational item and no action is necessary.

ISSUE 2: MEDI-CAL ESTIMATE

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Maricris Acon,** Department of Finance
- **Public Comment**

Proposed local assistance funding for the Medi-Cal program is summarized in the table below and includes total funds of $85 billion ($19 billion General Fund). The proposed 2016-17 Medi-Cal local assistance budget is approximately 8 percent less than the estimated 2015-16 budget, reflecting a budgeting issue related to managed care rates, rather than any significant policy change or reduction in services.

Medi-Cal Funding Summary *(Dollars In Millions)*	2015-16 Estimate	2016-17 Proposed	CY to BY $ Change	CY to BY % Change
General Fund	**$17,645.9**	**$19,084.1**	**$1,438.2**	**8.2%**
Federal Funds	$61,036.4	$54,046.5	($6,989.9)	-11.5%
Other Funds	$13,695.0	$11,907.7	($1,787.3)	-13.1%
Total Local Assistance	**$92,377.3**	**$85,038.5**	**($7,338.8)**	**-7.9%**
Medical Care Services	$87,917.9	$80,481.3	($7,436.6)	-8.5%
County Administration	$3,973.9	$4,100.4	($126.5)	3.2%
Fiscal Intermediary	$485.5	$456.7	($28.8)	-5.9%

BACKGROUND

The Medi-Cal Program

Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 51-year-old joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, people with disabilities, and childless adults. Each state has discretion to structure benefits, eligibility, service delivery, and payment rates within requirements of federal law. State Medicaid spending is "matched" by the federal government, historically at a rate averaging about 57 percent for California, based largely on average per capita income in the State. California uses a combination of state and county funds augmented by a small amount of private provider tax funds as the state match for the federal funds.

Medicaid is the single largest health care program in the United States. In California, the estimated average monthly enrollment is eight million or roughly one seventh of the national total program enrollment. Approximately 35 percent of Californians are enrolled in Medi-Cal. The federal Affordable Care Act (ACA) brought the expansion of Medicaid coverage to non-elderly Americans and legal immigrants who have been in the United States at least five years and who have incomes below 138 percent of the Federal Poverty Level.

Medi-Cal Caseload

DHCS estimates baseline caseload to be approximately 13.5 million average monthly enrollees in 2016-17 as compared to 13.2 million in 2015-16, a 1.5 percent increase. The significant 8 percent increase between 2014-15 and 2015-16 reflects the Medi-Cal expansion made possible by the ACA.

	2014-15	2015-16	2016-17	14-15 to 15-16 % Change	15-16 to 16-17 % Change
Medi-Cal Caseload	12,888,500	13,276,300	13,478,000	8.04%	1.52%

Since the implementation of the ACA expansion, a significant backlog of applications developed, creating long delays for people attempting to enroll in the program. DHCS states that the backlog has been effectively addressed and is now down to tens of thousands of individuals, as compared to the hundreds of thousands that were affected for some time.

Significant Medi-Cal Estimate Adjustments

Descriptions of the most significant adjustments to the Medi-Cal estimate include the following:

- **New Federal 1115 Waiver**. The new "Medi-Cal 20-20 Waiver" provides California with $6.2 billion in federal funding over 5 years and includes the following key elements:

  1. *Public Hospital Redesign and Incentives in Medi-Cal (PRIME)* - Designated Public Hospital (DPH) systems and District Hospitals (DMPH) will be eligible to receive incentive payments for meeting specified performance measures. This includes $3.27 billion for DPHs and $465.5 million for DMPHs.

  2. *Global Payment Program (GPP)* -- GPP transforms hospital funding for DPHs from a system focused on hospital-based services and cost-based reimbursement into a value-based payment structure.

  3. *Dental Transformative Initiative (DTI)* -- The DTI provides incentive payments to Medi-Cal dental providers who meet certain requirements and benchmarks. Up to $750 million annually will be available under the DTI.

  4. *Whole Person Care (WPC) Pilots* -- WPC allows for county-based pilots to target high-risk populations and integrate physical and behavioral health care along with other social services. The waiver authorizes up to $1.5 billion in federal funding over the five years of the waiver for the WPC.

- **Managed Care Rates**. The budget reflects a $2.4 billion reduction in federal funds in response to the federal government approving of rates specifically for the ACA expansion population (that is fully federally funded) that are lower than what the state anticipated.

- **Coordinated Care Initiative**. The budget assumes the continuation of the Coordinated Care Initiative through January 2017, at which point the administration will determine the financial viability of continuing the program based on enrollment and passage of an MCO tax, potentially ceasing operations in January 2018. The CCI will be discussed in more detail at the Subcommittee's hearing on March 14, 2016.

