AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MAY 1, 2017

2:30 P.M. - STATE CAPITOL ROOM 437

ITEMS TO BE HEARD

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4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: ASSEMBLYMEMBER NAZARIAN - PARKINSON'S DISEASE REGISTRY

PANELISTS

- **Assemblymember Nazarian**
- **Greg Oliva**, MPH, Assistant Deputy Director, Center For Chronic Disease Prevention And Health Promotion, Department of Public Health
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Assemblymember Nazarian requests $3.7 million over three years for the purpose of funding the California Parkinson's Disease (PD) registry, to support competitive grants and contracts to research institutes, universities, and nonprofit organizations to implement and maintain a comprehensive PD registry.

BACKGROUND

Assemblymember Nazarian provided the following background information:

According to the American PD Association, PD is a progressive disorder affecting the central nervous system that affects roughly one million Americans. PD is a progressive and disabling neurodegenerative disorder characterized by slowing of movement (bradykinesia), rigidity, tremor, and impaired balance. In addition to the primary motor symptoms, individuals with PD experience various neuropsychiatric symptoms, including anxiety, depression, sleep, and cognitive dysfunction. These "non-motor" symptoms can be extremely disabling and current medical treatments are largely ineffective. The prevalence of PD is estimated to be 329 per 100,000 people, and approximately 2,000 per 100,000 over age 65. As the elderly population increases, the prevalence is expected to double by 2030.

The annual economic costs of PD in the United States in 2010 were estimated at $22,800 per patient, 58% of which were direct medical costs. Prescription drugs and long-term care accounted for nearly 41% of these direct costs. Annual indirect costs, including lost productivity for patients and caregivers, were estimated at $9000 per patient. However, this is possibly a gross underestimate because of the overwhelming burden on caregivers as the disease progresses, in part due to lost productivity, early retirement and psychological burnout.

Assemblymember Nazarian states that the enormous cost associated with PD, the certain increase in prevalence, and the pain and suffering of both patients and caregivers demand a better understanding of the disease: its frequency, its causes and its course. Estimates of the frequency of PD are educated guesses; there is no systematic data on PD frequency in the US. Many environmental risk factors have been implicated, including pesticides, solvents, industrial toxins and air pollution, among others. However, measuring environmental exposures in PD has been extremely difficult, because there is no systematic data on PD frequency over time and place. Understanding the environmental origins of PD is essential to developing preventive methods and treatment options.

In 2004, the California Parkinson's Disease Registry Act (AB 2248, Frommer, Chapter 945, Statutes of 2004) was signed into law, which required the California Department of Public Heath (DPH) to create a confidential list of persons diagnosed with Parkinson's for tracking and research purposes. Since this bill was not funded by the State, a team of neurologists, scientists and epidemiologists at University of California – Los Angeles (UCLA), University of California – San Francisco (UCSF), the Parkinson's Institute, Stanford and Kaiser Permanente Division of Research were able to obtain seed money from the Michael J Fox Foundation, the National Institutes of Health and the Department of Defense to conduct a pilot project. The pilot project, which began in 2008, surveyed physicians, hospitals and pharmacies in order to accurately identify all cases of PD in four counties: Fresno, Kern, Santa Clara and Tulare. The data from the four counties showed that geographic areas with the highest level of pesticide use also had the highest rates of Parkinson's disease. These data in concert with ongoing studies at UCLA and UCSF helped to establish that environmental toxins, including well-water pesticides, persistent pollutants such as pesticides and solvents present in our soil and water are linked to an increased risk of Parkinson's disease.

It is reported that the pilot project was successful in establishing an infrastructure and best methods for developing a Parkinson's disease registry in four counties. This project has gained national and international recognition for its scientific importance. This proposal is to expand this pilot statewide. According to Assemblymember Nazarian, it will be the first Parkinson's registry in the nation and a model for other neurodegenerative diseases.

AB 2248 also required the former Department of Health Services (DHS) to conduct a program of epidemiological assessments of the incidence of PD. To do so, DHS would establish a statewide system for the collection of information determining the incidence of PD, thereby, creating the California PD registry. However, all of those provisions were conditioned upon the existence of sufficient federal and private funds. Despite the framework provided in existing law, the registry has lacked funding for the past thirteen years.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Nazarian to present this proposal.

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

ISSUE 2: ASSEMBLYMEMBER JONES-SAWYER - BOYS AND MEN OF COLOR

PANELISTS

- **Assemblymember Jones-Sawyer**
- **Jahmal Miller**, MHA, Deputy Director, Office Of Health Equity, Department of Public Health
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Assemblymember Jones-Sawyer requests $1.5 million for services to improve health and human services outcomes for boys and men of color. Under this proposal, the Department of Public Health Office of Health Equity will administer a grant program for nonprofit organizations to support Health Equity, including: 1) access to health care; 2) trauma informed care; 3) healthy living; and 4) health education. Qualifying nonprofit organizations must have a proven track-record of improving outcomes for the health and wellbeing of boys and men of color. This proposal suggests the following organizations to receive these grants:

1. Racial and Ethnic Mental Health Disparities Coalition
2. Black Students of California United
3. L.A.'s Best
4. South LA Youth Build Programs

BACKGROUND

Assemblymember Jones-Sawyer provided the following background:

A disproportionate number of California's boys and young men of color – primarily African American, Latino, Native American, and Southeast Asian males – experience underperforming schools, disadvantaged neighborhoods, poor health, inadequate social support, and limited job opportunities.

Since 2011, efforts to improve outcomes for boys and men of color have proliferated throughout California, led by the Assembly Select Committee on the Status of Boys and Men of Color in California. In the past five years, this Committee has supported several efforts to improve outcomes in these areas, including support for the successful implementation of the Local Control Funding Formula to more fairly distribute funds to public schools; addressing the disparate impact of suspension and expulsion policies on students of color; and finding innovative ways to address the health effects of adverse childhood experiences. With support from several philanthropic partners, youth and community leaders in 15 cities throughout California participate in local campaigns to improve outcomes for boys and men of color. These leaders are known as the LA's Best

and Youth Build. This statewide network seeks to ensure boys and men of color are physically and mentally healthy; live in safe neighborhoods; succeed in school, flourish in competitive work environments; and possess the knowledge, skills and leadership capacity to contribute to their families, communities, and the state's social and economic well-being.

Assemblymember Jones-Sawyer states: "California's future prosperity depends on its young people having a fair chance to thrive and succeed. This will require creating opportunities for all young Californians, including Californians of color: according to the 2010 Census, over 70 percent of Californians under the age of 25 identify as people of color, and this number is expected to grow."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Jones-Sawyer to present this proposal.

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

ISSUE 3: ASSEMBLYMEMBERS SALAS, FONG - VALLEY FEVER DATA COLLECTION

PANELISTS

- **Assemblymember Salas**
- **Gil Chavez**, MD, MPH, Deputy Director and State Epidemiologist, Center For Infectious Diseases, Department of Public Health
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Assemblymembers Salas and Fong propose $2 million and trailer bill to require each county to report all cases of valley fever to the Department of Public Health (DPH) and to require DPH to establish an enhanced monitoring system for, and a public education program about, valley fever.

