AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 5, 2018

2:30 P.M. - STATE CAPITOL ROOM 447

ITEMS TO BE HEARD

LIST OF PANELISTS IN ORDER OF PRESENTATION

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: DEPARTMENT OVERVIEW AND PROPOSED BUDGET, AND MEDI-CAL ESTIMATE

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Carla Castaneda**, Assistant Program Budget Manager, Department of Finance
- **Ryan Woolsey,** Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ann Hollingshead,** Senior Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 2: COUNTY ELIGIBILITY ADMINISTRATION FUNDING

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Cathy Senderling**, Deputy Executive Director, County Welfare Directors Association
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey,** Senior Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 3: PROPOSITION 56 UPDATES AND RATES PROPOSALS

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance

- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Linda Nguy**, Policy Advocate, Western Center on Law and Poverty
- **Children's Health Advocacy Coalition**

Public Comment

ISSUE 4: PEDIATRIC DAY HEALTH CARE RATE INCREASE MEMBERS' AND ADVOCATES' PROPOSAL

PANELISTS

- **Assemblymember Jim Patterson**
- **Terry Raccaito,** Chair Pediatric Day Health Care Coalition, President, Together We Grow

Public Comment

ISSUE 5: INCREASE MEDI-CAL RATES FOR BREAST PUMPS ADVOCATES' PROPOSAL

PANELISTS

- **Robbie Gonzalez-Dow,** Executive Director, California Breastfeeding Coalition

Public Comment

ISSUE 6: AIR AMBULANCE MEDI-CAL RATE INCREASE ADVOCATES' PROPOSAL

PANELISTS

- **Kathryn Scott**, Cal-AAMS

Public Comment

ISSUE 7: OPTION MEDI-CAL BENEFITS ADVOCATES' PROPOSALS

PANELISTS

- **Linda Nguy,** Western Center on Law and Poverty
- **Dr. John Abordo,** DPM, California Podiatric Medical Association

Public Comment

ISSUE 8: CA 1115 WAIVER – MEDI-CAL 2020 BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 9: HEALTH CARE REFORM FINANCIAL REPORTING BUDGET CHANGE PROPOSAL

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 10: HIPAA PRIVACY RULE COMPLIANCE BUDGET CHANGE PROPOSAL

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 11: ORANGE COUNTY RELOCATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 12: CA TECHNICAL ASSISTANCE PROGRAM NO COST EXTENSION BUDGET CHANGE PROPOSAL

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 13: HEALTH INFORMATION EXCHANGES STATE FUNDING ADVOCATES' PROPOSAL

PANELISTS

- **Michelle Baca**, Associate Director, Center for Government Relations, California Medical Association

Public Comment

ISSUE 14: ERRONEOUS PAYMENTS RECOUPMENT PROCESS ADVOCATES' PROPOSAL

PANELISTS

- **Michelle Baca**, Associate Director, Center for Government Relations, California Medical Association

Public Comment

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 15: MEDI-CAL MANAGED CARE NETWORK ADEQUACY - OVERSIGHT ISSUE

PANEL 1

- **Kimberly Chen,** California Pan Ethnic Health Network
- **Tam Ma**, Health Access California
- **Michelle Baca**, California Medical Association
- **Linda Nguy,** Western Center on Law and Poverty
- **David Lavine,** Health Alliance of Northern California

PANEL 2

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Marta Green,** Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips,** Deputy Director, Legislative Affairs, Department of Managed Health Care

Public Comment

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 16: DEPARTMENT OVERVIEW AND PROPOSED BUDGET

PANELISTS

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

Public Comment

ISSUE 17: CONVERSION OF LIMITED-TERM FEDERAL MENTAL HEALTH PARITY COMPLIANCE REVIEW RESOURCES BUDGET CHANGE PROPOSAL

PANELISTS

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

Public Comment

ISSUE 18: PRESCRIPTION DRUG COST TRANSPARENCY (SB 17) BUDGET CHANGE PROPOSAL

PANELISTS

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

Public Comment

ISSUE19: HEALTH CONSUMER ALLIANCE FUNDING ADVOCATES' PROPOSAL

PANELISTS

- **Linda Nguy**, Policy Advocate, Western Center on Law and Poverty

Public Comment

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: DEPARTMENT OVERVIEW AND PROPOSED BUDGET, AND MEDI-CAL ESTIMATE

PANEL

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Maricris Acon**, Principal Program Budget Analyst, Department of Finance
- **Carla Castaneda**, Assistant Program Budget Manager, Department of Finance
- **Ryan Woolsey,** Senior Fiscal & Policy Analyst, Legislative Analyst's Office
- **Ann Hollingshead,** Senior Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED DHCS BUDGET

Department of Health Care Services (DHCS) Budget

For 2018-19, the Governor's Budget proposes $104.5 billion for the support of DHCS programs (primarily Medi-Cal). Of this amount, approximately $629.1 million is budgeted for State Operations, while the remaining is for Local Assistance. The proposed budget reflects nearly a 1.2 percent ($1.3 billion) increase from the current year budget. The vast majority of DHCS's budget is for the Medi-Cal Program, for which the January budget proposes $101.5 billion ($21.6 billion General Fund). Given the size of the Medi-Cal program, the significant changes in the budget occur within the Medi-Cal estimate which is described in more detail below.

DEPARTMENT OF HEALTH CARE SERVICES (Dollars in Thousands)					
Fund Source	**2016-17 Actual**	**2017-18 Estimated**	**2018-19 Proposed**	**CY to BY Change**	**% Change**
General Fund	**$19,433,088**	**$20,514,661**	**$21,862,524**	**$1,347,863**	**6.6%**
Federal Fund	$59,310,318	$64,255,942	$67,456,188	$3,200,246	5.1%
Special Funds/ Reimburse-ments	$13,689,876	$18,509,305	$15,224,753	($3,284,552)	-17.7%
Total Expenditures	**$92,433,282**	**$103,279,908**	**$104,543,465**	**$1,263,557**	**1.2%**
Positions	3,458.0	3,364.0	3,395.5	31.5	0.9%

Resources Requests

DHCS is requesting approximately $16.5 million ($7.7 million General Fund), 23 new permanent positions, the conversion of 18.5 existing limited-term positions to permanent, 32.5 new limited-term positions, and the limited-term extension of 18 existing limited-term positions to support workload associated with the following:

- Health care reform financial reporting;
- Orange County office consolidation;
- Federal managed care regulations implementation;
- HIPAA Privacy Rule Compliance;
- 1115 Waiver ("Medi-Cal 2020") implementation;
- Mental Health Services Act oversight and implementation of related legislation;
- Graduate Medical Education Program oversight and monitoring;
- Hospital Quality Assurance Fee program workload;
- Federally Qualified Health center audits (AB 1863); and
- Drug Medi-Cal and Specialty Mental Health Services: Federally Qualified and Rural Health Centers (SB 323) implementation.

These proposals will be covered in detail under various issues in this and future Subcommittee agendas.

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").

MEDI-CAL ESTIMATE

Proposed local assistance funding for the Medi-Cal program is summarized in the table below and includes total funds of $101.5 billion ($21.6 billion General Fund). The proposed 2018-19 Medi-Cal local assistance budget is approximately 1.5 percent more than the estimated 2017-18 budget.

Medi-Cal Funding Summary *(Dollars In Millions)*	2017-18 Revised	2018-19 Proposed	CY to BY $ Change	CY to BY % Change
General Fund	**$20,058.5**	**$21,589.1**	**$1,530.7**	**7.6%**
Federal Funds	$63,684.9	$67,143.2	$3,458.3	5.4%
Other Funds	$16,296.7	$12,772.3	($3,524.4)	-21.6%
Total Local Assistance	**$100,040.1**	**$101,504.7**	**$1,464.6**	**1.5%**
Medical Care Services	$95,163.4	$96,807.3	$1,643.9	1.7%
County/Other Administration	$4,427.5	$4,369.3	($58.2)	-1.3%
Fiscal Intermediary	$449.2	$328.1	($121.1)	-27.0%

BACKGROUND

The Medi-Cal Program

Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 53-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.

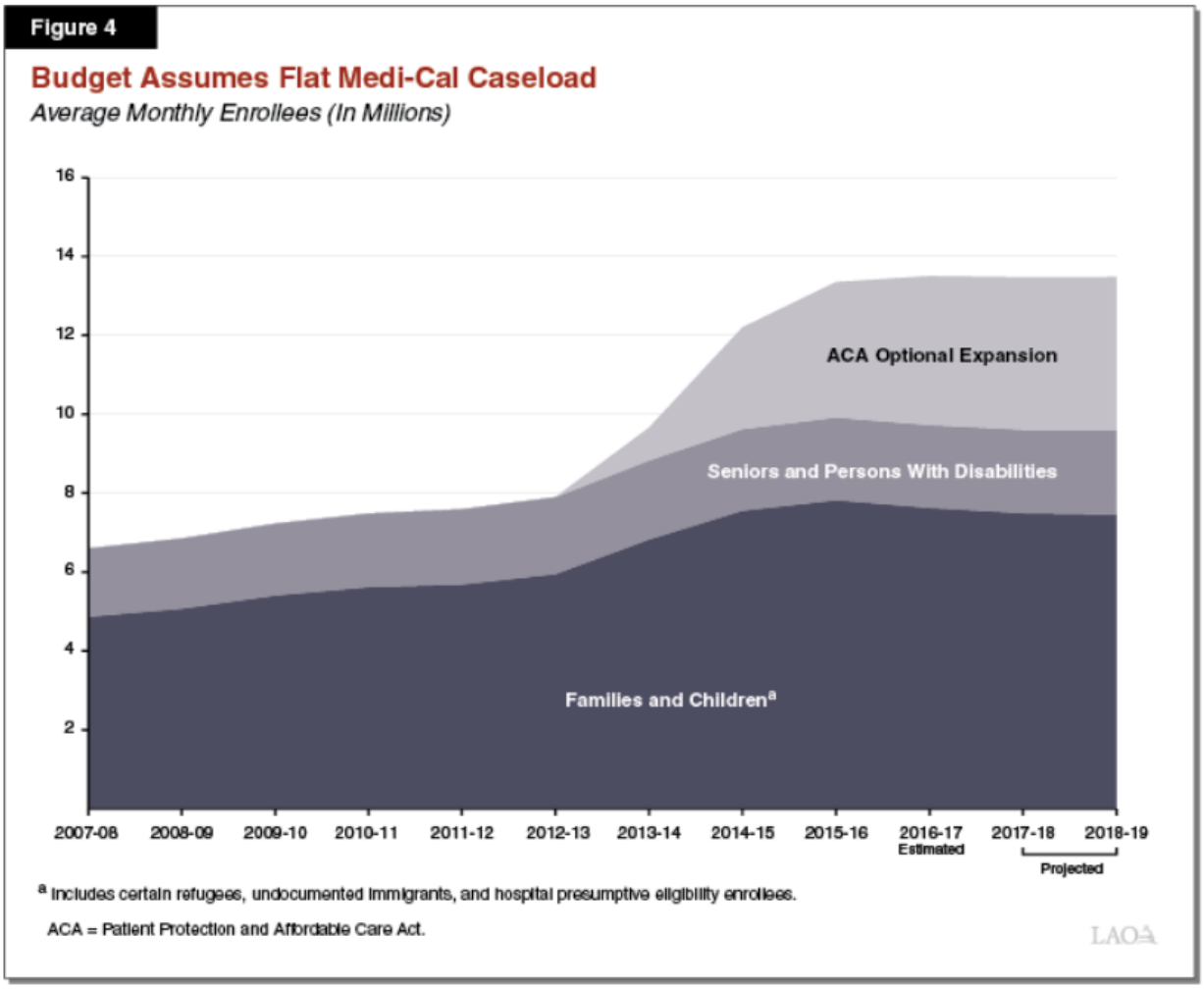
Medicaid is the single largest health care program in the United States. Approximately 37 percent of Californians are enrolled in Medi-Cal. The federal Affordable Care Act (ACA) brought the expansion of Medicaid coverage to non-elderly Americans and legal immigrants who have been in the United States at least five years and who have incomes below 138 percent of the Federal Poverty Level.

Medi-Cal Caseload

The Medi-Cal estimate assumes caseload to be approximately 13.5 million average monthly enrollees in 2018-19, as in the prior two years, reflecting the stabilization of the caseload.

	2016-17	2017-18	2018-19	CY to BY Change	CY to BY % Change
Medi-Cal Caseload	13,535,600	13,469,400	13,475,700	6,300	0.05%

The Legislative Analyst provided the following caseload chart in their *2018-19 Analysis of the Health and Human Services Budget*:



Estimate Overview

The Governor's budget revises estimates of General Fund spending in 2017-18 upward by $544 million (2.8 percent) relative to what was assumed in the 2017-18 Budget Act. The Governor's budget further proposes $21.6 billion for Medi-Cal from the General Fund in 2018-19, an increase of $1.5 billion (7.6 percent) over revised 2017-18 estimates. In terms of federal funds, the Governor's budget revises estimates of federal spending in Medi-Cal in 2017-18 downward from previous estimates by $5.2 billion (7.6 percent). The Governor's budget further estimates $63.7 billion in federal funding for Medi-Cal in 2018-19, an increase of $3.5 billion (5.4 percent) over revised 2017-18 estimates.