- **Undocumented Children's Coverage**. The budget extends full-scope Medi-Cal coverage to undocumented children, as approved through the 2015 Budget Act, including $182 million ($145 million General Fund) to provide full-scope benefits to 170,000 children beginning May 1, 2016.

- **Substance Use Residential Treatment Costs**. The Medi-Cal estimate assumes an expansion of residential treatment services for substance use disorders at a cost of $90.9 million ($32.5 million General Fund). Substance use services will be discussed in more detail at the Subcommittee's hearing on March 28, 2016.

- **Performance Outcome System**. The budget implements the Performance Outcomes System to track outcomes of Medi-Cal Specialty Mental Health Services for children and youth at a cost of $11.9 million General Fund, for implementing the system, including county collection of assessment data and related training.

- **County Administration**. The Medi-Cal estimate increases funding by $169.9 million ($57 million General Fund) in 2016-17 to counties for the administration of Medi-Cal eligibility determinations.

- **Medi-Cal Expansion**. The Medi-Cal estimate assumes net costs of $4 billion ($1.9 billion General Fund) in 2016-17 for the cost of the ACA mandatory Medi-Cal expansion and $14.1 billion ($740.2 million General Fund) in 2016-17 for the state's share of costs for the optional expansion.

- **1 Percent Federal Matching Increase for Preventive Services**. The budget includes an increase of $15.4 million General Fund to address the lower than anticipated increase in federal funding by implementing this federal match increase.

- **Behavioral Health Treatment Costs**. The estimate increases General Fund by $43.4 million to reflect solidified rates based on actuarial soundness as well as higher utilization than expected. Given federal guidance clarifying that Medicaid programs must cover behavioral health treatment, these costs are being transitioned to Medi-Cal for children who have been receiving them through Regional Centers. The administration began this transition for approximately 13,000 kids in February 2016 and intends to transition all of them within six months.

- **Hospital Quality Assurance Fee (QAF).** The existing QAF provides approximately $800 million in General Fund savings annually, including $280 million specifically for children's health services. This QAF expires January 1,

  2017. The budget assumes the QAF will end and therefore increases General Fund by $140 million to account for the loss of this funding for children's health care for the second half of the fiscal year. Although a ballot initiative that would extend the fee is pending, the LAO recommends that the Legislature extend the QAF during 2016.

Legislative Analyst

The LAO raises two significant budget issues in their analysis of the Governor's health budget. First, the ACA makes the development of Medi-Cal caseload projections especially challenging. The LAO finds that with the caseload estimates are more uncertain than in the past, due to the ACA, and the Legislature should take this into consideration when reviewing the budget. The LAO also recommends that the Legislature require DHCS to report at May Revise hearings on how the most recent data on caseload and redeterminations have informed and changed caseload projections.

Secondly, various significant fiscal uncertainties might affect the overall Medi-Cal budget. The LAO includes detailed discussion of the potential fiscal impacts of: 1) the status of the Hospital QAF; 2) recently proposed federal Medicaid managed care regulations; 3) the new federal 1115 Waiver; 4) ACA expansion costs; and 5) the future of federal "CHIP" (Children's Health Insurance Program) funding. The LAO recommends that the Legislature extend the Hospital QAF and generally consider these significant cost pressures and uncertainties in the course of analyzing and making decisions about the budget.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the Medi-Cal estimate, highlighting the major policy and fiscal proposals and changes proposed for 2015-16 and 2016-17, and to respond to the following:

1. Please describe the anticipated policy and fiscal impacts of the new federal 1115 Waiver.

2. Please explain the changes to the managed care rates and how they affect the Medi-Cal budget overall.

3. Please describe the most up-to-date data on the number of backlogged (delayed) applications to the Medi-Cal program. How many are adults and how many are children?

4. Please provide an update on the approved expansion to eligible kids regardless of immigrations status.

Staff Recommendation: This item should be held open pending updates and changes at May Revise.

ISSUE 3: COUNTY ELIGIBILITY ADMINISTRATION & COLA TRAILER BILL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Maricris Acon,** Department of Finance
- **Public Comment**

The Governor's budget proposes base funding for counties of $3.4 billion, supplementary funding of $655.3 million total funds ($217.8 million General Fund), and trailer bill to suspend the annual COLA for the budget year.

County Medi-Cal Administration Funding
(Dollars in Millions)

	2014-15 Appropriation	2015-16 Estimate	2016-17 Proposed
General Fund	$774.1	$817.7	$860.9
Federal Funds	$3,035.2	$3,156.2	$3,239.6
Total Funds	**$3,809.3**	**$3,973.9**	**$4,100.4**

BACKGROUND

DHCS reimburses counties for the costs they incur by performing administrative activities associated with the Medi-Cal eligibility process. Existing Welfare and Institutions Code Section 14154 states the Legislature's intent to provide the counties with a COLA annually. Nevertheless, the COLA has been suspended each fiscal year since 2009-10.