BACKGROUND

Valley fever has been reported from almost every county in California with 75 percent of cases found in people who live in the Central Valley, yet California does not currently have an official statewide database to track the rate of valley fever infections and is not currently funding any research programs. According to the U.S. Centers for Disease Control and Prevention (CDC), between 1999 and 2011, the rate of valley fever infections in California rose more than 600 percent, from 939 to 5,697 reported cases. Nationally, the CDC has never reported more than 23,000 cases despite estimates that the disease infects more than 150,000 people across the southwestern U.S., according to the Center for Health Journalism (CHJ) at the University of Southern California. The inability to streamline reporting of infections makes it difficult to target resources. This bill allocates $2 million for valley fever research and will streamline and enhance reporting of valley fever infections.

Valley fever (also known as coccidioidomycosis) is primarily a disease of the lung, caused by a fungus, which lives in the soil and is endemic to parts of the southwestern U.S. and elsewhere in the Western Hemisphere. The tiny seeds, or spores, are inhaled into the lungs when wind disturbs soil and swirls dust into the air. It is not contagious person to person. Agricultural communities with open fields, such as Kern County, are especially vulnerable to valley fever outbreaks. About 60 percent of persons who inhale the spores do not get sick at all and are unaware they are infected. For others, symptoms are similar to a cold or flu. Of those patients seeking medical care, the most common symptoms are fatigue, cough, chest pain, fever, rash, headache, and joint aches. More extreme cases include pneumonia-like symptoms. According to the CDC, 11,072 cases of valley fever were reported in the U.S. in 2015. Of these, 3,053 were in California, 7,662 in Arizona, and 397 in the rest of the country. According to DPH, valley fever contributes to an average of 78 deaths per year in California.

The usual course of disease in otherwise healthy people is complete recovery within six months. In most cases, the body's immune response is effective and no specific course of treatment is necessary. Approximately 5 to 10 percent of people who get valley fever will develop serious or long-term problems in their lungs. In about 1 percent of cases, the infection spreads from the lungs to other parts of the body, such as the central nervous system (brain and spinal cord), skin, or bones and joints. Meningitis is the most serious and lethal complication of disseminated disease and approximately one-half to one percent of persons with valley fever in its disseminated form die from meningitis.

Anyone who lives in or travels to the southwestern United States, parts of Mexico, or Central or South America can get valley fever. It is most common in adults aged 60 and older. According to the CDC, certain groups of people may be at higher risk for developing the severe forms of valley fever, including: those with weakened immune systems; pregnant women; people with diabetes; African Americans; and, Filipinos.

Begun in 1997, "VFVP" was a public-private cooperative venture involving DPH, California State University (CSU) Bakersfield, the California Health Care Foundation, Kern County, and the Rotary Club. In 1998, five researchers doing the most promising valley fever vaccine research agreed to participate in VFVP. By 2001, the project had identified a number of promising antigens from which a vaccine might be developed. However, as reported by CHJ in a series of articles in 2012, the search for a vaccine failed to progress because of inadequate funding and a lack of pharmaceutical industry interest. From its initial formation until 2010, VFVP had raised $16 million, including $9.7 million from the State General Fund.

DPH has a web page dedicated to valley fever. It includes links to brochures and fact sheets (in English, Spanish, and Tagalog), occupational health posters, resources on work-related illness, information for health professionals (including a recent update on valley fever in the Medical Board of California's 2017 newsletter), and data and statistics, including annual reported cases by county and epidemiological summaries. DPH notes that it can be difficult to determine whether valley fever cases represent recent infections or infections acquired in the past. Many cases initially reported as suspects are eventually not confirmed. Since symptoms of valley fever are non-specific and resemble other infections, such as influenza, some doctors may find it difficult to diagnose valley fever and laboratory testing is usually required. However, some laboratory tests cannot distinguish between a new diagnosis and exposure to valley fever fungus in the past.

DPH reports that it last received funding for valley fever in 2009-10 when $1 million in state funding was appropriated for valley fever vaccine development. Most of that funding was provided to an academic advisory group to coordinate vaccine research grants because DPH lacks technical expertise and capacity to monitor valley fever vaccine development projects. That funding was exhausted in 2010 and DPH is no longer involved in any research for a valley fever vaccine.

The proposed trailer bill:

1) Requires each county to ascertain and report the existence of every suspected and confirmed case of valley fever to DPH in a timely manner.

2) Requires DPH to do all of the following:

    a. Post all suspected and confirmed cases of valley fever on its Internet Website;
    b. Establish an enhanced monitoring system to track cases of valley fever throughout the state; and,
    c. Conduct an annual public outreach program to educate the public about valley fever.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Salas to present this proposal.

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

ISSUE 4: ASSEMBLYMEMBER THURMOND - SICKLE CELL TREATMENT

PANELISTS

- **Assemblymember Thurmond**
- **Greg Oliva**, MPH, Assistant Deputy Director, Center For Chronic Disease Prevention and Health Promotion, Department of Public Health
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Assemblymember Thurmond proposes trailer bill and $80 million over 5 years to require the Department of Public Health (DPH) to establish up to four sickle cell disease centers (centers) that are responsible for coordinating care of people with sickle cell disease and for providing specified training and outreach services for patients and health care professionals. This proposal is for $20 million in 2017-18 and $15 million for each of the following four years.

BACKGROUND

Sickle cell disease affects approximately 7,000 people in the State of California. It is an inherited disease that affects primarily African Americans and Hispanics. The disease results in an abnormality in the oxygen-carrying protein hemoglobin found in red blood cells. This often causes the red blood cells to have a rigid, sickle-like shape, hence the name sickle cell disease. Problems in sickle cell disease typically begin around five to six months of age. A number of health problems may develop, such as attacks of pain ("sickle-cell crisis"), anemia, swelling in the hands and feet, bacterial infections, and stroke. It is a lifelong disease that generally becomes medically more complex with age.

According to experts, for those with this disease the quality of life is poor related to the fact that there are few physicians specializing in adult sickle cell disease in the state (between two and six physicians). There is no coordination of care or resources within the state, there are no agreed upon standards of care within the state, the quality of care is substandard in many cases. It has been known for decades that the care for children who have sickle cell disease is very good if they live near a center and that the care for those over the age of 18 is substandard across the state. Morbidity and mortality rise exponentially after the age of 18. Life expectancy has not changed since the 1980's and remains between 45 and 50 years for most. Due to the lack of coordinated care young adults and older persons who have sickle cell disease disproportionately utilize emergency rooms and have high hospital admission rates and hospital readmission rates. There are treatments for sickle cell disease, but due to the lack of expertise and dedicated physicians few people who have sickle cell disease have access to these therapies.

On April 20, 2017, the New England Journal of Medicine (Journal) published a detailed review article about sickle cell disease which the Journal notes is an increasing global health problem. Estimates suggest that every year approximately 300,000 infants are born with sickle cell anemia. The Journal reports that recent studies of non-genetic factors, including climate and air quality, suggest more complex associations between environmental factors and clinical complications. New treatments and management strategies accounting for genetic and non-genetic factors could substantially and rapidly improve the quality of life and reduce health care costs for patients with sickle cell disease.

Assemblymember Thurmond explains that it is unthinkable that with all the advances in medical science, the life expectancy of an individual with sickle disease has not increased since the 1980s and remains at 45-50 years of age. Unfortunately, even though new and effective therapies exist for people who have sickle cell disease, there is no infrastructure to provide access to this care for many patients. Access to these therapies would improve the quality of life for people who have sickle cell disease by reducing hospitalization and ultimately decreasing the financial cost of this disease to the state. This proposal is intended to provide the infrastructure and expertise to decrease emergency room use and hospitalization for people suffering from sickle cell disease, thereby improving their quality of life. Currently there is no coordination of care and no standards of care for persons who have sickle cell disease in California. It is believed that the state now spends hundreds of millions of dollars annually for substandard care and possibly unneeded emergency room use and hospitalization.