Significant Medi-Cal Estimate Adjustments

The most significant adjustments to the November 2017 Medi-Cal estimate include the following:

Current-Year (2017-18) Adjustments:

1. One-time costs of about $300 million for retrospective payments to the federal government related to prescription drug rebates. Most of the increased costs from these payments is the result of a shift in timing, where some payments that were planned to be made in 2016-17 have been delayed until 2017-18.

2. Offsetting savings of about $270 million from a higher estimate of prescription drug rebates in managed care. Higher estimates for 2017-18 are based on actual rebate amounts coming in higher than previously budgeted.

3. Costs of about $200 million to correct a budgeting methodology used to construct estimates of managed care costs that previously underestimated costs for Seniors and Persons with Disabilities.

4. Higher projected General Fund spending of about $170 million related to a reduction in hospital quality assurance fee (HQAF) revenues available to offset General Fund costs in Medi-Cal. The amount of HQAF revenues available to offset General Fund costs is tied to the total amount of supplemental Medi-Cal payments made to private hospitals, the nonfederal share of which are financed with HQAF revenues. A technical change to how much federal funding is available for these supplemental payments resulted in lower total payments in some years and, therefore, decreased estimated HQAF revenues available to offset General Fund Medi-Cal costs in 2017-18.

Budget-Year (2018-19) Changes:

1. Higher projected spending of $540 million to backfill Proposition 56 tobacco excise tax revenues that, while offsetting General Fund Medi-Cal costs in 2017-18, are proposed under the Governor's budget to instead pay for supplemental payments to certain providers in 2018-19. Please see Issue 3 of this agenda for additional detail on Proposition 56.

2. Higher projected spending of $300 million to reflect a full year of an assumed reduction in federal funds, continuing from 2017-18, for CHIP. The lost federal funds are assumed to be backfilled with an equivalent amount of General Fund.

3. Increased costs of roughly $200 million related to the state's responsibility for a higher share of costs for the ACA optional expansion. The state's share of cost for newly eligible beneficiaries increases from an effective 5.5 percent in 2017-18 to an effective 6.5 percent in 2018-19.

4. Increased costs of about $130 million related to the planned expansion into additional counties of the Drug Medi-Cal Organized Delivery System waiver, a

joint federal-state-county demonstration project aimed at providing a full continuum of substance use disorder services to Medi-Cal enrollees.

5. Higher projected spending in the hundreds of millions of dollars related to general growth in health care costs.

Federal Children's Health Insurance Program (CHIP): Recent Federal Action

Congressional appropriation of federal funding for CHIP lapsed on September 30, 2017. However, California continued to operate CHIP at the higher 88 percent FMAP using a combination of rollover funding from the state's FFY 2016-17 allotment and funding redistributed from other states to California by CMS. On January 22, 2018, Congress passed (and the President later signed) a reauthorization of federal funding for CHIP, including the following major components:

- Appropriates Funding for CHIP Through FFY 2022-23. States will continue to receive annual allotments to cover the federal share of CHIP expenditures until September 2023. Annual allotments will continue to be calculated based on a state's CHIP FMAP and historical CHIP spending.

- Maintains Enhanced CHIP FMAP Under ACA Through FFY 2018-19. States will continue to receive the enhanced FMAP for CHIP authorized by the ACA until September 2019. As previously mentioned, under the ACA, California's current CHIP FMAP is 88 percent. As we will discuss later, federal funding at this higher FMAP will reduce the state's General Fund costs for CHIP in 2017-18, 2018-19, and the first quarter of 2019-20.

- Begins Ratcheting Down the Enhanced CHIP FMAP in FFY 2019-20 and Returns to Traditional CHIP FMAP in FFY 2020-21. For FFY 2019-20 (starting October 1, 2019), states will receive half of their FMAP enhancement for CHIP authorized by the ACA which, in California, results in a 76.5 percent FMAP instead of an 88 percent FMAP until September 2020. For FFY 2020-21 (beginning October 1, 2020), states will return to their traditional CHIP FMAPs which, in California, is a 65 percent FMAP.

- Maintains MOE Requirement for CHIP Under ACA Through FFY 2022-23. As previously mentioned, the ACA required states to maintain their March 23, 2010 Medicaid and CHIP eligibility levels for children through the end of FFY 2018-19. Federal reauthorization of CHIP funding generally extends the ACA's MOE requirement for CHIP until September 2023.

- Permits States to Limit Income Eligibility to 300 Percent of the FPL Starting in FFY 2019-20. One exception to the extension of the ACA's MOE requirement for CHIP through September 2023 is for children in families with household incomes above 300 percent of the FPL. Starting October 1, 2019, states can choose to limit income eligibility for CHIP to at or below 300 percent of the FPL. (Children in families with household incomes at or below 138 percent of the FPL would continue to be covered by Medicaid.) Only a small number of children in families

with household incomes above 300 percent of the FPL are currently eligible for CHIP in California.

Congress passed (and the President later signed) legislation authorizing CHIP funding (at the traditional CHIP FMAP) and the ACA's MOE requirement for CHIP for an additional four years—through FFY 2026-27.

Due to congressional appropriations made after the administration finalized its proposed 2018-19 budget, the proposed state budget makes assumptions about the reauthorization of federal funding for CHIP that differ from the recent federal action outlined above.

The proposed 2018-19 state budget assumed federal funding for CHIP would be reauthorized, but not at California's ACA-enhanced CHIP FMAP of 88 percent. Instead, it assumed the state would receive its traditional CHIP FMAP of 65 percent starting January 1, 2018. (The 2017-18 budget enacted last June had assumed a return to the traditional CHIP FMAP of 65 percent beginning on October 1, 2017.)

Assuming current caseload and program spending trends continue, reauthorization of federal CHIP funding at the enhanced FMAP of 88 percent will reduce estimated General Fund Medi-Cal costs by about $300 million in 2017-18 and about $600 million in 2018-19—relative to the Governor's proposed 2018-19 budget assumptions. The Governor's May Revision budget proposal will reflect this downward adjustment of General Fund costs totaling $900 million over 2017-18 and 2018-19.

Proposition 55 and Medi-Cal Funding

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

Prop 55 Calculation for Remaining EPA Amount for Health Care
2018-19 Governor's Budget

(Dollars in Millions)

		2018-19	2019-20	2020-21	2021-22
1	Revenues/Transfers (before Prop 55)	$124,928	$130,759	$134,347	$138,537
2	P98 GF Expenditures	54,564	55,694	56,065	56,583
3	N98 "Workload Budget" under P55 [1/]	77,089	82,657	86,603	91,791
4	Surplus or Deficit Before Prop 55 revenues	-6,725	-7,592	-8,321	-9,837
5	Incremental New Taxes for EPA (from P55)	4,864	8,160	8,251	8,475
6	Amount needed from P55 to fund workload budget	4,864	7,592	8,321	9,837
7	50% (up to $2 billion) of Remaining EPA Funds Available to Increase Funding for Existing Health Care Programs/Services	0	284	0	0

[1/] Finance interprets that $37 million of spending in 2018-19 does not fit the definition of "workload budget" for Prop 55 calculation purposes. This is spending authorized in the 2017-18 budget and estimated to value at $37 million in 2018-19 and $2019-20, and $1 million in 2020-21 and out years.

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.

The Subcommittee also requests DHCS to provide an overview of the Medi-Cal estimate, highlighting the major policy and fiscal proposals and changes proposed for 2017-18 and 2018-19.

The Subcommittee requests Department of Finance to provide an explanation of their Proposition 55 Medi-Cal funding calculations and assumptions used in revenue and workload cost estimates.

The Subcommittee requests the LAO to provide an overview of their analysis of the Proposition 55 trigger for Medi-Cal funding.

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

ISSUE 2: COUNTY ELIGIBILITY ADMINISTRATION FUNDING

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Cathy Senderling**, Deputy Executive Director, County Welfare Directors Association
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey,** Senior Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The January Budget proposes an increase of $54.8 million ($18.5 million General Fund) in 2018-19 based on an adjustment to the existing funding level using the increase in the California Consumer Price Index. A similar increase will be applied for two years as the county eligibility systems move to a single Statewide Automated Welfare System. The Department will work with the County Welfare Directors Association (CWDA) to improve processing of eligibility determinations and annual redeterminations, correct beneficiary aid codes, and produce timely data and reports.

BACKGROUND

Currently, counties are budgeted for their activities based upon claimed expenditures from prior years. The DHCS County Administration Unit provides the funding for counties to determine eligibility for the Medi-Cal program. A beneficiary's eligibility is reviewed whenever the county is notified of a change in status, and at designated times, such as at annual redetermination. The responsibility to run these processes is placed with each of the State's 58 counties who use state and federal guidelines and statutes to determine eligibility and perform case maintenance activities for California's Medi-Cal population. Currently, the base estimate for county administration consists of three parts, the costs identified as: 1) staff costs; 2) support costs; and 3) staff development costs. The Affordable Care Act (ACA) changed verification requirements and expanded the role and responsibilities of DHCS and county workload as Medi-Cal expanded to cover significantly more individuals and families, which has directly affected the caseload and work carried out by the eligibility workers and staff at the counties.

The passage of SB 28 (Hernández, Chapter 244, Statutes of 2013) required DHCS to develop and implement a new budgeting methodology for county administration of the Medi-Cal program. This new methodology was to be developed in consultation with county staff and fiscal representatives, and to reflect the changes in county operation as a result of implementation of the ACA in 2014. In FY 2014-15, in an attempt to handle the additional workload associated with this effort, DHCS received two limited-term positions as well as funding to hire a contractor to perform advanced research activities and data verification. DHCS hired two staff who engaged in efforts to learn current county processes and spending patterns, research prior efforts to create a new

budgeting methodology, and prepare documents required to engage the services of a contractor. In addition, the two staff began the work needed to convene a joint state and county workgroup that would help create the new budgeting methodology.

However, actual workgroup meetings were placed on hold because County Welfare Director's Association (CWDA) and DHCS agreed that there were too many ongoing changes to county business processes and eligibility systems during the two years after implementation of the ACA. Data necessary to develop the new budgeting methodology would be too unstable and unreliable.

Subsequently, DHCS implemented a Request for Proposals (RFP) process for a contractor, however DHCS was unable to procure a qualified vendor due to limited responses to the request for proposals. Therefore, DHCS is proposing to re-establish the base payment by combining the old base with the ACA-related augmentation, and adding a new COLA. Moreover, as stated above, DHCS intends to work with CWDA to improve processing of eligibility determinations and annual redeterminations, correct beneficiary aid codes, and produce timely data and reports.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present the proposed county funding and respond to any questions. The Subcommittee also requests CWDA to provide their perspective on the current state of county eligibility administration funding.

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

ISSUE 3: PROPOSITION 56 UPDATES AND RATES PROPOSALS

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Lindy Harrington**, Deputy Director, Health Care Financing, Department of Health Care Services
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Jessica Sankus**, Finance Budget Analyst, Department of Finance
- **Ben Johnson,** Fiscal & Policy Analyst, Legislative Analyst's Office
- **Linda Nguy**, Policy Advocate, Western Center on Law and Poverty
- **Children's Health Advocacy Coalition**

Public Comment

PROPOSAL

Home Health Rate Increase. DHCS is proposing a 50 percent rate increase for home health services provided through the fee-for-service system and home and community based waivers, effective July 1, 2018. The Governor's budget assumes $64.5 million total funds ($31.6 million Prop 56 funds) for this increase in 2018-19.

Proposition 56. For 2018-19, the Governor's budget proposes an increase of approximately $232 million in Proposition 56 funding for supplemental payments for dental and physician services, and maintains the supplemental payment or rate increases for all other affected providers (ICF-DD, HIV/AIDS Waiver and Women's Health Services). The total 2018-19 Proposition 56 funding for these providers, including the increase for doctors and dentists, is $649.9 million. DHCS estimates the total funding (both federal and Proposition 56) in 2017-18 for these payments is $1,147 million and in 2018-19 is $2,025 million.

Also noted in the Governor's budget, DHCS plans to analyze the impact of the FY17-18 payment changes and may modify or revise the methodologies for payments for services beginning in the budget year. If these payments are not demonstrating the intent of improving access to services for Medi-Cal beneficiaries, the Administration plans to work with the Legislature to modify the supplemental payments.

Finally, the budget includes $169.4 million in 2018-19 to support new growth in Medi-Cal expenditures compared to the 2016 Budget Act.

BACKGROUND

The 2017-18 Proposition 56 Budget Agreement

The 2017-18 budget package included a two-year budget agreement on Proposition 56 revenues in Medi-Cal. Broadly speaking, the agreement dedicates Proposition 56 Medi-Cal between two main uses of Proposition 56 funding: (1) increasing payments for certain Medi-Cal providers and (2) paying for anticipated growth in state Medi-Cal costs over and above 2016-17 Budget Act levels, which offsets what otherwise would be General Fund costs.