The administration indicates that it is the administration's policy and practice to end all automatic annual COLAs, consistent with Government Code Section 11019.10. Consistent with this policy, AB 8 X4, (Evans), Chapter 8, Statutes of 2009-10, Fourth Extraordinary Session, eliminates the automatic annual COLA for the State Supplemental Payment (SSP) program and for the CalWORKS program. The administration also points out that it has proposed to provide the counties with substantial increases in funding to address the substantial increase in ACA-driven workload, this year and over the past few years; hence, counties are being funded at a level higher than if they were just provided a COLA. Finally, as described below, DHCS expects to develop a new reimbursement methodology for counties in the near future.

Increased Funding Related to the Implementation of the ACA

DHCS and the County Welfare Directors Association (CWDA) describe an on-going significant increase in workload for counties due to an increase in enrollment that vastly exceeds projections, ongoing technology system delays and manual workarounds to process this substantial increase in eligibility determinations and renewals. Therefore,

the 2013-14 and 2014-15 budgets included supplemental funding for the counties reflecting the substantial increase in workload expected as a result of implementation of the ACA of $240 million total funds for each of the two fiscal years. In recognition that the county workload was still growing and exceeding expectations, the 2015 budget continued the $240 million augmentation for 2015-16 and included an additional $150 million total funds for 2014-15, and $245.3 million total funds for 2015-16, continuing the $150 million augmentation for an additional year and adding another $95.3 million total funds.

New Reimbursement Methodology

Currently, counties are budgeted for their activities based on claimed expenditures from previous years, and there is no county share of cost for administrative activities in the Medi-Cal program. DHCS states that, therefore, historically, there has been no incentive for counties to maximize efficiency or to control their administrative costs. SB 28 (Hernandez & Steinberg) Chapter 442, Statutes of 2013, requires DHCS, in consultation with stakeholders, to create a new methodology for budgeting and allocating funds for county administration for the Medi-Cal program, and for this new methodology to be implemented in 2015-16. According to DHCS, the new methodology will seek to use a performance and outcome-based system to determine accurate county funding levels, reward increased county efficiency, and determine effectiveness of county efforts.

DHCS intends for the development of the new county budget methodology to be a comprehensive overhaul that will include specific reviews of annual time studies, claimed expenditures, and other data metrics. DHCS has entered into a contract with an entity that will conduct this time study, create an ongoing monitoring plan and train Audits and Investigations staff on monitoring and evaluation of time studies. DHCS explains that the time study and development of the new methodology have been delayed due to the volatility in enrollment resulting from the ACA as well as due to delays in the full operation of CalHEERs, the eligibility and enrollment system for Covered California.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the proposed county funding, provide an update on the CalHEERs challenges, and present the proposed trailer bill.

Staff Recommendation: Staff recommends holding this issue open for further discussion and review, and May Revise updates.

ISSUE 4: DENTI-CAL PROGRAM

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Maricris Acon,** Department of Finance
- **Public Comment**

BACKGROUND

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

For children in Medi-Cal, dental care is provided on a fee-for-service basis in all counties, with Sacramento and Los Angeles Counties also offering services through managed care plans. Covered dental services include 24-hour emergency care for severe dental problems, urgent care (within 72-hours), non-urgent appointments (offered within 36-days), and preventive dental care appointments (offered within 40-days). Federal regulations mandate that California's state plan meet the requirements for providing early and periodic screening, diagnostic, and treatment (EPSDT) services for beneficiaries under the age of 21 years. EPSDT services include dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age and dental care, at as early an age as necessary, to relieve pain and infections, restore teeth, and maintain dental health.

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

Dental Program Administration

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

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

Keen Act, they can qualify for the beneficiary dental exemption, which allows them to move into the fee-for-service delivery system. In 2012, about 143,000 child beneficiaries received services under the dental managed care plans operating in the counties of Los Angeles and Sacramento.

First 5 Report on Sacramento's Geographic Managed Care

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

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

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

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

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

- Inadequate prevention services were provided; and,

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

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

DHCS Response and Action

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

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

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

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

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

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

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

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

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

2012 Budget Trailer Bill

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

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

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

- *Dental Plan Performance Measures*. The bill requires DHCS to establish a list of performance measures to ensure that dental health plans meet quality criteria. The bill requires DHCS to post on its website on a quarterly basis, beginning January 1, 2013, the list of performance measures and each plan's performance. The bill requires the performance measures to include: provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations

and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers. The bill also requires DHCS to designate an external quality review organization to conduct external quality reviews for all dental health plan contracting.