Assemblymember Thurmond states that this proposal seeks to create a network of interrelated centers, clinics, and other infrastructure and support to provide for the care of persons who have sickle cell disease, with the express purpose of providing best care practices within the state, to provide access to therapies that are currently available but under-utilized, with the purpose of decreasing emergency room use and hospitalization for persons who have sickle cell disease and improving their quality of life. By providing adequate care for people who have sickle cell disease outside the emergency room and decrease both the need for and length of hospital stays, the enormous financial and social cost of sickle cell disease could be reduced.

The proposed trailer bill:

1) requires DPH to establish a sickle cell disease center pilot program;

2) creates a competitive grant program administered by DPH to establish three or four centers;

3) enables coordination between the centers to improve the care of people who have sickle cell disease and to establish a seamless sickle cell treatment program in the state;

4) evaluates the overall program on a biannual basis;

5) requires two centers to be established in southern California, one center in northern California, and one center, if established, in a location to be determined by DPH to best serve the population of state residents with sickle cell disease;

6) requires each center to provide various services and collaborations, including, but not limited to, the following:

   A. primary care for patients with sickle cell disease;
   B. outreach to the community;
   C. support a statewide database of people with sickle cell disease;
   D. sickle cell disease and trait counseling; and
   E. transfusion services, as specified.

7) requires each center to have an identified medical director;

8) requires DPH, with the assistance of the centers, to establish and maintain an internet web-based information center with specified capabilities;

9) requires DPH to convene an eight member advisory committee that includes one individual with sickle cell disease, one parent of a child with the disease, and six other specified individuals;

10) requires DPH to report no later than January 1, 2021 to the legislature and the governor on the efficacy of the program;

11) establishes in the state treasury the sickle cell disease centers program account, which is continuously appropriated to DPH, to be used to fund the grant program established by this bill;

12) permits the remaining funds to be used by DPH, in its discretion, for any or all of the following:

   A) grants to health care providers or clinics that are not affiliated with an established center but that provide care to patients with sickle cell disease;

   B) grants for the establishment and maintenance of a telehealth system or an online consultation service to support patients with sickle cell disease and the health care professionals who treat them;

   C) hemoglobinopathy testing to confirm diagnosis of sickle cell disease in patients in California and parents of children known to have sickle cell disease; and

13) sunsets the provisions of this bill on January 1, 2024.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Thurmond to present this proposal.

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

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND REVIEW
7760 DEPARTMENT OF GENERAL SERVICES

ISSUE 5: RELOCATION RENT ADJUSTMENT BUDGET CHANGE PROPOSAL

PANELISTS

- **Fran Mueller,** Chief Deputy Director, Office of Statewide Health Planning and Development
- **Patrick Foster,** Chief, Real Estate Leasing and Planning Section, Department of General Services
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

OSHPD requests increased expenditure authority in the amount of $1.2 million (special funds, existing resources) to support increased rent costs for the new Sacramento headquarters and Los Angeles office locations.

The Subcommittee first heard this proposal on February 24, 2017, and, at that time, asked OSHPD to come back to the Subcommittee, with the Department of General Services, for a follow-up discussion regarding concerns of Subcommittee Members.

BACKGROUND

The California Public Employees' Retirement System (CalPERS) provided OSHPD and the Department of General Services (DGS), serving as OSHPD's real estate agent, notification that it would not renew the lease for its Sacramento downtown headquarters location once the soft term has ended on November 30, 2020. OSHPD plans to relocate its headquarters to the new location in Natomas in the Spring of 2017. OSHPD's headquarters' relocation is a large project requiring approximately 125,000 square feet for multiple programs and more than 400 employees. Given the limited real estate options in downtown Sacramento and surrounding areas for a project this size, OSHPD worked quickly with DGS to secure available office space in a tight market. OSHPD explains that moving before the current lease expires ensures sufficient time for a well-planned and efficient move, and protects the department from incurring increased rent costs under the existing soft term lease agreement.

The Metropolitan Water District (MWD), lessor of OSHPD's current LA location, provided OSHPD and DGS notification that it would not renew the lease once the soft term has ended on May 31, 2017. MWD is conducting seismic retrofitting of the current building and needs the OSHPD space to relocate its staff. OSHPD is currently working with DGS to secure a new location and expects to complete the move for the LA relocation in late 2017.

The new leases result in increased rent costs estimated at $1.2 million ongoing beginning in FY 2017-18. Approximately $1 million is attributable to the Sacramento headquarters relocation and $200,000 is attributable to the LA relocation.

All relocation costs for both OSHPD facilities are being absorbed within existing resources. OSHPD has established an Architectural Revolving Fund (ARF) for both relocations. OSHPD has deposited $8 million over FY 2014-15 and FY 2015-16 into the ARF for the headquarters relocation and is still responsible to fund an estimated additional $1 million in ARF-ineligible costs. OSHPD has deposited $2 million from FY 2015-16 into the ARF for the LA relocation and is still responsible to fund an estimated additional $800,000 in ARF-ineligible costs. The majority of these additional costs will be absorbed in FY 2017-18. However, the amounts deposited in the ARF did not include increased rent.

Since the Subcommittee's hearing on February 24, 2017, OSHPD and DGS provided the following clarifying information about this proposal:

The significant increase in rent in Sacramento reflects all of the following:

- Significant cost increases since OSHPD signed its current lease;
- Rates continue to rise, particularly downtown;
- Very tight market (minimal availability) of appropriate space that can accommodate OSHPD at an affordable price;

The justification for OSHPD paying increased rent to relocate three years prior to the actual end of its current lease:

- CalPERS needs their space and therefore is pressuring OSHPD to leave as soon as possible;
- Rents keep increasing, and therefore if they wait, they will be even higher than what they were able to secure in Natomas;
- There are very few options that truly accommodate the department and are affordable within the general downtown area, and therefore they may have no options if they wait until closer to the end of their current lease, making a move of 400 people impossible.

The $8 million in relocation resources in the ARF came about through the following:

- Hospitals pay fees to OSHPD for review of construction plans. These fees are paid over the course of the construction project, and therefore OSHPD experiences occasional significant increases in fee revenue, which is what led to the $8 million balance. As statutorily provided, these funds can be used only for the OSHPD hospital seismic safety program and for OSHPD administration. Therefore, these funds cannot be used for other types of programming, such as for health care workforce programs.

STAFF COMMENTS/QUESTIONS

OSHPD has provided substantial and sound justification for the increased costs associated with their new leases and upcoming relocations. There are many restrictions and challenges associated with finding appropriate and affordable office space for this department, yet they are being forced to move by both of their current government lessors. OSHPD has approximately 400 employees in their Sacramento office who need to move, and whose lives are organized around downtown-based employment.

The Subcommittee requests OSHPD and DGS to present this proposal.

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

0950 STATE TREASURER

ISSUE 6: COMMUNITY CLINIC LIFELINE GRANT PROGRAM PROPOSAL

PANELISTS

- **Ruth Holton-Hodson**, Senior Policy Advisor, Health and Retirement Initiatives, State Treasurer

Public Comment

PROPOSAL

The Treasurer proposes to use $20 million from the current HELP II Fund balance for a one-time grant program directed at the most fiscally vulnerable, non-profit safety net clinics to help non-profit small or rural clinics in critical service areas keep their doors open should there be losses to federal health care funds.