The Legislative Analyst's Office (LAO) provided the following "Figure 6" (*2018-19 Budget: Analysis of the Health and Human Services Budget*) which summarizes the use of Proposition 56 funding in Medi-Cal under the 2017-18 budget agreement between the Legislature and the administration. Specifically, it authorized up to $546 million in 2017-18 and up to $800 million in 2018-19 in provider payment increases, with any remaining Proposition 56 Medi-Cal funding from 2017-18 ($711 million) and 2018-19 ($125 million) to be used to offset General Fund spending on cost growth in the program.

Figure 6

The 2017-18 Budget Agreement on the Use of Proposition 56 Funding in Medi-Cal

(In Millions)

	2017-18	2018-19	Total
Provider payment increases[a]	$546	$800	$1,346
Offsets to General Fund spending on Medi-Cal cost growth[b]	711	125	836
Total Proposition 56 Spending in Medi-Cal	**$1,257[c]**	**$925[c]**	**$2,182**

[a]The 2017-18 budget agreement authorized supplemental provider payment funding amounts up to the amounts listed in this figure.

[b]Any Proposition 56 Medi-Cal funding not allocated to augment the program, such as to increase provider payments, is available to offset General Fund spending.

[c]Amounts reflect the administration's projection of total Proposition 56 revenue allocated to Medi-Cal as of the *2017-18 Budget Act*. The Governor's 2018-19 budget revises upward estimated Proposition 56 revenue allocated to Medi-Cal in both 2017-18 and 2018-19.

The LAO's "Figure 8" below details the specific provider rate increases and supplemental payments that were included in the 2017 budget package:

Figure 8

2017-18 Budget Agreement on Proposition 56 Provider Payment Increases[a]

(In Millions)

	2017-18	2018-19	Two-Year Total
Authorized maximum increases to supplemental payments:			
Physician services[b]	$325	$503	$828
Dental services[b]	140	216	356
Women's health[c]	50	50	100
Intermediate Care Facilities for the Developmentally Disabled[c]	27	27	54
AIDS Medi-Cal Waiver Program[c]	4	4	8
Totals	**$546**	**$800**	**$1,346**

[a]The 2017-18 budget agreement authorized supplemental provider payment funding amounts up to the amounts listed in this figure.

[b]The 2017-18 Proposition 56 budget agreement authorized physician and dental services provider payment increases to be increased by up to $254 million between 2017-18 and 2018-19 (bringing total Proposition 56 funding for increased provider payments to $800 million). After 2018-19, continuation of physician and dental services provider payment increases is expected to be reevaluated.

[c]Payment increases are intended to be ongoing, though they might be funded with an alternative fund source following 2018-19.

For 2017-18, the 2017-18 budget agreement came with a structure of fixed dollar amount or fixed percentage increases in provider reimbursement levels that applied to an identified set of Medi-Cal services ranging from physician and dental visits to certain women's health visits. Moreover, the budget agreement provides that for any provider payment increases in 2018-19 above the total 2017-18 amount, 70 percent is to be dedicated to physician services payment increases and 30 percent is to be dedicated to dental services payment increases. As the 2017-18 budget agreement only goes through 2018-19, future use of Proposition 56 funding for Medi-Cal will be determined through the annual budget process.

Governor's 2018-19 Proposition 56 Budget Proposal

The Governor proposes spending the maximum amount authorized in the 2017-18 budget agreement ($1.346 billion) on provider payment increases within the provider and service categories designated in the 2017-18 agreement. Specifically, the Governor's budget proposal would extend the provider payment increases structured in the 2017-18 agreement into 2018-19 and allocate the remaining Proposition 56 funding dedicated to provider payment increases to pay for new provider payment increases above 2017-18 levels.

The LAO's "Figure 7" below summarizes the Governor's updated 2018-19 budget proposal on the use of Proposition 56 funding in Medi-Cal. The figure shows that the Governor proposes spending slightly more Proposition 56 resources from 2017-18 and 2018-19 on provider payment increases—$1.378 billion—than the maximum amount authorized under the two-year 2017-18 budget agreement. The increase is attributable to the Governor's proposed payment rate increase for Medi-Cal home health services.

Figure 7

The Governor's 2018-19 Budget Proposal on Proposition 56 Funding in Medi-Cal

(In Millions)

	2017-18	2018-19	Total
Provider Payment Increases:			
Provider categories in 2017-18 agreement[a]	$412	$412	$823
Additional funding to be committed[b]	—	523	523
Home health services (new)	—	32	32
Subtotals	**($412)**	**($966)**	**($1,378)**
Offsets to General Fund Spending on Medi-Cal Cost Growth[c]	**$711**	**$169**	**$880**

[a]Amounts listed represent annual cost estimates of supplemental payments structured in the 2017-18 budget agreement by the fiscal year that the affected services are rendered. As a result, the amounts do not account for supplemental payments that are delayed into subsequent fiscal years and are not directly reflected in the Governor's 2018-19 budget display totals.

[b]Allocated by the Governor's 2018-19 budget to broad provider categories included in the 2017-18 budget agreement without a planned payment structure.

[c]Any Proposition 56 Medi-Cal funding not allocated to augment the program, such as to increase provider payments, is available to offset General Fund spending.

Under the Governor's overall Proposition 56 budget proposal, the LAO estimates that $523 million in total Proposition 56 funding is available for additional provider payment increases beyond those structured in the 2017-18 budget agreement. (LAO notes that this amount represents a preliminary estimate that is subject to change at the May Revision.) However, the Governor's budget proposal does not include a detailed plan for how to structure these additional provider payment increases.

New Proposed Provider Payment Increase for Home Health Services

The Governor's budget dedicates a portion of Proposition 56 Medi-Cal funding to pay for payment rate increases for a health care service type—home health services—that was not targeted to receive payment increases in the 2017-18 budget agreement. Relative to the agreement, this proposal increases the total amount of Proposition 56 revenue proposed to be used to increase Medi-Cal provider payments and decreases the amount of Proposition 56 Medi-Cal funding available to offset General Fund spending on cost growth in the program.

Home health services are services provided to patients in their residence instead of an inpatient setting such as a hospital. Home health service providers such as home health agencies hire registered nurses, licensed vocational nurses, and certified home health aides to—for example—administer patients' oral medications, insert feeding tubes, and treat wounds. All Medi-Cal beneficiaries are generally eligible for home health services as long as the services are medically necessary. Medi-Cal reimburses home health services at levels based on the type of health professional who provides the services and the length of time needed. These services are available through the two main Medi-Cal delivery systems, fee-for-service (FFS) and managed care, as well as through Medi-Cal's various Home and Community Based Services (HCBS) waiver programs. (HCBS waiver programs allow states to deliver long-term services and supports, such as home health services, to Medicaid beneficiaries in their residences.)

The department monitors access to home health services in Medi-Cal FFS through federally mandated access monitoring and self-generated studies on access to particular services. For example, in a late 2016 self-generated study of access to home health services largely within the California Children's Services program, DHCS concluded there was a gap between the number of hours authorized for eligible beneficiaries and the number of hours rendered by providers. While the study could not explain the disparity, it cited for additional study specific barriers to access, including provider rates, staffing shortages, and geographic disparities. The administration cites this study in support of its proposal to increase certain home health service provider rates in 2018-19.

Starting July 1, 2018, the administration proposes to increase provider rates for home health services participating in Medi-Cal FFS and four HCBS waiver programs—the Home and Community-Based Alternatives Waiver, the In-Home Operations Waiver, the Pediatric Palliative Care Waiver, and the AIDS Medi-Cal Waiver Program—by 50 percent. The administration estimates the total cost of the provider rate increase in 2018-19 would be $65 million—$41 million for the rate increase, and $24 million for an

anticipated increase in utilization of home health services by 15 percentage points. The Governor's budget proposes to fund the nonfederal share in 2018-19—$32 million—using Proposition 56 revenues. While the administration proposes that these rate increases be ongoing, it does not identify funding for the nonfederal share after 2018-19.

Stakeholder Proposals

Several organizations, including Western Center on Law and Poverty (WCLP) and a coalition of children's advocacy organizations have requested that Proposition 56-funded supplemental payments be expanded to include specific additional dental services as follows:

WCLP requests that basic preventive dental services be eligible for supplemental payments, stating that: "Maintaining an individual's teeth is always preferable to having to restore teeth and function after loss due to decay and disease, which will also save the Medi-Cal program money in the long-run. In addition, to ensure that the restoration of gum treatment services are actually utilized, we request periodontal services (gum treatment) be eligible for supplemental payments. There is strong and growing evidence of the relationship between poor gum health and medical problems, including diabetes and heart disease. Thus, gum treatment is essential not just to oral health, but overall health."

The children's coalition states that the services receiving supplemental payments this year misses "an opportunity to realize the Proposition 56 goals for children because the health care billing codes identified in the SPAs as eligible for Supplemental Payments were skewed towards codes that covered adult populations and conditions and are problem-oriented evaluation and management services rather than prevention-focused services."

"Preventive pediatric physician service and dental service codes that should receive Medi-Cal supplemental payments include:

- 99381, 99382, 99383, 99384, and 99385 which are age-specific initial comprehensive preventive medicine services for new patients;
- 99173, 99174, and 99177 for vision screenings;
- 92551, 92552, and 92567 for hearing screenings;
- 96110 for developmental screenings;
- 96127 for emotional/behavioral assessments;
- 90460 for pediatric immunization administration;
- D1203/1208 for topical application of fluoride to help prevent dental decay;
- D1206 for topical fluoride varnish, therapeutic application for moderate to high caries risk patients;
- D1351 for dental Sealant to prevent the progression of dental decay; and
- D9992 for dental Case Management and care coordination for when dental services are provided in community locations outside of dental offices or clinics."

LAO Concerns and Recommendation

The LAO points out that the Governor's budget proposes to use $32 million in Proposition 56 revenue that would otherwise be available to offset General Fund spending on cost growth in Medi-Cal to increase payment rates for home health services. In support of its proposal, the administration has provided some evidence that access to home health services could be a challenge for certain Medi-Cal beneficiaries. In deciding whether to approve the Governor's proposal, however, the LAO recommends that the Legislature consider the following:

- Whether the rate increases should be ongoing or limited term, given the uncertain cause of the gap between the number of authorized hours and rendered hours for home health services.

- Whether the rate increases should assume increased utilization of roughly 15 percentage points in 2018-19 and, if not, whether the amount of Proposition 56 revenues allocated for these rate increases should be higher or lower to reflect a different assumption about changes in utilization.

The LAO recommends that, should the Legislature consider these issues and wish to increase payment levels for home health services in the amount proposed by the Governor's budget, the Legislature direct DHCS to conduct an additional study to determine the primary cause of the gap between the number of authorized hours and rendered hours for home health services in Medi-Cal. The LAO also recommends the Legislature direct DHCS to report back to the Legislature on changes in utilization of home health services (and associated costs) in Medi-Cal after the rate increases went into effect.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present their proposals on the use of Proposition 56 revenue and respond to the following:

For the Denti-Cal supplemental rates, the 40 percent supplemental payment increases for certain services did not commence until five-months after the budget was approved due to the federal CMS approval process. Even if continued funding is approved, the existing SPA will end on June 30, likely disrupting supplemental payments for several months.

1. What can DHCS do to ensure that a disruption in FFS supplemental payments will not happen? Does DHCS have adequate authority to ensure that this does not happen?

For 2018-19, DHCS is proposing an additional $69.9 million in new supplemental payments, in addition to federal funds.

2. Are there sets of services DHCS is looking at for this new funding and what factors and assumptions are being used to project this figure? (e.g. caseload mix, population growth, utilization increase, percentage federal share?)

DHCS states the change from last year (i.e., $140 million Healthcare Treatment Fund) to the revised 2017-18 estimate ($78.8 million) is a decrease due to updated projected costs and a payment lag. It appears that DHCS underspent by $61million.

3. How much of this underspending is payment lag, caseload and dental treatment mix, percentage federal share?

4. What is happening to the additional $61 million that is not estimated to be spent in 2017-18?

As described above, the Governor's budget states that DHCS plans to analyze the impact of the FY17-18 payment changes and may modify or revise the methodologies for payments for services beginning in the budget year. If these payments are not demonstrating the intent of improving access to services for Medi-Cal beneficiaries, the Administration plans to work with the Legislature to modify the supplemental payments.

5. Please describe this process.

6. When will DHCS have sufficient data to be able to see the impact of Proposition 56 supplemental payments and rate increases?

7. Does DHCS believe that it is possible for short-term supplemental payments to have a significant impact on increasing provider participation in Medi-Cal?

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

ISSUE 4: PEDIATRIC DAY HEALTH CARE RATE INCREASE MEMBERS' AND ADVOCATES' PROPOSAL

PANELISTS

- **Assemblymember Jim Patterson**
- **Terry Raccaito,** Chair Pediatric Day Health Care Coalition, President, Together We Grow

Public Comment

PROPOSAL

Assemblymembers Patterson, Chavez, Dahle, Fong, Gallagher, Maienschein, and Steinorth, and the Pediatric Day Health Care Coalition request $8 million total funds ($4 million state funds) to provide a 50 percent rate increase for Pediatric Day Health Care (PDHC) Facilities.