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

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

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

Study on Fee-for-Service

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

DHCS March 2013 Report

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

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

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

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

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

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

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

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

2012 Hearings

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

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

2014 Denti-Cal Audit

On December 11, 2014, the California State Auditor issued a report titled *"California Department of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care".* The report showed that insufficient dental providers willing to participate in Medi-Cal, low reimbursement rates, and a failure to adequately monitor the program, led to limited access to care and low utilization rates for Medi-Cal

beneficiaries across the State. In fiscal year 2013, nearly 56 percent of the 5.1 million children enrolled in Medi-Cal did not receive dental care through the program.

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

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

Additionally, DHCS has not enforced certain terms of its $7.8 billion contract with Delta Dental of California (Delta Dental) related to improving beneficiary utilization rates and provider participation. DHCS' contract with Delta Dental requires the development of a provider services manual, an action plan to increase provider participation in underserved counties, beneficiary outreach and education, in addition to other provisions.

2014 Budget Act

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

Stakeholder Proposal

Western Center on Law and Poverty and the California Pan Ethnic Health Network propose the restoration of the remaining dental benefits for adults that have yet to be restored. The administration estimates the cost of this restoration to be $260.1 million total funds ($93.1 million General Fund). This would include preventive, diagnostic, and restorative procedures, as well as root canals, laboratory processed crowns, periodontics, implants and partial dentures.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to respond to the following:

1. Please provide an update on improvements to pediatric dental care, both managed care and fee-for-services.

2. Please provide the most up-to-date pediatric utilization numbers, statewide, for both managed care and fee-for-service.

3. Please describe the access monitoring done by DHCS for pediatric and adult dental care. Please explain the difficulty with monitoring access in fee-for-service counties.

4. Please provide an update on the department's outreach to young children referenced above under "2014 Budget Act."

5. Please provide the level of increased utilization since the restoration of adult services; how closely aligned is utilization with what the administration anticipated for this point in time?

6. Please describe the anticipated impacts of the new Waiver resources and the DTI. How will the Waiver help to increase provider participation in Medi-Cal?

7. Please describe how the incentive program payments will be made and how the incentives will be structured? How will effectiveness be measured?

The Subcommittee requests the LAO to provide any feedback and analysis they have on the Denti-Cal program and to present the request being made by stakeholders to restore adult dental services.

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

ISSUE 5: TECHNICAL TRAILER BILL ON DRUG REBATES

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, DHCS
- **Amber Didier**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ben Johnson**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Maricris Acon,** Department of Finance
- **Public Comment**

This proposal would make minor technical changes to Welfare and Institutions (W&I) Code §14105.436 and §14105.86 as amended by SB 870, to preserve the intent and purpose of SB 870, 2014 Health Trailer Bill [Senate Bill (SB) 870, Committee on Budget and Fiscal Review, Chapter 40, Statutes of 2014]. SB 870 extended the state's authority to collect state supplemental drug rebates based on drug utilization data from all Medi-Cal programs, including fee-for-service (FFS) and managed care plans (MCPs). SB 870 applies to certain prescription drugs, including, but not limited to, drugs used to treat hepatitis C, HIV/AIDS, cancer, and hemophilia.

BACKGROUND

Prior to SB 870, DHCS had the authority to collect state supplemental drug rebates based on drug utilization data from FFS and County Organized Health Systems only. SB 870 provided new authority to DHCS to invoice manufacturers of contracted drugs and collect state rebates based on utilization data from all MCPs for prescription drugs subject to coverage policies and where DHCS reimburses MCPs through separate capitated rate payments or other supplemental payments.

SB 870 amended three sections of the California Welfare and Institutions Code, revising the description of utilization data to determine state rebates: §14105.33 (pertaining to state rebates and contracts with drug manufacturers), §14105.436 (pertaining to HIV/AIDS and cancer drug rebates), and §14105.86 (pertaining to blood factor rebates).

This proposal would make minor technical changes to W&I Code §14105.436 and §14105.86 as amended by SB 870. These technical changes will correct non-sequential lettering errors and inconsistent and erroneously omitted language in order to accurately preserve the intent and purpose of SB 870, to collect supplemental drug rebate revenues for certain prescription drugs based on drug utilization from all eligible Medi-Cal programs.

DHCS states that the technical cleanup of SB 870 will enable DHCS to improve uniform access to high cost prescription drugs for all Medi-Cal beneficiaries at the lowest cost to the Medi-Cal program. If left uncorrected, the errors may lead to a misinterpretation of the intent of SB 870 and place the state at risk of losing supplemental drug rebate revenues.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to explain the rebate-related policy changes that were adopted through SB 870 as well as the need for, and effects of, this proposed trailer bill.

Staff Recommendation: Staff recommends holding this proposal open at this time to allow for additional time for discussion.