The grants would support core operations to allow clinics to continue providing care to their patients while they develop a more long-term sustainability plan such as increasing private foundation and business support, and developing public-private partnerships with other service providers.

Proposed Grant Program

- One–time 3-year core support grants to be used for direct patient services; retain and hire medical personnel, clinic administration, and improve delivery of care.
- Maximum grant of $250,000 per clinic, a minimum of 80 total grants.
- Eligibility: Any licensed non-profit small or rural primary care clinic in medically underserved areas at risk of severely cutting its services or closing its doors.

BACKGROUND

The Treasurer provided the following background information:

Non-profit community-based clinics are the backbone of the health care safety net: 1 out of 7 Californians are seen in community clinics and health centers every year. In many inner-city and rural communities, safety net providers are the only source of care for low-income residents. Congressional actions to reduce Medicaid funding to the states and eliminate subsidies for those qualified under Covered California could have a potentially devastating impact on community–based clinics and the clients and communities they serve.

Since the Affordable Care Act (ACA) went into effect, approximately 3.7 million adults became newly eligible for Medi-Cal through the expansion. In the 2017-18 budget 14.3 million individuals are projected to be covered by Medi-Cal, or 1 in 3 Californians. Under the ACA, an additional 1.2 million Californians are getting subsidies. This group of low-income Californians had among the highest rates of uninsurance prior to the ACA, and would be among the most likely to become uninsured if the benefits of the ACA were limited or repealed all together.

Under any of the potential scenarios to limit or repeal the ACA, California's safety net clinics will see a significant rise in the uninsured population and once again have to struggle to provide uncompensated care. Even under an optimistic scenario where the ACA survives as is for a few more years, it is likely that those in mixed families who may qualify for subsidies or state only Medi-Cal will not apply because of their fear of repercussions to their family of taking advantage of any publically funded services; the attack on planned parenthood clinics may well lead to the closure of some of the smaller planned parenthood clinics and an increase demand for women's health services provided by other community-based clinics in the area.

California's Community-based Clinics:

- There are 1,237 licensed community clinics in the state.
- Over 80% of community health center patients are below 200% of the Federal Poverty Level.
- 57% of patient revenue is from Medi-Cal.
- 61% of patients are between the ages of 20-64, 62% are women; 32% are children.
- 30% of Medi-Cal beneficiaries are enrolled in community clinics.
- In LA County:
- 57% of LA clinic patients rely on Medi-Cal for their care 1.5 million residents receive coverage through Medi-Cal or Covered CA
- Medi-Cal expansion allowed clinics to serve 23% more patients
- Rural Health Clinics: There are 52 rural non-profit community health centers with multiple clinic sites across the state serving low income residents where there is often a shortage of medical services. Patients they see tend to be sicker and more medically in need.

This proposal is to provide core support because evaluations of foundation sponsored core support programs have shown that core support provides clinics the ability to be more strategic about how they tackle the challenges they face and craft their own solutions to enhance their effectiveness.

$20 million enables a sufficient grant fund, while ensuring that the HELP II Loan program can continue to be a vibrant, self-sustaining, low-interest loan program. HELP II currently has a $29.6 million fund balance, 10-yr average loan volume is $4.3 million. With $20 million grant program HELP II an still provide two self-sustaining loan programs with an annual volume of: 1) $5 million in loans with a 2% interest rate and 15-yr maturity; and, 2) $4 million in loans with a 2% interest rate and a 20 yr. maturity.

The HELP II loan program is a self-sustaining low-interest loan program. The dollars that have accumulated over time are from the 3% interest rate (just recently it was reduced to 2%) and fully paid back loans; there have been no defaults.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Treasurer's Office to present this proposal.

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

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 7: DEPARTMENT OVERVIEW AND PROPOSED BUDGET

PANELISTS

- **Howard Backer,** MD, MPH, FACEP (Director), Director, California Emergency Medical Services Authority
- **Dan Smiley,** Chief Deputy Director, California Emergency Medical Services Authority
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

OVERVIEW

The Emergency Medical Services Authority's (EMSA) mission is to coordinate emergency medical services (EMS) statewide; develop guidelines for local EMS systems; regulate the education, training, and certification of EMS personnel; and coordinate the state's medical response to any disaster.

The EMSA is comprised of the following three divisions:

- ***Disaster Medical Services Division*.** The Disaster Medical Services Division coordinates California's medical response to disasters. It is the responsibility of this division to carry out the EMS Authority's mandate to provide medical resources to local governments in support of their disaster response, and coordinate with the Governor's Office of Emergency Services, Office of Homeland Security, California National Guard, California Department of Public Health, other local, state, and federal agencies, private sector hospitals, ambulance companies and medical supply vendors to improve disaster preparedness and response.

- ***EMS Personnel Division*.** The EMS Personnel Division oversees licensure and enforcement functions for California's paramedics, personnel standards for pre-hospital emergency medical care personnel, trial studies involving pre-hospital emergency medical care personnel, first aid and CPR training programs for child day care providers and school bus drivers.

- ***EMS Systems Division*.** The EMS Systems Division oversees EMS system development and implementation by the local EMS agencies, trauma care and other specialty care system planning and development, EMS for Children program, California's Poison Control System, emergency medical dispatcher

standards, EMS Data and Quality Improvement Programs, and EMS communication systems.

PROPOSED BUDGET

The Department's proposed budget is summarized in the table below. For 2017-18, the Governor's Budget proposes $36.8 million for the support of EMSA. Of this amount, approximately $15.8 million is budgeted for State Operations, while the remaining is for Local Assistance. The proposed budget reflects a 2 percent increase from the current year budget

The primary source of funding for this department is federal funds, which is included in the lines below labeled "Federal Trust Fund" and "Reimbursements," as those are federal funds that come through other departments first, namely the Departments of Health Care Services and Public Health.

EMERGENCY MEDICAL SERVICES AUTHORITY
(Dollars In thousands)

Fund Source	2015-16 Actual	2016-17 Projected	2017-18 Proposed	CY to BY Change	% Change
General Fund	**$8,482**	**$8,753**	**$8,793**	**$40**	**0.5%**
Emergency Medical Services Training Program Approval Fund	$208	$205	$207	$2	1.0%
Emergency Medical Services Personnel Fund	$2,408	$2,106	$2,647	$541	25.7%
Federal Trust Fund	$5,944	$6,089	$6,216	$127	2.1%
Reimbursements	$16,894	$17,413	$17,421	$8	0.05%
Emergency Medical Technician Certification Fund	$1,592	$1,498	$1,503	$5	0.3%
Total Expenditures	**$35,528**	**$36,064**	**$36,787**	**$723**	**2.0%**
Positions	73.4	66.9	68.9	2	3.0%

STAFF COMMENTS/QUESTIONS

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

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

ISSUE 8: E-COMMERCE ONLINE PARAMEDIC LICENSING MODULE (EGOV) BUDGET CHANGE PROPOSAL

PANELISTS

- **Howard Backer,** MD, MPH, Director, California Emergency Medical Services Authority
- **Dan Smiley,** Chief Deputy Director, California Emergency Medical Services Authority
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Emergency Medical Services (EMS) Authority requests increased expenditure authority from the Emergency Medical Services Personnel-(EMSP) Fund (0312) of $211,000 in Fiscal Year (FY) 2017-18 and $71,000 annually thereafter. The one-time funding will be utilized to purchase the propriety software (eGov) required to modify the existing paramedic licensing system, My License Office (MLO), which will enable paramedic license applicants to apply for their license on-line, submit licensing fees electronically, and provide other program functionality and the on-going funding will be utilized for system administration and hosting costs. There is sufficient revenue within the EMSP Fund to fund this request while still maintaining a 5% reserve as required by statute.