BACKGROUND

The Assemblymembers making this request provided the following background information:

There are nearly 4,400 children statewide with severe long-term, complex, and catastrophic health needs that are eligible in the state's fee-for-service (FFS) Medi-Cal system. Within this system, families have the option to receive nursing services inside the home (via home health agencies) and/or to participate in outside activities for play, learning, and social interaction (via PDHC facilities). PDHC's are the only option for many families who want this social oriented type of care provided for their children. However, of the last 18 years, out-of-date reimbursement rates have increasingly made it difficult to hire and retain nurses, which have resulted in decreased access to reliable, quality care for these children. This has also caused PDHC facilities to close or limit hours as well as much-needed facilities under consideration to ultimately not be opened.

The Governor's 2018 proposed budget includes a 50 percent rate increase for home health services effective July 1, 2018, but this rate increase does not apply to PDHCs. Supporters of this request state that PDHCs face the same barriers as home health agencies, compete for the same nurses to provide services, and provide those services to the same medically fragile children. Providing this increase to PDHCs would ensure that families continue to have options when deciding what type of care would benefit their child. They state further that by increasing PDHC rates, Medi-Cal beneficiaries will be ensured access to essential care for their medically fragile children and relief for their families.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Patterson and Terry Raccaito to present this proposal.

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

ISSUE 5: INCREASE MEDI-CAL RATES FOR BREAST PUMPS ADVOCATES' PROPOSAL

PANELISTS

- **Robbie Gonzalez-Dow,** Executive Director, California Breastfeeding Coalition

Public Comment

PROPOSAL

The California WIC Association and the California Breastfeeding Coalition request an increase to the reimbursement rate for personal breast pumps, kits and manual pumps. No increase is requested for the rental of hospital grade breast pumps.

	HCPCS E0603 Personal breast pump	HCPCS E0602 Breast pump kit	HCPCPS E0602 Manual breast pump	HCPCS E0604 Hospital grade pump-rental
Current reimbursement rate:	$93.15	$23.62	$23.62	$2.72/day
Suggested reimbursement rate:	$186.18	$40.32	$40.00	No suggested change
Maximum budget impact:	$5,826,473	$551,380	$245,440	$0

BACKGROUND

The California WIC Association provided the following background information:

Progress has been made in California over the last two decades with improved maternity care practices, state and federal laws and cultural acceptance of breastfeeding. Breastfeeding rates, including for low-income women, while still very low, have increased for initiation and duration. Despite this, there are still challenges, one being the low reimbursement rates for quality breast pumps and supplies that imposes a barrier to access for low-income women in California.

A huge barrier to obtaining quality breast pumps and supplies under Medi-Cal for low-income women is the inadequate reimbursement rates for breast pumps and supplies. The current Medi-Cal rates were set 30 years ago. These low rates are untenable for durable medical equipment suppliers and manufacturers to provide breast pumps, including ones, such as WIC uses, that are effective. As a result it has gotten more difficult to acquire an effective breast pump through a Medi-Cal plan. A recent actuarial analysis, *Breastfeeding Support in the Medi-Cal Population: A Large Return on a Small Investment*, reported that for total breastfeeding support, counseling and breast pump supplies, the per member per year costs would be only be $1.16. Medi-Cal could realize

a savings of $405,000-$940,000 per 100,000 births, by providing breastfeeding support and supplies.

To continue to breastfeed, especially with a majority of mothers returning to work and school, most mothers need effective and quality breast pumps. Some mothers need a breast pump to overcome initial challenges. Medi-Cal was always supposed to be the first level of support for breastfeeding needs, including pumps. In reality though, mothers have not gotten the support they need through their health plan and medical provider, especially for a time-sensitive medical need such as breastfeeding, and have turned to WIC or stopped breastfeeding.

WIC has for nearly 30 years, provided low-income women with support and counseling for how to breastfeed and address challenges. One component of support has been the provision of high quality breast pumps, when appropriate for initial problems, and when available for return to work or school.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Robbie Gonzalez-Dow to present this proposal.

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

ISSUE 6: AIR AMBULANCE MEDI-CAL RATE INCREASE ADVOCATES' PROPOSAL

PANELISTS

- **Kat Scott**, Cal-AAMS

Public Comment

PROPOSAL

Emergency air providers are requesting a Medi-Cal rate increase commensurate with the Rural Medicare rates. The cost estimate for this rate increase is $40 million total funds ($20 million state funds) annually, however this amount would be offset by remaining special fund resources, as described below, by $12 million per year in 2018-19 and 2019-20.

BACKGROUND

Cal-AAMS provided the following background information:

Emergency air ambulance services are an essential part of the Statewide EMS system and provide a critical link between rural areas and urban tertiary care hospitals (trauma centers, heart/stroke centers, burn units, Children's Hospitals and neonatal centers, etc.). They also play a key role in disaster response and homeland security.

The vast majority of the emergency air ambulance services throughout California are provided by private entities that do not receive local tax support. These critical service providers transport all emergency patients without knowing if the patient has any form of medical insurance or ability to pay for the service. A significant number of emergency patients transported by air ambulances have no insurance, and have no ability to pay for the service, yet these patients are given the same high level of care as those with medical insurance.

Medi-Cal rates for air ambulance services have not increased in more than twenty years. AB2173 (Jim Beall, Chapter 547, Statutes of 2010) augmented the then 15-year-old Medi-Cal fee schedule by making supplemental payments to air ambulance providers. Specifically, the Emergency Medical Air Transportation Act (EMATA) placed a $4 penalty on moving violations which is then matched with federal funds, and distributed to providers by way of supplemental payments. In the face of growing concerns over the magnitude of penalties assessed on moving violations, the Legislature has determined that the EMATA program will expire in 2019. The Cal-AAMS states that the loss of these funds will be devastating to these emergency providers.

The 20-plus year old Medi-Cal fee schedule pays less than half of the rural Medicare rate. Unlike hospitals and ground ambulance services which are able to augment their Medi-Cal payments by use of a Quality Assurance Fee (i.e. a provider tax), air ambulances are precluded from doing so by federal law, as they are licensed air carriers. They state that air ambulance providers will be devastated by the impending end to the EMATA funding. An increase to the Rural Medicare rate will sustain services, preventing potential base closures or reductions in services, despite the fact that the rural Medicare fee schedule reimburses providers at approximately 2/3^{rds} of the costs of providing the service.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Kat Scott to present this proposal.

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

ISSUE 7: OPTION MEDI-CAL BENEFITS ADVOCATES' PROPOSALS

PANELISTS

- **Linda Nguy,** Western Center on Law and Poverty
- **Dr. John Abordo,** DPM, California Podiatric Medical Association

Public Comment

PROPOSAL

Western Center on Law and Poverty (WCLP) requests restoration of the remaining optional benefits that were eliminated during the recession (2009), specifically: audiology, podiatry, speech therapy, and incontinence cream & washes. The California Podiatric Society requests restoration of full podiatry services, regardless of health care setting.

All the restorations combined are estimated to cost $130,807,000 ($43,209,000 General Fund) annually, as shown in the chart below. The podiatry benefit is estimated to cost $15,296,000 total funds ($4,996,000 General Fund) annually.

BACKGROUND

Through the 2009 Budget Act and health trailer bill, the state eliminated several Medicaid optional benefits from the Medi-Cal program. These benefits were eliminated for budgetary reasons in response to the fiscal crisis. Several of these benefits have been restored and there is support for restoring the remaining benefits to the Medi-Cal program. The restorations include:

2013:

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

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

2016:

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

2017:

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

- ***Optical Benefits*** - $12.5 million (General Fund) in 2019-20 and $26.3 million ongoing and trailer bill to restore the Optician/Optical Lab optional Medi-Cal benefits beginning January 1, 2020.

States establish and administer their own Medicaid programs (Medi-Cal in California) and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to provide other "optional benefits." Although these benefits were "eliminated," there were exceptions for certain facilities and populations for which the benefits continue to be covered; they include: Federally Qualified Health Centers and Rural Health Centers, emergency room services, patients with developmental disabilities, pregnant women, children (i.e. EPSDT) and PACE programs.

Optional Benefits Costs

The chart below shows the various optional benefits that were eliminated in 2009 (that still have not been restored, with the exception of optical services which will be restored in 2020 contingent upon funding included in the 2019-20 budget) and the estimated costs to restore the benefits.

November 2017 Estimate
Optional Benefits Restoration

FY 2018-19 *(lagged)**	FFS	Managed Care	TF	GF	FFP
Optional Benefits Restoration:	A	B	A+B		
Audiology	$3,859,000	$6,632,000	$10,491,000	$3,124,000	$7,367,000
Chiropractic	$483,000	$4,866,000	$5,349,000	$1,262,000	$4,087,000
Incontinence Cream and Washes	$7,102,000	$9,789,000	$16,891,000	$5,208,000	$11,683,000
Optician / Optical Lab[3]	$16,772,000	$58,104,000	$74,876,000	$20,810,000	$54,066,000
Podiatry	$2,131,000	$12,768,000	$14,899,000	$3,404,000	$11,495,000
Speech Therapy	$246,000	$2,357,000	$2,603,000	$722,000	$1,881,000
Grand Total	**$30,593,000**	**$94,516,000**	**$125,109,000**	**$34,530,000**	**$90,579,000**

FY 2018-19 *(no-lag)*	FFS	Managed Care	TF	GF	FFP
Optional Benefits Restoration:	A	B	A+B		
Audiology	$4,578,000	$6,632,000	$11,210,000	$3,370,000	$7,840,000
Chiropractic	$573,000	$4,866,000	$5,439,000	$1,293,000	$4,146,000
Incontinence Cream and Washes	$8,426,000	$9,789,000	$18,215,000	$5,660,000	$12,555,000
Optician / Optical Lab[3]	$19,895,000	$58,104,000	$77,999,000	$21,876,000	$56,123,000
Podiatry	$2,528,000	$12,768,000	$15,296,000	$3,540,000	$11,756,000
Speech Therapy	$291,000	$2,357,000	$2,648,000	$737,000	$1,911,000
Grand Total	**$36,291,000**	**$94,516,000**	**$130,807,000**	**$36,476,000**	**$94,331,000**

FY 2018-19 Notes:

1/ ACA Optional Funding for FY 2018-19 is 94% FF / 6% GF (Jul-Dec 2018), and 93% FF / 7% GF (Jan-Jun 2019)
2/ For fee-for-service (FFS), payment lags are assumed with a July Implementation date.
3/ SB 97 (Chapter 52, Statutes of 2017) includes language in Welfare & Institutions Code (W&I) 14131.10(g) to restore the Optical Lab and optician services no sooner than January 1, 2020 or January 1st of the subsequent calendar year following an act from the Legislature.
4/ For managed care, Member Months (MMs) were updated to projected FY 2018-19 amounts.
5/ Applied MMs to each Category of Aid. The cost impact depends on the weight of the population type. Typically, SPDs will cost more than Adults.
6/ Prior optional benefits restoration (OBR) managed care estimates used May 2009 estimate data. This current OBR estimate uses FFS claims data from FY 2007-08 and FY 2008-09 to come up with the per-benefit PMPM.

Annual	FFS	Managed Care	TF	GF	FFP
Optional Benefits Restoration:	A	B	A+B		
Audiology	$4,578,000	$6,632,000	$11,210,000	$3,751,000	$7,459,000
Chiropractic	$573,000	$4,866,000	$5,439,000	$1,766,000	$3,673,000
Incontinence Cream and Washes	$8,426,000	$9,789,000	$18,215,000	$6,128,000	$12,087,000
Optician / Optical Lab[3]	$19,895,000	$58,104,000	$77,999,000	$25,708,000	$52,291,000
Podiatry	$2,528,000	$12,768,000	$15,296,000	$4,996,000	$10,300,000
Speech Therapy	$291,000	$2,357,000	$2,648,000	$860,000	$1,788,000
Grand Total	**$36,291,000**	**$94,516,000**	**$130,807,000**	**$43,209,000**	**$87,598,000**

Annual Notes:

1/ Funding for Annual estimate assumes 90% FF / 10% GF for ACA Optional with FY 2018-19 caseload from the November 2017 Estimate.
2/ Payment lags were not applied to the Annual Fiscal Impact.
3/ SB 97 (Chapter 52, Statutes of 2017) includes language in Welfare & Institutions Code (W&I) 14131.10(g) to restore the Optical Lab and optician services no sooner than January 1, 2020 or January 1st of the subsequent calendar year following an act from the Legislature.

The WCLP provided the following background information:

Access to these optional benefits prevents deterioration of health and the need to utilize costlier emergency services. For example, podiatry services are particularly critical for many diabetics who often need more expensive services from complications if they do not get the podiatric services, including amputations. Access to podiatrists can prevent complications for patients and provide savings in addition to improved quality of life. Restoring audiology, podiatry, speech therapy, and incontinence cream & washes benefits would only cost the state about $15 million in General Fund dollars but would greatly improve the health outcomes for some poor Californians. In a time of recovery and surplus, it is paramount that the state's most vulnerable residents have access to these medically necessary services.

The California Podiatric Medical Association provided the following background information:

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

Currently, podiatrists perform physician services and have full medical staff admitting and surgical privileges in hospitals and surgery centers. However, they are prohibited from providing podiatric services to patients in the Medi-Cal system unless certain conditions are met or the treatment is provided in a specific setting (for example, podiatrists may be reimbursed only if the treatment is performed in a Federally Qualified Health Center, Rural Health Clinic, emergency room, or in-patient hospital setting). This limitation on podiatry has led to a delay in cases of diabetic foot care, traumatic foot, and ankle injuries.