BACKGROUND

In response to the legislative mandates of AB 2917, Chapter 274 Statutes of 2008, the EMS Authority completed a Feasibility Study Report (Information Technology project #4120-13, approved in April 2009). The California Department of Technology (CDT) approved the FSR to establish a statewide public Emergency Medical (EMT) electronic registry system for issuing, monitoring, and tracking EMT and advanced EMT certification and paramedic licensure status. The project included two phases: 1) the implementation of a centralized EMT electronic registry system to manage paramedic licensure, EMT/AEMT certification, and paramedic enforcement information that included the web-based, public registry look-up component; and 2) a real-time, self-service online paramedic licensing electronic government (eGov) module option for new, renewing, and reinstating paramedic license applicants.

As noted in the Post Implementation Evaluation Report (PIER), the scope of the project was reduced to exclude the implementation of the eGov licensure module because of technical problems related to delays in virtual server procurement and the acquisition of

a debit/credit card payment processor to support the eGov online licensing software. After several months, CDT was able to create the virtual servers to support the MLO system and the EMS Authority was able to purchase credit card payment equipment to process payments received in-person and by mail at the EMS Authority office.

This S1BA review process, in collaboration with the California Health and Human Services Agency (CHHSA) and the Office of the Agency Information Officer (CAIC), has been completed and both oversight agencies agree that the addition of the paramedic on-line licensing module to the MLO system falls under the category of Maintenance and Operations (M&O).

The MLO eGov module will be located in a cloud-base network environment that is hosted, administered, and maintained by the current MLO system vendor, System Automation (SA); eliminating the need for CDT to create virtual servers or partner with a third party credit card payment service vendor. SA hosting services include exceptional network redundancy, premier data center and managed services, technological support, and backup and recovery services.

The EMS Authority continues to face an increase in staff workload associated with application and fee payment deficiencies, address change requests, and public requests for staff assistance in the completion of their applications. Deficiencies are often the result of illegible, erroneous, or incomplete handwritten or typed information on the paper-generated paramedic licensing application forms received by staff.

Deficiencies require staff to take additional steps to finalize a license application that include the issuance of deficiency letters and response time for the applicant to take corrective action. On average, a fully legible and complete paper-generated paramedic license application is processed within twenty (20) minutes; however, applications with deficiencies can take up to four weeks to process as staff work with applicants to take corrective action.

The EMS Authority is requesting $211,000 in FY 2017-18 and $71,000 annually thereafter based on the scope of work received from SA to implement the MLO Paramedic on-line licensing and fee collection system which will provide an electronic environment that supports legible, accurate, and complete data entry by paramedic licensing applicants. As applicants enter their information and/or applicant change of address sections of the system, information that does not conform to the mandated requirements or programmed field character tables, will automatically reject the information and provide the applicant further instructions prior to submission of their application packet online. For those applications, fee payments, and change of address requests received correctly, the information will automatically interface with the in-house MLO electronic licensure system and established public lookup central registry. As a result, application information received by staff from the online licensure system will be complete, more accurate, and legible, thereby, reducing the need for staff to issue as many deficiency letters.

For renewing paramedic applications, the MLO online licensure system will auto-populate already known paramedic license information from the MLO licensure system into the applicants online licensure application through his/her account. With the exception of EMS Authority discovery, or applicant disclosure, of applicant disciplinary or criminal actions during the past two year renewal cycle, a renewing paramedic applicant who electronically declares all information on the application is true and correct, will automatically result in a renewed paramedic license. Bypassing staff time normally required to review and upload renewal applicant information and fee payments into the MLO system, will reduce staff time spent processing renewals to six (6) minutes; the time it takes to print the paramedic license card and letter.

The EMS Authority recognizes that not all applicants will elect to use the online licensure system; however, by reducing overall staff time spent processing applications, fee payments, and change of address requests, staff will be able to focus their efforts on more quickly processing paper-generated applications, fee payments, and change of address requests and provide quicker responses to requests for assistance by applicants found with deficiencies in their applications. When workload efficiencies are realized staff will be redirected to address other program services currently underserved within the unit such as increasing the number of random audits of continuing education reported by paramedics during the licensing renewal application review process to ensure compliance with existing paramedic licensing regulations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA to present this proposal.

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

ISSUE 9: EMT-P DISCIPLINE WORK CASELOAD BUDGET CHANGE PROPOSAL

PANELISTS

- **Howard Backer,** MD, MPH, Director, California Emergency Medical Services Authority
- **Dan Smiley,** Chief Deputy Director, California Emergency Medical Services Authority
- **Koffi Kouassi**, Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Emergency Medical Services (EMS) Authority requests 2 permanent positions (an Attorney I and a Staff Services Analyst) and temporary Emergency Medical Services Personnel (EMSP) Fund Authority (0312) of $314,000 during Fiscal Year (FY) 2017-18 and FY 2018-19. The requested positions and temporary budget authority will be utilized to address the increased Emergency Medical Technicians Paramedic (EMT-P) disciplinary legal caseload currently being handled by retired annuitants and student assistants. During FY 2018-19, the EMS Authority will reassess personnel needs and determine the appropriate staffing level based on caseload. There is sufficient revenue within the EMSP Fund to fund this request while still maintaining a 5% reserve as required by statute.

BACKGROUND

The formation of the EMS Authority Paramedic Program occurred pursuant to the chaptering of Assembly Bill 3123 in 1994, which mandates that EMS Authority assume sole responsibility, previously a local EMS shared responsibility, for the certification, licensing, and discipline of all active Emergency Medical Technicians - Paramedics (EMT-P) throughout the state.

Pursuant to Health and Safety Code (HSC) section 1797.172, the EMS Authority charges fees for the licensure and licensure renewal of paramedics in an amount sufficient to support the paramedic licensure and enforcement program at a level that ensures qualifications of the individuals licensed to provide quality care. Fees collected are deposited in the EMSP Fund. Monies in the EMSP Fund are held in trust for the benefit of the EMS Authority's paramedic licensure and enforcement program. The EMS Authority is required by statute to maintain a reserve of 5 percent of the fund balance at the end of each fiscal year.

Paramedics are required to renew their licenses every two years. The statute allows for separate additional fees to be charged, at the option of the EMS Authority, for services that are not shared by all applicants for licensure and licensure renewal and are specified in regulations.

The EMS Authority may deny, revoke, suspend, or place on probation a paramedic's license pursuant to California Health & Safety Code Section 1798.200. Proceedings against a paramedic's license must be held in accordance with Chapter 5 (commencing with Section 11500) of Part I of Division 3 of Title 2 of the Government Code (Administrative Procedure Act). The EMS Authority legal counsel is responsible for disciplinary actions under Section 1798.200.