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

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

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

STAFF COMMENTS/QUESTIONS

- The Subcommittee requests Linda Nguy and Dr. John Abordo to present these proposals.

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

ISSUE 8: CA 1115 WAIVER – MEDI-CAL 2020 BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS requests to extend limited-term (LT) resources to continue supporting compliance with California's Section 1115(a) Medicaid Waiver - Medi-Cal 2020 (2020 Waiver). The requested resources include two-year LT funding equivalent to 2.0 positions and one-year LT contract funding:

Total funding request:

Fiscal Year	Total Funds	General Fund	Federal Fund
2018-19	**$4,463,000**	**$2,232,000**	**$2,231,000**
Staffing:	*$263,000*	*$132,000*	*$131,000*
External Contracts:	*$4,200,000*	*$2,100,000*	*$2,100,000*
2019-20	**$263,000**	**$132,000**	**$131,000**
Staffing:	*$263,000*	*$132,000*	*$131,000*

BACKGROUND

According to DHCS, the 2020 Waiver is a fundamental component in California's efforts to improve population health and strengthen overall health care delivery. Its primary aim is to improve care coordination and reinforce monitoring and accountability of managed care plan partners. With the approval of the 2020 Waiver, several programs, such as the Whole Person Care (WPC) Pilot Program were developed. The overarching goal of WPC program is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities have identified targeted populations and begun sharing data between systems, coordinating care real time, and evaluating individual and population progress—all with the goal of providing comprehensive coordinated care for the beneficiary, resulting in better health outcomes. Waiver programs contain a required external evaluation. CMS has reviewed and approved the evaluation design.

SB 586 (Hernández, Chapter 625, Statutes of 2016) tasked DHCS to establish the Whole-Child Model (WCM) program in designated County Organized Health System (COHS) or Regional Health Authority counties. The goal is to incorporate California Children's Services (CCS) program-covered services for Medi-Cal eligible CCS children and youth into a managed care plan. DHCS has developed a "Whole-Child Model" to be implemented in 21 specified counties, no sooner than July 2018. The results are expected to be improved care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions. DHCS states that the benefits are consistent with CCS program standards and provided by CCS paneled providers, specialty care centers and pediatric acute care hospitals. WCM approach meets the six goals for CCS Redesign: Implement Patient and Family - Family Centered Approach; Improve Care Coordination through an Organized Delivery System; Maintain Quality; Streamline Care Delivery; Build on Lessons Learned; and to be Cost Effective. The approach is consistent with the primary goals of providing comprehensive treatment and focusing on the whole child, including the child's full range of needs rather than only on the CCS health condition. There are 21 counties and 5 health plans that will participate in the WCM. DHCS is amending the 2020 Waiver to include the WCM program.

DHCS previously submitted two budget change proposals (BCP) for the 2020 Waiver including 1115 Waiver Renewal - "Medi-Cal 2020" 4260-301-SFL-DP-2016-A1 and MediCal 2020 Contract Funding 4260-010-BCP-2017-GB. Both BCPs added resources to support implementation. BCP 4260-301-SFL-DP-2016-A1 added LT funding equivalent to 9.0 positions, 2.0 of which were approved for only two years. DHCS requests continuation of the funding equivalent to these 2.0 positions in order to extend the department's ability to retain subject matter experts and allow a smooth transition from implementation to operational management and monitoring as outlined in the Special Terms and Conditions of the 2020 Waiver.

- In BCP 4260-301-SFL-DP-2016-A1, DHCS allocated one-time external evaluation contract funding of $1,000,000 in FY 2016-17 only, comprising $500,000 each for the evaluations of the WCM and SPD programs, respectively.

- In BCP 4260-010-BCP-2017-GB, DHCS requested funding of $1,000,000 per year in FY 2017-18 to FY 2020-21 for WPC learning collaborative pilots. Because of a delay in approval of the evaluation design, DHCS was not able to contract for the required external evaluation component in the first year. When CMS reviewed the evaluation designs, it identified additional requirements that would need to be included in order to achieve its approval.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 9: HEALTH CARE REFORM FINANCIAL REPORTING BUDGET CHANGE PROPOSAL

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Ryan Woolsey**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Administration Division, Financial Management Branch (FMB), requests to extend 18.0 limited-term (LT) resources for three additional years. The associated LT expenditure authority is $1,926,000 ($963,000 General Fund (GF); $963,000 Federal Fund (FF)), annually for Fiscal Year (FY) 2018-19 to FY 2020- 21.

Resources are set to expire on June 30, 2018. DHCS states that continued staffing is needed to address the existing Centers for Medicare and Medicaid Services (CMS) requirements for Affordable Care Act (ACA) federal reporting.

BACKGROUND

In State Fiscal Year (SFY) 2015-16, DHCS was authorized 18.0 three-year LT positions to address the increases in CMS-mandated ACA reporting requirements. The 18.0 positions complete ACA workload including, but not limited to, processing accounts payable invoices, processing accounts receivable and federal reporting. The number of invoices, receivables, and federal reporting worksheets increased drastically due to ACA, which was implemented on January 1, 2014.

Federal reporting of the CMS-64 quarterly claim consists of several reports based on state plan amendments, waivers, and base provider payments. All expenditures are unique, based on special terms and conditions agreed to by CMS and DHCS. Each expenditure has specific reporting requirements that are complex and require significant research, utilizing different IT systems that were designed for different reporting requirements. The reconciliation of these separate systems, with the expenditures and the correlating federal fund drawdowns, requires both quarterly and annual audits. The workload of these staff continue at maximum capacity as they are tasked with meeting all reporting/reconciliation requirements in addition to providing support for special and recurring audits. Failure to meet federal reporting requirements can result in the loss of federal grant award funding which would create pressure for the General Fund.

The federal audits performed by CMS, the federal Government Accountability Office, the federal Office of Inspector General, and the annual grant reconciliations consist of complex detailed information and require the entire federal reporting staff's time. These audits have resulted in additional federal fund receipts and repayment of funds to CMS.

DHCS is the single state agency that administers the Medi-Cal program. The federal reporting requirements of the ACA expanded FMB beyond its capacity in 2014. Despite any federal uncertainty, the additional federal reporting requirements, enacted in 2014 will continue. Therefore, DHCS requires the extension of the current staffing levels to meet the continued, expanded federal reporting requirements, per the following:

- ACA federal reporting requirements increased the workload for Medi-Cal reporting. CMS required 8,100 forms for the financial reporting of Medi-Cal benefits prior to ACA. Currently, CMS requires 9,936 forms.

- Per current federal law, the expanded federal reporting requirements will continue.

- Due to the complexity of the ACA, reconciliation workload of the benefits payments increased and are expected to remain at or above this level. The ACA requires current staff dedicated solely to ACA, as the guidelines, population and modified adjusted gross income information are significantly different from the pre-ACA MediCal benefits payments.

- Reconciliation for Drug Rebates, Overpayment Collections, and False Claims Act settlements for the ACA population increased the workload for FMB and the corresponding programs, due to the complexity of the federal requirements.

- 18.0 LT staff are performing the current workload and need to continue to meet ACA requirements. Not meeting the federal reporting requirements for these reconciliations can negatively impact the receipt and amount of the State's quarterly federal Medicaid grant award. Further, delays in making payments to the federal government for the collection of provider overpayments, drug rebates, and settlements result in additional interest charges owed by the State. Finally, flawed, incomplete, and/or delayed federal reporting would result in the State's failure to comply with the Code of Federal Regulations (CFR) requirements for Medicaid funding.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 10: HIPAA PRIVACY RULE COMPLIANCE BUDGET CHANGE PROPOSAL

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Information Management Division (IMD), Office of Health Insurance Portability and Accountability Act (HIPAA) Compliance (OHC), requests 4.0 permanent positions and expenditure authority to address the rapid and continuous increase in privacy and security breaches of protected health information (PHI) or personally identifiable information (Pll).

Total funding request: $513,000 ($257,000 GF; $256,000 FF) in FY 2018-19 and $477,000 ($239,000 GF; $238,000 FF) in FY 2019-20 and ongoing.

BACKGROUND

DHCS is a HIPAA covered entity and therefore is responsible for the management of potential privacy and security incidents, along with notifications to Medi-Cal members impacted by a breach of their PHI/PII. In recent years, DHCS has grown in number of programs provided, members served, and complexity. The increase in programs resulted from the incorporation of programs from the Department of Public Health, Department of Social Services, and former Departments of Mental Health and Alcohol and Drug Programs, the Managed Risk Medical Insurance Board, and the California Medical Assistance Commission. At the same time, members served by DHCS have increased from 7.5 million members in 2012 to nearly 14 million in 2017. DHCS maintains over 400 contractual relationships with HIPAA business associates, which have privacy and security incident reporting obligations to DHCS. These changes have contributed to the increase of PHI/PII volume and the number of potential incidents related to that information.

Privacy and security requirements in state and federal law continue to increase, as do potential threats and risks. The sophistication and potential harm from malicious attacks has risen significantly in recent years. DHCS is responsible for protecting confidential data for nearly 14 million members in Medi-Cal, as well as Californians participating in the full range of DHCS programs.

Title 45 of the Code of Federal Regulations requires that HIPAA covered entities notify individuals impacted by a breach of their PHI/PII within 60 days of discovery. The federal Office for Civil Rights (OCR) actively enforces HIPAA privacy laws at the

national level. As of May 2017, OCR has imposed more than $72.9 million in civil penalties to HIPAA covered entities for failure to comply with timely notification requirements. DHCS is also required to comply with the requirements of California Civil Code 1798.29, including the requirement that notifications of breached security information be made without unreasonable delay and in the most expedient time possible.

The OHC, Information Protection Unit (IPU) monitors information privacy and security throughout Medi-Cal and coordinates Corrective Action Plans and notifications when an information breach occurs. IPU's foremost function is to serve as the Department's monitoring force in ensuring privacy and security standards are being met. This includes a rapidly increasing workload of reported privacy and security breaches, which entails research, triage and adjudication. Additional efforts to enforce security and privacy standards include IPU's responsibility for the creation, delivery, maintenance, and tracking of the annual privacy and security training for all DHCS employees.

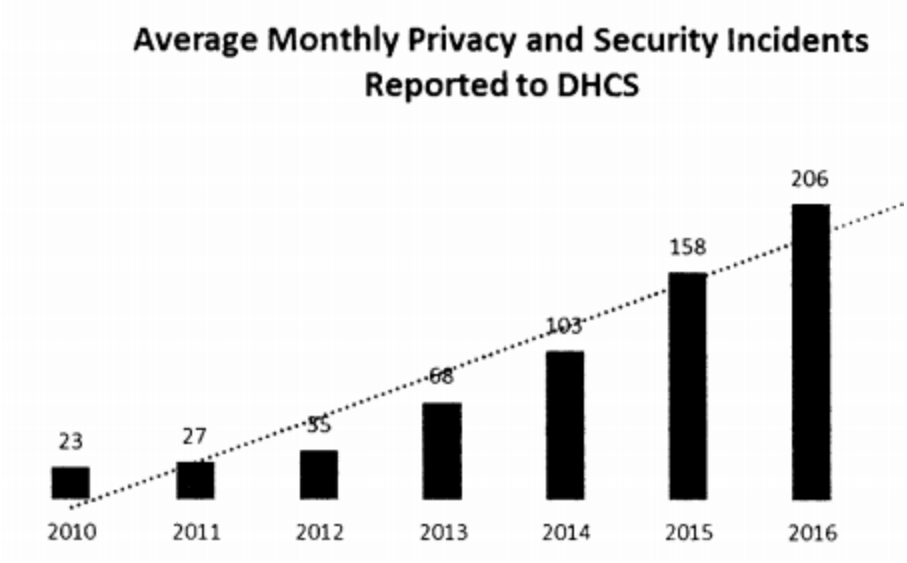
As a covered entity, DHCS provides a process for the public to make complaints concerning the covered entity's policies and procedures, including access via email and telephone. IPU is responsible for documenting all HIPAA complaints received and their disposition. Staff must log and research each complaint, in order to respond and close it in a timely manner. As with incident reports, IPU receives an increasing number of HIPAA complaints from the public each year (see chart on next page).

Additionally, the IPU was assigned the task of developing and implementing a program of in-person, DHCS division-directed privacy and security training for delivery throughout the Department. This program entails designing each individual training session to the needs and applicability of the division in which it is being directed. IPU staffing has not increased for this new responsibility.

Over the past several years, DHCS has been the subject of multiple audits that have recommended improvements in the management of privacy and security compliance. These audits have specifically highlighted the need for increased staffing to handle the increase in reported incidents. In 2013, IPU was the subject of a Federal Information Security Management Act (FISMA) audit (currently known as the State Leadership Accountability Act-SLAA), which found responses/resolutions for reports of breach were not always timely, and additional training regarding Privacy and Security was needed throughout the Department. At that time, IPU received an average of 68 reports of breaches per month for a total of 866 incidents that year. At the end of November 2017, IPU received an average of 231 reports per month for a rate of 2,772 per year. There has not been a corresponding increase in IPU staffing to address this continued increase in workload.

In 2016-17, DHCS was the subject of a California Office of Health Information Integrity (CalOHII) compliance review, which highlighted the concern that "[s]taffing issues are preventing the Department from performing critical compliance responsibilities and functions." The compliance review identified staffing concerns as an area of risk. The compliance review also identified breach and breach notification as a high-risk item, due to the "ongoing increase in open incidents for the past 2 years."

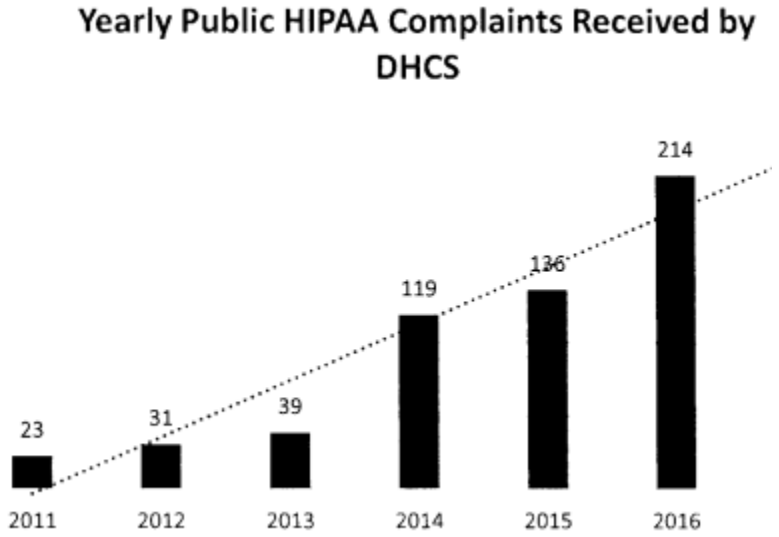
These state and federal security audits have increased in recent years, thereby increasing the potential for fines and negative outcomes. For example, the federal OCR has levied multi-million dollar penalties on both state and private health-care entities. As such, DHCS places a high priority on maintaining the highest level of compliance with HIPAA, and has identified a number of HIPAA security rule areas where the level of compliance must be strengthened to avoid OCR fines and further protect the private information of its Medi-Cal members.



In 2016, the unit received an average of 206 reports of incidents per month, compared to 158 per month the prior year. This represents a 30 % increase in incidents over one year, and is almost ten times the number of incidents reported in 2010 (see above chart). As described above, this upward trend in reported incidents can be attributed to the dramatic increase in the number of beneficiaries (7.5 million in 2012 to nearly 14 million in early 2016), as well as an increased awareness of reporting responsibilities. The number of incidents open at any point in time has also increased, thereby delaying the implementation of remediation steps and the carrying out of corrective action plans by the organizations reporting the breach.

As of November 29, 2017, IPU currently has 278 unresolved reports of privacy/security incidents. As cases are triaged and adjudicated, those that are determined to be breaches take 42 percent longer to close. With the current staffing levels, IPU will continue to fall further behind in our adjudication and notifications of breaches of Medi-Cal PHI/PII.

In addition to the privacy/security breach reporting responsibilities, IPU receives HIPAA complaints from the public. IPU logs, researches, and responds to each complaint. In 2013, IPU received 39 public complaints; however, in 2016, IPU received 214 public complaints, representing a 448 % increase (see increase in chart below).



In an effort to address the increasing workload, OHC has attempted to cross train and temporarily redirect other staff. However, with the current backlog and the estimated increase in reporting, these attempts have been insufficient. Permanent new positions are needed to address the workload and reduce the Department's vulnerability to federal fines, penalties and the loss of public trust.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 11: ORANGE COUNTY RELOCATION BUDGET CHANGE PROPOSAL

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Administration Division, Program Support Branch (PSB) requests permanent expenditure authority for new-leased space to relocate staff out of the Santa Ana State Building at 605 W. Santa Ana Boulevard, in Santa Ana, CA and consolidate with staff from 770 The City Drive South, in Orange, CA, to one location.

DHCS is moving out of the Santa Ana State Building in coordination with the Department of General Services' (DGS) effort to vacate the building and consolidate State programs into a larger leased office building that will better serve DHCS and other tenant departments.

The total funding request is $562,000 ($281,000 General Fund (GF); $281,000 Federal Fund (FF)) in Fiscal Year (FY) 2018-19, including $155,000 to cover one-time costs and $407,000 for facilities rent with an estimated annual increase of 4% per year thereafter.

BACKGROUND

Over the past five years, DHCS has had to address numerous employee concerns at the Santa Ana State Building. DHCS has documented building weaknesses such as leaking windows, floors with uneven surfaces that do not meet Americans with Disabilities Act (ADA) regulations, and walls that are not structurally sound.

The building's aging infrastructure contributes to an inefficient functionality and design, poor energy efficiency and security issues. DGS identified over $16 million in required repairs. DGS has pursued a long-term lease where the current tenants of the Santa Ana building will consolidate functions. The lease includes a turn-key tenant improvement package that allows DHCS to provide an efficient, safe and accessible office where DHCS employees can better serve the public. In addition to the ADA and structural issues, crime incidences in the area have increased.

The Santa Ana State Building no longer meets DHCS program needs due to the age and condition of the building. Renovations and remodels are cost prohibitive and often unable to be completed due to the presence of hazardous materials.

In addition to this relocation, DHCS is striving to comply with Executive Order B-17-12 to reduce DHCS's leased square footage throughout the State by consolidating the 67 staff from Santa Ana and the 22 staff from the Orange location, into one building. Since the current leased space in Orange will not accommodate all 89 staff, DHCS plans to move the staff from the Orange location to the space DGS is able to find for the Santa Ana staff.

With the site search under way by DGS, DHCS is projecting the rent will increase by $407,000 per year, with an estimated increase of 4% each year moving forward. In addition to the rent increase, DHCS will be responsible for $155,000 in one-time costs associated with completing the setup of the new location. These costs include voice and data line installation, moving services contracts, anticipated electrical contracts, and any unexpected change orders. DHCS states that if this proposal is not approved, it increases risks related to unsafe working environment.

LAO Recommendation

The LAO recently published a Budget and Policy Post about a similar proposal from the Department of Alcoholic Beverage Control (ABC) to move ABC staff out of the same building in Santa Ana. In that post, the LAO describes the Joint Legislative Budget Committee (JLBC)'s concerns about the proposal, as well as its ultimate decision not to proceed with the administration's plan to move ABC and other departments—including DHCS—out of the Santa Ana State Building. Accordingly, this proposal is not needed at this time, and the LAO recommends rejection. LAO states that, "Should the administration submit a new proposal through—for example—the annual budget process, the Legislature could assess the revised proposal and subsequently decide whether additional resources are necessary for affected departments such as DHCS."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal and provide an update related to the LAO's recommendation.

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

ISSUE 12: CA TECHNICAL ASSISTANCE PROGRAM NO COST EXTENSION BUDGET CHANGE PROPOSAL

PANELISTS

- **Erika Sperbeck**, Chief Deputy Director, Policy and Program Support, Department of Health Care Services
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS, Information Management Division, Office of Health Information Technology (CHIT), requests a two-year no-cost extension and re-appropriation of any remaining funds from the original $3,750,000 Major Risk Medical Insurance Fund (MRMIF) apportionment per SB 870, Ch. 40, Statutes of 2014 (MRMIF was absorbed into the Health Care Services Plans Fines and Penalties Fund beginning FY 2017- 18). The request will extend the California Technical Assistance Program's (CTAP) end date from June 30, 2018 to June 30, 2020 (via Budget Bill Reappropriation Language), allowing the four contracted vendors an additional two years to continue achievement of program objectives and milestones. This request has no impact on State General Fund or Special Fund expenditures.

BACKGROUND

DHCS established CHIT in order to implement and administer the Medi-Cal Electronic Health Records (EHR) Incentive Program. More than $1.4 billion in 100% Federal Financial Participation (FFP) has been disbursed to Medi-Cal professionals and hospitals as incentive payments for the adoption, implementation or upgrade (AID) and meaningful use (MU) of certified EHR.

OHIT received federal approval for 90/10 reimbursement for the implementation of a $37.5 million CTAP supporting the advancement of EHR adoption and provider participation in the Medi-Cal EHR Incentive Program through the provision of technical assistance for these new technologies.

Per SB 870 (Committee on Budget and Fiscal Review, Chapter 40, Statutes of 2014), the funding is supported with a state allocated 10% match of $3.75 million in special funds. This funding allowed CHIT to procure four vendors for the CTAP effort. The vendors aid Medi-Cal providers and specialists in the AIU and MU of certified EHR technology. SB 870 appropriated $3,750,000 from the MRMIF to the Department for the CTAP in accordance with the State Medicaid Health Information Technology Plan (SMHP) as specified in Welfare and Institutions Code section 14046.1. The appropriated sum amounts to a ten percent match for the $37,500,000 approved by CMS to procure vendors for the CTAP for eligible providers.

When the CTAP was initiated, the estimated timeline for the program was established as July 1, 2015, through June 30, 2018. The program's initiation was delayed due to difficulties in procuring the necessary contracts for program implementation. These contracts were executed in October 2015.

Since implementation of the CTAP in October 2015, continuous and unanticipated CMS changes to the Final Rule governing the Medi-Cal EHR Incentive Program have required significant modifications to the State Level Registry (SLR), which is used by providers to apply for incentive payments. These modifications have delayed providers' ability to attest to AlU or MU, and adversely impacted CTAP vendors' ability to timely achieve CTAP milestones identified in the contracts and receive payments.

As a result, the program will not expend the full $37,500,000 and complete all milestones by the current program end date of June 30, 2018. A two-year no-cost extension and reappropriation of the remaining funding is requested to fully achieve program goals and expenditures. CMS is supportive of a two-year no-cost extension and will continue to support its financial commitment. CMS is currently reviewing draft contract amendments for the two-year no-cost extension in order to provide a formal approval of this request. This request will extend, at no additional cost, the CTAP through June 30, 2020. This request will result in no additional State General Fund or Special Fund expenditures.

The CTAP entered the third and final year of the program with a remaining funding balance of $28,404,000 ($25,564,000 90% FFP and $2,840,000 10% SF) as of July 1, 2017. The $9,096,000 in expenditures to date has resulted in 6,691 of the 7,500 eligible providers becoming enrolled for assistance through the CTAP. This funding also accounts for the CTAP vendors assisting their assigned providers in achieving 4,667 specific task milestones within the Medi-Cal EHR Incentive Program.

The two-year no-cost extension is necessary due to the continuous and unanticipated CMS changes to the Final Rule governing the Medi-Cal EHR Incentive Program. These changes have required significant modifications to the SLR, which is used by providers to apply for incentive payments. These modifications have delayed providers' ability to attest to AlU or MU, and adversely impacted CTAP vendors' ability to timely achieve CTAP milestones identified in the contracts and receive payments.

DHCS explains that approval of this two-year no-cost extension will allow the CTAP to achieve remaining program objectives and milestones. Medi-Cal providers will continue to receive the technical assistance necessary to accomplish MU of EHR technology. MU of EHR technology is an underpinning of numerous health initiatives, including the State Health Care Innovation Plan and Accountable Care Organizations with improvement in quality of care and overall health of Medi-Cal beneficiaries as described in the Triple Aim of better care, better health, and lower costs.

DHCS also states that the approval of this proposal will provide the state with resources needed to continue and further advance the Medi-Cal EHR Incentive Program through the CTAP. California will be able to meet the objective of supporting 7,500 Medi-Cal

providers and specialists in achieving MU. DHCS will also utilize the opportunity to leverage substantial enhanced federal funding that is currently available. In addition, this extension will prevent a greater burden from being placed on CHIT staff to support Medi-Cal provider questions, which will compromise the ability to administer the program and pay incentives in a timely fashion. CTAP constitutes workload beyond what CHIT is currently staffed to perform. While CHIT provides oversight to the four CTAP vendors, the technical assistance these vendors provide is beyond the scope and limits of what OHIT's staffing can provide. Without the significant resources and assistance provided by the vendors to coordinate and conduct CTAP activities, the Department may be unable to continue meeting the requirements for state participation in the incentive program, which is expected to distribute $2 billion in federal incentive funds to California providers.

Proposed Budget Bill Language:

4260-490-Reappropriation, State Department of Health Care Services. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2020:

3311—Health Care Services Plan Fines and Penalties Fund

1) Section 15, Chapter 40, Statutes of 2015, as reappropriated by Item 4260-490, Budget Act of 2015 (Chapter 10, Statutes of 2015), as reappropriated to the Health Care Services Plan Fines and Penalties Fund by Welfare and Institutions Code 15893(e) (Section 79, Chapter 52, Statutes of 2017)

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 13: HEALTH INFORMATION EXCHANGES STATE FUNDING ADVOCATES' PROPOSAL

PANELISTS

- **Michelle Baca,** Associate Director, Center for Government Relations, California Medical Association

Public Comment

PROPOSAL

The California Medical Association (CMA) requests $5 million General Fund for DHCS to provide a state match to draw down additional Health Information Technology for Economic and Clinical Health (HITECH) funds. These funds, for which the federal government provides a 90 percent match, would provide the state with a total of $50 million to assist Health Information Exchanges (HIEs) with onboarding new providers, connecting them to a HIE so that they can successfully use its services.