Currently, the legal unit consists of a full-time attorney, two retired annuitant (RA) attorneys, one staff services analyst (SSA) RA, and one student assistant. The full-time attorney provides all legal services to the EMS Authority, which include: advice functions to the Director, review of contracts, legal support for all EMS Authority divisions, review of local EMS agency solicitations and ambulance exclusive operating areas (EGA), public records act request review, subpoena and litigation response, employee discipline, and paramedic enforcement case supervision. The two RA attorneys prepare paramedic enforcement cases, negotiate settlements, and represent the EMS Authority at administrative hearings at various locations throughout the State. The SSA RA and student assistant provide administrative support to all three attorneys.

Due to a continued increase in departmental litigation matters, which include local EMS plan appeals and local EMS agency Exclusive Operating Area (EOA) solicitation reviews, the EMS Authority's fulltime attorney is unable to devote sufficient time to review and monitor EMT-P enforcement cases. The increased departmental litigation activities that the full-time attorney must now address has led to an increase in the caseload of each retired annuitant for EMT-P enforcement litigation activities that were previously handled by the full-time attorney resulting in an approximate on-going caseload per RA attorney of 30-35 cases.

As retired annuitants have limited hours per year (960) available to work, RA attorneys are insufficient to meet the increased EMT-P caseload, resulting in delayed litigation of EMT-P cases until their hours are renewed at the start of each new fiscal year (FY). Additionally, RA and student assistants are by their very nature temporary and extended recruitment efforts including initial training requirements, have resulted in key case preparations not being completed in a timely manner resulting in a backlog of EMT-P cases.

In FY 2014-15, there were 145 EMT-P discipline cases of various types received by the legal unit and of these cases, 51 required a court hearing. In FY 2017-18, based on an average yearly growth of 8% it is anticipated that the EMS Authority will receive 209 EMT-P discipline cases of various types, a more than 44 percent increase over FY 2014-15, and 86 of these actions will require a court hearing which is an increase of 68 percent over FY 2014-15.

An average of 25 hours per EMT-P discipline case is required for attorney activities for EMT-P discipline cases that proceed to a hearing and for cases that do not proceed to hearing, 12 hours per case is required for review, processing, and closure or settlement. Additionally, an average of 12 hours per case received is required for legal administrative support activities.

During 2017-18, it is anticipated that of the 209 EMT-P discipline cases received, all 209 will require 2,508 (12 hours per case x 209 cases) hours of legal support work hours, 86 cases will require an EMT-P disciplinary hearing resulting in 2,150 (25 hours per case x 86 cases) of attorney work hours, and 123 cases not requiring a hearing will result in 1,476 (12 hours per case x 123 cases) hours of attorney work hours. The increased EMT-P case workload, emerging need for analysis of current cases and trends, and the increased number of hearings indicates that it is unwise for the EMS Authority to continue to rely on retired annuitants and part time student assistants to perform these attorney and legal administrative support functions. The EMS Authority requires the benefit of a permanent, full time Attorney and Staff Services Analyst to prepare and present cases at hearings and to assist counsel in the preparation of EMT-P disciplinary cases to ensure the timely processing of all discipline cases and elimination of the current EMT-P case backlog.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA present this proposal.

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

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 10: 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
- **Mary Watanabe,** Deputy Director, Health Policy and Stakeholder Relations, Department of Managed Health Care
- **Noah Johnson,** Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez,** Principal Program Budget Analyst, Department of Finance
- **Brian Metzker**, 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 2017-18 budget proposes $76.9 million, an increase of $0.6 million (0.7%) over current year spending for DMHC's overall budget.

DEPARTMENT OF MANAGED HEALTH CARE
(Dollars In Thousands)

Fund Source	2015-16 Actual	2016-17 Projected	2017-18 Proposed	CY to BY Change	% Change
Federal Trust Fund	$560	$100	$0	($560)	-100%
Managed Care Fund	$60,863	$73,549	$76,753	$3,204	4.4%
Reimbursements	$2,362	$2,679	$171	($2,508)	-93.6%
Total Expenditures	**$63,785**	**$76,328**	**$76,924**	**$596**	**0.78%**
Positions	373.9	305.6	310.6	5	1.6%

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 11: HELP CENTER CASE BACKLOG AND WORKLOAD 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
- **Mary Watanabe,** Deputy Director, Health Policy and Stakeholder Relations, Department of Managed Health Care
- **Noah Johnson,** Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez,** Principal Program Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The DMHC requests 11.0 permanent positions and $3,422,000 for FY 2017-18, $3,299,000 for FYs 2018-19 and 2019-20, and $2,691,000 for FY 2020-21 and ongoing to address the increased workload and subsequent backlog attributed to full implementation of the Affordable Care Act (ACA) and conforming legislation.

This request includes $1,342,000 for FY 2017-18 and ongoing for consultant resources to assist with Independent Medical Review processing. Also included in this request are three-year limited-term resources in the amount of $648,000 for FY 2017-18 and $608,000 (equivalent to 5.0 staff) for FYs 2018-19 and 2019-20 to address the Help Center's increased consumer calls and complaints workload.

BACKGROUND

The mission of the DMHC is to protect consumers' health care rights and ensure a stable health care delivery system. The DMHC's Help Center is at the core of this mission as it is the first point of contact for consumers. The Help Center is responsible for providing a variety of assistance to enrollees, including responding to enrollee calls, reviewing and resolving complex complaints, administering Independent Medical Reviews (IMRs) and addressing urgent nurse complaints.

The Help Center has seen a significant increase in the volume of calls, complaints and IMR requests received as a result of the growth of DMHC's jurisdiction to 25 million health plan enrollees. Additionally, the complexity of cases has increased, resulting in more cases requiring time-intensive legal review.

Since 2014, the Help Center has experienced an unprecedented increase in consumer calls, complaints and IMR requests. This has resulted in a delay in answering consumer calls and reviewing and resolving consumer complaints within the mandated timeframes. The Help Center call volume increased by over 40 percent from 2014 to 2015, and complaints and IMRs received increased by 33 percent. Many complaints are now more legally complex given the overlay of the ACA and the Knox Keene Act. Complaints include issues involving disputes over timely access, cancellation for non-payment, deductible/out-of-pocket accumulations and continuity of care.

As displayed in the following tables, the Help Center's overall workload volume in calendar year 2015, not including Division of Plan Surveys workload, has increased more than 36 percent since 2014. In 2016, the workload associated with consumer calls and initial review of incoming complaints increased by another 12.2 percent. Additionally, the workload associated with standard complaints and IMRs increased by 46.6 Percent.

Workload Volume by Type of Contact	2014	2015	Percentage Change	2016	Percentage Change
Callers Assisted by Agent	47,129	66,824	41.8%	69,313	3.7%
Total Cases Created (Initial Review)	13,680	16,048	17.3%	23,683	47.6%
TOTAL	**60,809**	**82,872**	**36.3%**	**92,996**	**12.2%**

The Help Center received 37.5 positions in FY 2014-15 and 2015-16 to address anticipated workload resulting from the implementation of the ACA. These positions were authorized through three BCPs: (1) FY 2014-15, SB X 1 2 Individual Market; (2) FY 2014-15, AB X 1 1 Medi-Cal Expansion; and (3) FY 2015-16, Additional Enrollment into Individual Market. As illustrated in this table, the workload substantiating the additional positions did materialize. However, a backlog to close standard complaints and IMRs still exists.

Type of Contact	FY 2014-15 SB X 1 2 Individual Market BCP	FY 2014-15 AB X 1 1 Medi-Cal Expansion BCP	FY 2015-16 Additional Enrollment into Individual Market	**Total Anticipated Tasks in BCPs[1]**	Actual 2015 IM and Medi-Cal Data[2]
Standard Complaints	1,021	834	179	**2,034**	6,131
IMRs	510	417	89	**1,016**	997

1/ Represents workload data identified in the FY 2014-15 and 2015-16 Medi-Cal and Individual Market BCPs.
2/ Represents the actual number of Medi-Cal and Individual Market standard complaints and IMRs processed during 2015.

The DMHC is required to complete its review and close standard complaints within 30 days. In an attempt to address the increased workload, mandatory overtime has been enforced and permanent intermittent (PI) positions have been utilized. The total of temporary help and overtime costs has increased each year since FY 2013-14 as displayed in the table below.

Help Center Overtime and Temporary Help by Fiscal Year
(In Whole Dollars)

Resource Type	FY 2013-14	FY 2014-15	Percentage Change	FY 2015-16	Percentage Change
Overtime	$22,922	$91,416	298.8%	$49,577	-45.8%
Temporary Help	$184,088	$257,470	39.9%	$335,695	30.4%
TOTAL	**$207,010**	**$348,886**	**68.5%**	**$385,272**	**10.4%**

As displayed in the table above, overtime expenditures incurred during FY 2015-16 decreased compared to the previous fiscal year. This reduction was the result of two factors, (1) the hiring of additional temporary help staff and (2) a more conservative approach to using overtime in order to address spikes in workload. However, the overall increase in these expenditures is evident, since FY 2013-14 these costs have increased by 86.1 percent.

Even with the additional temporary help and overtime, the Help Center is not able to complete case reviews and close standard complaints and IMRs within the mandated timeframe. Additionally, there has been an increased delay in answering consumer calls due to the exponential call volume. For example, the average time for a consumer to reach a live agent in July 2015 was 1 minute 58 seconds as compared to July 2016, when it was 3 minutes 26 seconds. This increased wait time resulted in 522 more consumers abandoning their call prior to receiving assistance.

Since the implementation of the ACA, the Help Center's workload has continued to increase. Actual workload is exceeding the capacity of the additional positions provided to DMHC to address workload from the increase in enrollment into plans under the DMHC's jurisdiction. The workload increased by 52.9 percent from 2014 to 2016, while staffing increased by 32 percent. This chart displays workload volume compared to staffing levels from 2014 to 2016 and the percentage increase/decrease:

	2014	2016	Net Change from 2014 to 2016
Workload Volume	60,809	92,996	52.9%
Positions*	91.3	120.5	32.0%

*Does not include Division of Plan Surveys Positions

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

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

ISSUE 12: INFORMATION TECHNOLOGY RESOURCE REQUEST 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
- **Mary Watanabe,** Deputy Director, Health Policy and Stakeholder Relations, Department of Managed Health Care
- **Noah Johnson,** Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez,** Principal Program Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The DMHC requests 2.0 permanent positions and $746,000 for FY 2017-18, $722,000 for FYs 2018-19 and 2019-20, and $289,000 for FY 2020-21 and ongoing to address information security needs and transition to an efficient IT systems architecture and forward looking roadmap to meet business intelligence requirements.

This request includes $290,000 in contracted consulting costs for FYs 2017-18, 2018-19 and 2019-20 to assist the DMHC with security monitoring and Cloud migration activities. This request also includes three-year limited-term resources of $152,000 for FY 2017-18 and $144,000 for FYs 2018-19 and 2019-20 to address legacy application upgrades.

BACKGROUND

Over the past decade, the DHMC has experienced significant challenges in the context of technological complexity, aging infrastructure and increased security risks. This has increased the demand for consistent IT services to address business needs for DMHC employees, stakeholders and the public. Currently, DMHC lacks sufficient IT staffing to incorporate critical technology advancements to upgrade and strengthen the IT infrastructure in order to adequately address information security mandates, business processing needs, and align with key strategic initiatives, such as those outlined in the California Health and Human Services Agency (CHHS) and State IT Strategic Plans.

The DMHC's Office of Technology and Innovation (OTI) is maintaining an outdated and aging IT infrastructure with several in-house developed legacy applications. Currently, IT staff receives over 2,500 change and service requests per year for new features, reports, enhancements, infrastructure upgrades/changes, new hardware/software, user management, remote access and application permissions. Additionally, DMHC has a backlog of change requests to improve the functionality, reliability, security and availability of business applications requested by program areas and external stakeholders.

OTI has not been able to transition its IT systems architecture to a forward looking roadmap to efficiently leverage data assets, address business intelligence needs and align with the "Cloud First" strategy as outlined in the CHHS IT Strategic Plan.

The passage of the Affordable Care Act and conforming legislation has resulted in additional regulatory oversight and workload for DMHC. With over 25 million Californians now enrolled in health care service plans under the DMHC's jurisdiction, the DMHC has experienced a significant increase in workload and program staffing. As a result, OTI's responsibilities and workload have increased due to technological complexity and IT risks. Currently, OTI does not have sufficient staffing to address changes to data security, infrastructure, applications and programs.

IT staff has not grown at the same rate as the overall Department. The DMHC's current ratio of IT to departmental staff, or 6.73%, is lower than the 10% ratio that is a common benchmark used by departments for optimal support of IT business needs. With the additional 2.0 permanent positions and three-year limited-term resources equivalent to a Systems Software Specialist II (Technical), OTI will reach a staffing ratio of 7.4% compared to the total Department (33.0 PYs to 443.5 PYs) in FY 2017-18, which will bring the ratio closer to FY 2010-11 levels.

With additional resources and consulting dollars, DMHC can execute and implement an efficient forward-looking IT roadmap to reduce investments in legacy applications and accelerate migration to the Cloud.

DMHC states that implementing an efficient IT solutions architecture will greatly improve efficiency and productivity by:

- Consolidating and replacing legacy applications with standards-based, third-party solutions
- Delivering superior business intelligence with data modeling and warehousing capabilities
- Leveraging data assets within DMHC and enabling information sharing across the agency
- Upgrading the infrastructure to eliminate security related technology gaps
- Facilitating a smooth migration to the Cloud by virtualization of workstations, servers and applications

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

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

ISSUE 13: PROHIBITION OF SURPRISE BALANCE BILLING (AB 72) 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
- **Mary Watanabe,** Deputy Director, Health Policy and Stakeholder Relations, Department of Managed Health Care
- **Noah Johnson,** Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez,** Principal Program Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The DMHC requests 16.0 permanent positions, limited-term resources (equivalent to 3.75 staff) and expenditure authority of $3,588,000 in FY 2017-18, $3,173,000 in FY 2018-19, $2,963,000 in FY 2019-20, $2,251,000 in FY 2020-21 and ongoing to meet the requirements of AB 72 (Bonta, Chapter 492, Statutes of 2016).

BACKGROUND

AB 72 establishes mandates to eliminate the practice of "surprise balance billing" by non-contracting providers when enrollees receive non-emergency care at an in-network facility. The bill also creates a default reimbursement rate and an independent dispute resolution process (IDRP) for non-emergency services provided by non-contracting providers at in-network facilities or resulting from services provided at in-network facilities.

When a non-contracting provider is not satisfied with a plan's reimbursement, the provider may attempt to collect the remaining balance directly from the enrollee. This practice is known as "balance billing." The type of balance billing addressed in AB 72 is referred to as "surprise balance billing," as the enrollee generally is not aware or informed that the provider is out-of-network.