BACKGROUND

The CMA provided the following background information:

The federal HITECH Act, enacted as part of the American Recovery and Reinvestment Act of 2009, allows states to receive an enhanced federal match for incentive payments to eligible Medicaid providers to encourage the adoption of electronic health records (EHR) technology and for administrative expenses related to the promotion of the exchange of health care information. For example, the 2014 Budget Act provided $3.75 million in funding from the Major Risk Medical Insurance Fund following the elimination of the Managed Risk Medical Insurance Board. This funding, along with a 90 percent federal match, established the California Technical Assistance Program (CTAP), which supports the advancement of EHR through provider participation in the Medi-Cal EHR Incentive Program.

In 2016, the federal Center for Medicare and Medicaid Services (CMS) expanded previous federal guidance on the use of HITECH funds, allowing states to apply for the enhanced federal match for a wider array of providers and services. Included in the allowable activities that states can claim for is onboarding Medicaid providers to HIEs or interoperable systems. In general, onboarding encompasses the technical and administrative functions necessary to build the interface to the provider's electronic health record (EHR) system and begin secure messaging. Costs for these activities are typically in the range of $5,000-$10,000 for an individual provider and up to $150,000 for a complex hospital system. The significant upfront costs of connecting to a HIE often present a barrier for providers when it comes to utilizing HIEs, preventing them from taking advantage of the quality improvements and efficiencies that can result from robust data exchange.

Also included in the expanded activities that states can claim for is the use of HITECH funds in helping HIEs and providers to connect directly to state prescription drug monitoring programs (PDMPs). California's PDMP is known as the Controlled Substance Utilization Review and Evaluation System (CURES). Per the passage of AB 40 (Santiago, Chapter 607, Statutes of 2017), the California Department of Justice is currently working on a project to build a HIE interface to the CURES database. One of the most common complaints by providers using the CURES database is that it requires a separate login, forcing them to leave their EHR environment to check the system. Through a HIE, information from CURES will be integrated seamlessly into the provider's EHR, allowing for much easier use of the database.

The CMA states that this one-time expenditure, which will result in no out-year General Fund cost pressure, makes a sound investment in California's health IT system for the following reasons:

- The funding supports safety net providers that provide the bulk of the services in the Medi-Cal program.

- The federal government will match California's contribution 9-to-1. This multiplier greatly increases the impact of the investment.

- The state will reap future savings as there is abundant evidence that the use of robust HIEs can save money by creating efficiencies and better coordination of care.

- California already has the infrastructure in place to ensure that this funding is used effectively. Through the CTAP, DHCS contractors are already supporting thousands of safety net providers with Health IT technical assistance.

- This funding brings a technological solution to help alleviate the opioid crisis. By using HIEs, providers will be able to directly incorporate data from the CURES Database into their EHR systems, making it much easier for providers to use the system.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Michelle Baca to present this proposal.

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

ISSUE 14: ERRONEOUS PAYMENTS RECOUPMENT PROCESS ADVOCATES' PROPOSAL

PANELISTS

- **Michelle Baca**, Associate Director, Center for Government Relations, California Medical Association

Public Comment

PROPOSAL

The California Medical Association (CMA) requests trailer bill in order to reform the recoupment process that occurs when the Medi-Cal program has erroneously overpaid Medi-Cal providers.

BACKGROUND

The CMA provided the following background:

The CMA has significant concerns with the absence of a statutory process to recoup provider overpayments for services provided in Medi-Cal fee-for-service that are specifically due to a state error. Provider overpayments may result from actions such as erroneous billings, failure to achieve timely implementation of provider rate cuts, such as those resulting from AB 97 (Budget Committee, Chapter 3, Statutes of 2011), or provider error. Once an overpayment has been identified, the provider receives a generic “Dear Provider” letter that does not specifically address the individual and has no information on the amount of the overpayment or the specific service provided. The provider is then required to research and review previous records, often for services provided in prior years, to determine exactly how much the state intends to recoup. DHCS then has the authority to recover the overpayments by withholding payment for current and future services.

Presently, there is no limit on the timeframe that DHCS can retroactively recoup overpayment for services or on the amount of a provider’s current payment that can be withheld and used to pay the amount owed. As a result, providers are essentially required to work without pay for providing services to current beneficiaries. In contrast, under the Knox-Keene Act, health plans have a one-year timeframe to recoup overpayments from providers.

To create a more equitable process, CMA requests trailer bill language to limit the length of time that DHCS can recoup overpayments for state errors to one year and the percentage of a current payment that can be withheld to 20 percent until the total amount is recouped. With over 13.5 million Californians enrolled in MediCal and continued growth expected in the program, it is imperative that the state also explore additional ways to encourage provider participation. The CMA believes that placing reasonable limits on the recoupment of provider overpayments resulting from state

errors will help to reduce another barrier that physicians face when deciding to become Medi-Cal providers.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Michelle Baca to present this proposal.

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

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 15: MEDI-CAL MANAGED CARE NETWORK ADEQUACY - OVERSIGHT ISSUE

PANEL 1

- **Kimberly Chen,** California Pan Ethnic Health Network
- **Tam Ma**, Health Access California
- **Michelle Baca,** California Medical Association
- **Linda Nguy,** Western Center for Law and Poverty
- **David Lavine,** Health Alliance of Northern California

PANEL 2

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Sarah Brooks**, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- **Marta Green,** Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips,** Deputy Director, Legislative Affairs, Department of Managed Health Care

Public Comment

ISSUE

The Subcommittee is concerned about the realities of access to care in the Medi-Cal program, and specifically whether or not Medi-Cal managed care network adequacy standards and enforcement are sufficient. The administration engages in extensive access monitoring and oversight of network adequacy, yet recent evidence suggests that the data from plans, or sub-contractors of plans, may be fabricated to meet statutorily-mandated timely access standards. Even when plans are in fact in compliance with the law, it remains unclear whether 13.5 million Medi-Cal beneficiaries truly have good (or at least adequate) access to care. This oversight issue is for the purpose of exploring this issue and gaining a better understanding of the realities of network adequacy and access to care in the Medi-Cal program.

BACKGROUND

Knox-Keene Act and Network Adequacy. The Knox-Keene Health Care Service Plan Act of 1975, and subsequent amendments, is one of the most robust regulatory regimes for managed care organizations in any state in the nation. In addition to requirements related to financial stability, the Knox-Keene Act imposes various network adequacy

requirements on health care service plans, including Medi-Cal managed care plans (except COHS).

Timely Access Regulations require that health plans meet a set of standards which include specific time frames under which enrollees must be able to access care. These requirements generally include the following standards for appointment availability:

1. *Urgent care without prior authorization*: **within 48 hours**.
2. *Urgent care with prior authorization*: **within 96 hours**.
3. *Non-urgent primary care appointments*: **within 10 business days.**
4. *Non-urgent specialist appointments*: **within 15 business days.**
5. *Non-Urgent mental health appointments*: **within 15 business days for psychiatrists, within 10 business days for non-physician mental health provider**.
6. *Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition*: **within 15 business days**.

Plans are also generally required to ensure geographic access in that there are a sufficient number of providers located within a reasonable distance from where each enrollee lives or works. For example, primary care physicians and hospitals are located within 15 miles or 30 minutes from work or home.

Health plans must also ensure provider capacity in that its networks have enough of each of the right types of providers to deliver the volume of services needed. For example, plan networks include one primary care provider for every 2,000 beneficiaries.

Non-COHS Medi-Cal managed care plans are required to have a Knox-Keene license and are, therefore, required to be in compliance with these provisions. DHCS contracts with COHS plans to provide health care services to Medi-Cal beneficiaries in those counties. Although they are not required to have a Knox-Keene license, the department's sample contract with COHS plans includes the same or greater network adequacy and timely access requirements as the Knox-Keene Act.

Recent Medicaid Managed Care Regulations Expand Network Adequacy Requirements. In May, 2016, the federal Centers for Medicare and Medicaid Services (CMS) released a final rulemaking for state Medicaid programs with beneficiaries served by managed care organizations. One of the most significant changes imposed by the regulations is the requirement that capitation rates be set at a single rate, rather than in a range, which will change the way DHCS and Mercer calculate capitation rates for Medi-Cal managed care plans. In addition, the rules require:

- California's network adequacy standards expand from one provider type (primary care) to an additional six provider types.
- Collection of quality data to be used to improve the managed care program.
- Enhanced beneficiary supports.
- Monthly, rather than semi-annual, updates of provider directories
- Implementation of an 85 percent medical loss ratio (MLR) for Medi-Cal managed care plans.

2017 Legislation Specifies Network Adequacy Requirements for Medi-Cal Managed Care. AB 205 (Wood) and SB 171 (Hernandez), Chapters 738 and 768, Statutes of 2017, codified in state law specific requirements for Medi-Cal managed care related to implementation of the federal managed care regulations. In particular, these bills manage the implementation of the 85 percent MLR for Medi-Cal managed care plans, including the remittance process, and establish time and distance and appointment availability standards for the various classes of providers covered by the new federal rules.

Commencing January 1, 2018, the time and distance standards are as follows:

- *Primary care providers*: **10 miles or 30 minutes** from the beneficiary's place of residence.
- *Hospitals*: **15 miles or 30 minutes** from the beneficiary's place of residence.
- *Dental managed care*: **10 miles or 30 minutes** from the beneficiary's place of residence.
- *Obstetrics and gynecology*: **10 miles or 30 minutes** from the beneficiary's place of residence.

Commencing July 1, 2018, the time and distance standards are as follows:

- *Specialists*, including cardiology/interventional cardiology, nephrology, dermatology, neurology, endocrinology, ophthalmology, ear, nose, and throat/otolaryngology, OB-GYN specialty care, orthopedic surgery, gastroenterology, physical medicine and rehabilitation, general surgery, psychiatry, hematology, oncology, and pulmonology, HIV/AIDS specialists/infectious diseases, and outpatient mental health services, the following time and distance standards by county:

    1. **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;

    2. **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;

    3. **45 miles or 75 minutes** from the beneficiary's place of residence: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba; and,

    4. **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

- *Pharmacy services*: 10 miles or 30 minutes from the beneficiary's place of residence (all counties).

- *Outpatient substance use disorder services* other than opioid treatment programs, the following time and distance standards by county:

    1. **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;

    2. **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura; and,

    3. **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

- For outpatient mental health services, as follows:

    1. **Up to 15 miles or 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;

    2. **Up to 30 miles or 60 minutes** from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;

    3. **Up to 45 miles or 75 minutes** from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba; and,

Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

- *Opioid treatment programs*, as follows:

    1. **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;

    2. **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;

3. **45 miles or 75 minutes** from the beneficiary's place of residence: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba;

4. **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

- *Skilled nursing facility and intermediate care facility services*, the following availability standards by county:

1. Within **five business days** of the request: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

2. Within **seven business days** of the request: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;

3. Within **fourteen calendar days** of the request: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba; and,

4. Within **fourteen calendar days** of the request: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

- *County Drug Medi-Cal-Organized Delivery System (DMC-ODS*): appointment within **three business days** to an opioid treatment program (all counties).

- *Dental managed care plan services*:
  Routine pediatric services: appointment within **four weeks** of a request.
  Specialist pediatric services: appointment within **thirty calendar days** of a request.

Alternative Access: Permits DHCS, upon request of a MCMC plan, to allow alternative access standards for the time and distance standards established if either of the following occur:

a) The requesting MCMC has exhausted all other reasonable options to obtain providers to meet the applicable standard; or

b) DHCS determines that the requesting MCMC plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

The request for alternative access must be submitted at the same time as the Medi-Cal managed care plan submits its annual demonstration of compliance with time and

distance standards, if applicable. The request must be approved or denied on a ZIP code and provider type, including specialty type, within 90 days of submission of the request.

Provider Participation May Not Be Keeping Pace With Enrollment. In 2012-13, just prior to the implementation of the Affordable Care Act, 5.1 million Californians were enrolled in Medi-Cal managed care. As of the 2017 Budget Act, 2017-18 enrollment in Medi-Cal managed care was projected to be 10.9 million, an increase of 214 percent over 2012-13. While this significant increase in coverage has provided measurable health benefits to lower-income Californians, it is unclear whether Medi-Cal managed care plan provider networks have been able to keep pace with the sharp rise in enrollment.

A June 2017 report from the California Health Care Foundation titled "*Physician Participation in Medi-Cal: Is Supply Meeting Demand?*" surveyed physicians renewing licensure in 2015 to gauge participation in the Medi-Cal program. The report found that, between 2013 and 2015, the percentage of physicians serving Medi-Cal patients decreased from 69 percent to 64 percent, although the overall number of full-time equivalent physicians serving Medi-Cal patients increased by nine percent, likely due to previously uninsured patients seen by these physicians gaining coverage under the Medi-Cal expansion. However, the report also found this modest increase in full-time equivalent physician participation did not keep pace with the growth in enrollment, as the number of full-time equivalent physicians for each 100,000 Medi-Cal beneficiaries declined significantly. For primary care physicians, there were 39 full-time equivalents in 2015 compared to 59 in 2013, a 33.9 percent decline. For non-primary care physicians, there were 63 full-time equivalents in 2015 compared to 91 in 2013, a 30.8 percent decline.

SynerMed

SynerMed, founded in 2001, served as a managed-care middleman between health plans and independent physician practices and overseeing managed care services for people on Medicare and commercial insurance –1.2 million patients in all. On November 17, 2017, DHCS sent a "SynerMed Corrective Action Plan" to Medi-Cal Managed Care Plans due to a whistleblower complaint documenting widespread deficiencies in SynerMed's utilization management (UM) processes. Also in November 2017, the Department of Managed Health Care (DMHC) ordered nine health plans across the state to move 600,000 Medi-Cal beneficiaries from Employee Health Systems (EHS) to new medical groups by early February. Consumer advocates expressed alarm at the whistleblower's findings and questioned why these problems went undetected for so long, raising issues of accountability from the department and agency in Medicaid managed care. According to a DMHC order filed on December 26, 2017, "SynerMed took steps to narrow EHS's provider networks by restricting access to services and removing the ability of patients to be seen by certain contracted providers who were suppressed from EHS's specialist network based in whole or in part on the cost of the provision of services. As described herein, Respondents, through EHS, have engaged in the practice of economic profiling." Therefore, DMHC has ordered health plans contracted with EHS to terminate their contracts by early February.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Panel 1 speakers to describe their knowledge of, and experience with, Medi-Cal managed care network adequacy, and respond to the following:

1) Please provide real-world examples of sufficient or insufficient access to care, particularly in Fresno.

The Subcommittee requests Panel 2 speakers to respond and react to the information shared by panel 1, and respond to the following questions:

DMHC:

1) For the recently released Timely Access Report for Measurement Year 2016 – please comment on the survey data reported by managed care plans generally and specifically the health plans in Fresno.

2) Please provide a status update of the SynderMed investigation. If not possible to comment, please describe the process and where the DMHC currently is in this process.

3) Please provide an update of the EAS medical group transition - what is the status of those enrollees, how many were impacted? Any issues with the transition or the provider capacity of the medical groups or providers absorbing these patients? Are there any areas of concern?

DHCS:

1) Please provide an update on AB 205/SB 171 implementation.

2) The American Academy of Pediatrics recommends a ratio of one physician for every 1,600 patients; how does the state justify having a lower standard of 1 physician for every 2,000 patients?

3) Given evidence of fabrication of documents related to network adequacy, how does DHCS and DMHC validate this type of data?

4) What proposals does the administration have to address medical workforce shortages in order to address this overall issue?

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

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 16: DEPARTMENT OVERVIEW AND PROPOSED BUDGET

PANELISTS

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

Public Comment

BACKGROUND

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

The Department achieves this mission by:

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

PROPOSED BUDGET

The DMHC receives no General Fund and is supported primarily by an annual assessment on each HMO. The annual assessment is based on the Department's budget expenditure authority plus a reserve rate of 5 percent. The assessment amount is prorated at 65 percent and 35 percent to full-service and specialized plans

respectively. The amount per plan is based on its reported enrollment as of March 31st of each year. The Knox-Keene Act requires each licensed plan to reimburse the department for all its costs and expenses. As summarized in the table below, the Governor's 2018-19 budget proposes $79.2 million, a decrease of approximately $1 million (1.2%) from current year spending for DMHC's overall budget.

DEPARTMENT OF MANAGED HEALTH CARE
(Dollars In Thousands)

Fund Source	2016-17 Actual	2017-18 Projected	2018-19 Proposed	CY to BY Change	% Change
Federal Trust Fund	$83	-	-	$0	0%
Managed Care Fund	$73,614	$79,996	$79,036	($960)	-1.2%
Reimbursements	$1,547	$171	$171	$0	0%
Total Expenditures	**$75,244**	**$80,167**	**$79,207**	**$960**	**1.2%**
Positions	408.0	416.6	417.6	1.0	0.2%

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to provide an overview of the department and its proposed budget.

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

ISSUE 17: CONVERSION OF LIMITED-TERM FEDERAL MENTAL HEALTH PARITY COMPLIANCE REVIEW RESOURCES BUDGET CHANGE PROPOSAL

PANELISTS

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

Public Comment

PROPOSAL

The DMHC requests conversion of limited-term expenditure authority in the amount of $529,000 (Managed Care Fund) to ongoing for clinical consultant resources to assist the DMHC with conducting clinical reviews of commercial plans' classification of benefits, quantitative treatment limits (QTLs) and non-quantitative treatment limits (NQTLs), including clinical policies, updating the clinical aspect of compliance filing instructions and forms on an ongoing basis, and resolving clinical issues arising in compliance filings with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its Final Rules.

BACKGROUND

In 2008, Congress enacted the MHPAEA, requiring only large group health plans that offer mental health and substance use disorder (MH/SUD) benefits to do so in a manner comparable to medical and surgical (M/S) benefits. After the enactment of the Affordable Care Act in 2010, federal regulations and a state statute implementing essential health benefits made MHPAEA also applicable to individual and small group health insurance products. On November 13, 2013, federal regulators issued Final Rules for implementing parity, which laid out how health plans must conduct parity analyses to comply with MHPAEA. The Final Rules apply to all group products as employers renew or purchase coverage, as well as individual products.

The DMHC's Office of Plan Licensing (Licensing) initiated a MHPAEA compliance project in FY 2014-15 to perform a comprehensive review of one to fifteen standard individual, small group Exchange, and large group products from 26 plans' commercial coverage to determine compliance with MHPAEA. This project was completed in FY 2015-16. Upon completion not a single plan was found to be in full compliance, and DMHC found variation in levels of compliance across products with the same plan.

Starting in 2016, the DMHC began ongoing MHPAEA compliance reviews with the assistance of clinical consultants for:

1. New licensees entering the commercial market.

2. Plans that make significant changes to benefit designs, cost-sharing structure, or enrollee utilization or access.

3. Plans' existing products that previously were not reviewed by the DMHC for MHPAEA compliance. "

4. Current licensees proposing to add new products.

DMHC's MHPAEA compliance reviews consist of two components: 1) front-end reviews conducted by DMHC's Licensing of documentation submitted by plans to determine compliance with MHPAEA, and 2) back-end reviews conducted by DMHC's Division of Plan Surveys that entail onsite reviews to verify plans are operating in accordance with compliance filings.

The DMHC received resources for MHPAEA activities that span the department, however, the resources identified in this proposal are only those that are relevant to the front-end compliance reviews conducted by Licensing.

In FY 2014-15, Licensing received a one-time augmentation of $369,000 for clinical consultants to perform initial front-end compliance reviews to assess compliance with MHPAEA, as well as 1.0 permanent position and $170,000 ongoing as part of a MHPAEA Proposal sponsored by Senator Beall.

In FY 2016-17, Licensing received two-year limited-term resources in the amount of $529,000 for clinical consultants to perform the clinical aspect of Licensing's MHPAEA compliance reviews. This request is specifically for the continuation of these resources as they will expire on June 30, 2018, and the MHPAEA clinical consultant workload has been determined to be permanent in nature.

The MHPAEA compliance review process requires clinical expertise to complete in accordance with state and federal law. Clinical consultants provide the specialized medical, mental health, and substance use disorder knowledge that is not available through the civil service system but is necessary for reviewing critical aspects of MHPAEA compliance, such as the classification of benefits and NQTLs. The classification of benefits is a threshold issue that must be determined in a plan filing before the actuary can evaluate compliance in the financial requirements and QTLs, and before the attorneys can evaluate compliance in EOCs and other enrollee disclosures. Consultants evaluate a plan's explanation regarding the clinical appropriateness of classifying a benefit in one of the clinical categories, which requires analysis of the plan's logic for classifying benefits and whether the benefits listed comply with state and federal law for individual, small group, or large group contracts. Additionally, the analysis of plans' NQTLs, and the dozens of supporting policies and procedures for those NQTLs, involves an extensive review to determine if the plan is applying factors to limit access to MH/SUD benefits more stringently than how the plan applies those same factors to M/S benefits.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

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

ISSUE 18: PRESCRIPTION DRUG COST TRANSPARENCY (SB 17) BUDGET CHANGE PROPOSAL

PANELISTS

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

Public Comment

PROPOSAL

The DMHC requests 1.0 permanent position and expenditure authority in the amount of $307,000 in FY 2018-19, $281,000 in FY 2019-20 and ongoing to implement SB 17 (Hernandez, Chapter 603, Statutes of 2017). This amount includes funding for a consultant.

BACKGROUND

The DMHC regulates health plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act). Under the Knox-Keene Act, health care service plans (health plans) are subject to strict limitations on consumer cost-sharing for medically necessary prescription drugs. For example, for non-grandfathered individual and small group plan designs, the Knox-Keene Act limits cost — sharing for a covered outpatient prescription drug for an individual prescription to no more than $250 for a supply of up to 30 days, (or $500 for a bronze-level plan, and, in the case of high deductible plans, after the deductible is met). The Knox-Keene Act also requires health plans to file specified rate information, including supporting data, with the DMHC for contracts in the individual, small group, and large group markets, and for the DMHC to conduct an annual public meeting regarding large group rates within three months of posting that information.

SB 17 addresses the high prices for prescription drugs by creating greater transparency in drug pricing. The bill requires drug manufacturers to notify state purchasers, health plans, health insurers, and pharmacy benefit managers (PBMs) prior to increasing the wholesale acquisition cost (WAC) of a drug and notify the Office of Statewide Health Planning and Development (OSHPD) prior to introducing a new high-priced drug into the commercial market, as specified. The WAC refers to the manufacturer's list price and does not include discounts or rebates to payers. SB 17 also requires health plans that file rate information to report information on drug costs and require the DMHC to compile this information in an annual report. In addition, the bill requires health plans to include information on drug costs in their aggregate large group rate filings. Specifically, the bill impacts the DMHC as follows:

- No later than October 1 of each year, beginning October 1, 2018, requires a health plan that files certain rate information to report to the DMHC the following information for all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs dispensed at a plan pharmacy, network pharmacy or mail order drugs for outpatient use:
  - The 25 most frequently prescribed drugs,
  - The 25 mostly costly drugs by total annual plan spending, and
  - The 25 drugs with the highest year-over-year increase in total annual plan spending.

- Requires the DMHC to compile the information described above in a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. The DMHC will be required to aggregate the report data so that information specific to individual health plans remains confidential, and to publish this report on the DMHC's website by January 1 of each year, beginning January 1, 2019. The DMHC will also be required to include the report as part of the DMHC's annual public meeting on aggregate trends in the large group market.

- No later than October 1 of each year, beginning October 1, 2018, requires a health plan that files annual large group rate information to file specified information regarding:

  - The percent of premium attributable to drug costs for each category of prescription drugs (e.g., generic, brand name, and brand name/generic specialty).
  - Year-over-year increase, as a percentage, in per member, per month costs for each category,
  - Year-over-year increase in per member, per month costs for drug prices compared to other components of the health care premium,
  - Specialty tier formulary list,
  - Percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available, and
  - Information on use of a PBM, if any, including which components of prescription drug coverage are managed by the PBM.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

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

ISSUE19: HEALTH CONSUMER ALLIANCE FUNDING ADVOCATES' PROPOSAL

PANELISTS

- **Linda Nguy**, Policy Advocate, Western Center on Law and Poverty

Public Comment

PROPOSAL

The Western Center on Law and Poverty (WCLP) requests funding for Consumer Outreach and Assistance Program be set at $2.6 million and adjusted annually for inflation, an increase of $100,000 over current funding of $2.5 million.

BACKGROUND

WCLP provided the following background information:

HCA is a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Greater Bakersfield Legal Assistance, Legal Aid Society of Orange County, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the National Health Law Program, and the Western Center on Law and Poverty.

HCA has been the consumer assistance partner with the Department of Managed Health Care (DMHC) since 2012 and currently receives $2.5 million a year through the Consumer Outreach and Assistance Program (COAP). HCA is the only statewide resource in California for all health care consumers to obtain advocacy when confronting barriers to eligibility, coverage, or obtaining services through free legal assistance. HCA makes a substantial commitment to culturally and linguistically diverse outreach, focusing on low-income populations and consumers who are vulnerable due to a variety of factors, including physical and mental health disabilities, homelessness, linguistic barriers, age, and geographic isolation.

In 2017, HCA served over 17,000 individuals and successfully closed nearly 15,000 cases by the end of the year. Of those opened cases, almost 10,000 were eligibility cases which includes assisting when coverage is rescinded, terminated, or proposed for termination. This allows clients to keep, maintain, and most importantly use health coverage. In addition, this provides market stability as individuals are less likely to churn in and out of programs and reduces the time individuals go without health coverage.

The initial consumer assistance program was funded at $1.6 million in 2012, increased to $2.5 million in 2014, and has remained the same since then. In recognition of the important work HCA does and to account for COLAs over the past four years, WCLP is

requesting a $100,000 increase in funding, applying the Social Security Administration COLA. HCA is the only resource available to provide individuals the technical, legal assistance and advocacy they need, focusing on solutions that are unique to each individual. WCLP states that federal funding uncertainty results in a vulnerable time for health care consumers, making this request especially timely.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Linda Nguy to present this proposal.

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