To implement AB 72, staff resources are requested for all of the following sections of DMHC:

- Help Center – 7.0 positions
- Office of Plan Monitoring – 5.0 positions
- Office of Financial Review – 1.0 position
- Office of Enforcement – 2.0 positions

- Office of Legal Services – 0.75 position
- Office of Administrative Services – 2.0 positions
- Office of Technology and Innovation – 1.0 position

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

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

ISSUE 14: MEDI-CAL INTERAGENCY AGREEMENT REDUCTION 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
- **Mary Watanabe,** Deputy Director, Health Policy and Stakeholder Relations, Department of Managed Health Care
- **Noah Johnson,** Finance Budget Analyst, Department of Finance
- **Guadalupe Manriquez,** Principal Program Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The DMHC is requesting a reduction of 18.5 positions and $3,398,000 in Managed Care Fund expenditure authority in FY 2017-18, $2,876,000 in FY 2018-19 and ongoing to reflect the termination of existing Interagency Agreements (IAs) between DMHC and DHCS. Additionally, the DMHC is requesting a reduction in reimbursement authority of $1,870,000 in FY 2017-18, $1,438,000 in FY 2018-19 and ongoing. This proposal reflects the following position reductions:

Office/Classification	FY 2017-18 & Ongoing
Help Center	
Consumer Assistance Technician	2.0
Nurse Evaluator II	0.5
Associate Governmental Program Analyst	0.5
Office of Financial Review	
Corporation Examiner IV (Supervisor)	1.0
Corporation Examiner	5.0
Office of Plan Monitoring	
Health Program Specialist I	2.0
Health Program Specialist II	0.5
Associate Health Program Adviser	1.0
Supervising Health Care Service Plan Analyst	1.0
Staff Health Care Service Plan Analyst	4.0
Associate Health Care Service Plan Analyst	1.0
Total Positions	**18.5**

BACKGROUND

The DMHC licenses and regulates health plans that provide full-service and specialty services to approximately 25 million Californians. The DMHC regulates health plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended. To meet its mission of protecting consumer health care rights and promoting ensuring a stable health care delivery system, the DMHC resolves grievances, conducts onsite medical surveys and financial exams, monitors timely access and health plan network adequacy, and reviews plan contracts, disclosures and vendor arrangements.

Released in May 2016 by the federal Centers for Medicare and Medicaid Services, Final Rule 2390-P (Final Rule) changed the Medicaid managed care regulations to reflect the increased utilization of managed care as a delivery system. It aligns the rules governing Medicaid managed care with those of other major sources of coverage, including Qualified Health Plans and Medicare Advantage Plans. The rule also implements statutory provisions, changes actuarial payment provisions, promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. The rule requires California's network adequacy standards be expanded from one provider type (primary care) to at least seven provider types. The rule also regulates the collection of quality data to be used to improve the managed care program, enhances beneficiary supports and mandates monthly, rather than semi-annual, updates of provider directories. Implementation of the Final Rule must be executed no later than July 1, 2018.

Therefore, as a result of the Final Rule, DMHC is proposing to terminate four lAs with DHCS encompassing medical surveys, medical loss ratio financial exams, and network adequacy reviews for the 1115 Waiver Demonstration Project (1115 Waiver), Medi-Cal Rural Expansion Project (Rural Expansion), Coordinated Care Initiative and Cal MediConnect Program (CCI/ Cal MediConnect), and the Medi-Cal Dental Managed Care Program (DMC).

DHCS is the single state agency responsible for the administration of California's Medicaid program, known as Medi-Cal, which provides health care for more than 14 million members. Since FY 2010-11, the DMHC has received resources through multiple Budget Change Proposals (BCPs) to perform workload focused on Medi-Cal managed care health plans on behalf of DHCS. These services are currently provided through four lAs between the DMHC and DHCS. DHCS reimburses DMHC for 50 percent of costs associated with the lAs, and 100 percent of consulting services costs incurred to support the Cal MediConnect Ombudsman Program.

1115 WAIVER DEMONSTRATION PROJECT

In FY 2010-11, the DMHC received resources to conduct medical surveys, medical loss ratio financial exams, and network adequacy reviews related to the 1115 Waiver. The 1115 Waiver enables Medicaid participants to receive benefits through certain providers and permits the State to require that individuals receive benefits through managed care providers who could not otherwise be required to enroll in managed care, thus allowing statewide coverage and different benefit packages.

RURAL EXPANSION

As a result of Chapter 23, Statutes of 2012 (AB 1467), approximately 400,000 individuals in twenty-eight rural counties transitioned from fee-for-service to managed care Medi-Cal plans. Chapter 438, Statutes of 2012 (AB 1468) required DHCS to enter into an lA with DMHC to conduct financial audits, medical surveys, and a review of the provider networks with the expansion of Medi-Cal managed care into the 26 rural counties. In order to implement AB 1468, DMHC received 3.5 positions and funding starting in FY 2013-14.

MEDI-CAL DENTAL MANAGED CARE

DHCS started contracting with six DMC plans in 2013. These dental plans receive a negotiated, monthly per capita rate for each Medi-Cal beneficiary enrolled in the plan. Beneficiaries enrolled in the contracted plans receive dental benefits from providers within the plan's provider network.

In FY 2012-13, the DMHC received 3.0 limited-term positions and funding to conduct financial exams and medical surveys focused on the Medi-Cal line of business of these six plans participating in DMC. In FY 2013-14, a BCP was approved to convert the 2.0 limited-term positions to permanent.

COORDINATED CARE INITIATIVE/CAL MEDICONNECT PROGRAM

Chapter 33, Statutes of 2012 (SB 1008), Chapter 438, Statutes of 2012 (AB 1468) and Chapter 717, Statutes of 2012 (AB 1496) authorized the formation of CCI, which seeks to provide better health outcomes for dual eligibles by enrolling them into managed health care plans. SB 1008 required DHCS to enter into an lA with DMHC to perform health plan surveys and financials reviews, readiness review activities, and provide consumer assistance to eligible beneficiaries of CCI. The Ombudsman Program conducts outreach and enhances awareness of Ombudsman service availability, investigates and resolves Cal MediConnect enrollees' issues with managed care plans and refers Cal MediConnect enrollees to various resources and assistance programs.

DMHC was granted one-year limited-term resources for 13.0 positions and consultant funding through a FY 2012-13 Spring Finance Letter to evaluate plan readiness and oversight of health plans in up to 10 counties providing managed health care services, including the addition of long-term support and services to dual eligible beneficiaries. In a 2013-14 BCP, DMHC was granted a three-year extension of the FY 2012-13 resources, an additional 3.5 positions and funding for consulting services to conduct medical surveys and financial reviews. Subsequently, a FY 2016- 17 Spring Finance Letter extended a portion of these limited-term resources and funding through December 31, 2017.

Released in May 2016, the Final Rule changed the Medicaid managed care regulations to reflect the increased utilization of managed care as a delivery system. Through the Federal Managed Care Regulation BCP (4260-018-BCP-2017-GB), DHCS is requesting additional resources to perform the requirements of the Final Rule, including the existing workload DMHC was conducting through the 1115 Waiver, Rural Expansion, DMC and CCI/Cal MediConnect lAs. Therefore, these existing lAs and resources at DMHC to perform this workload will cease as of June 30, 2017.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

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

ISSUE 15: STAKEHOLDER PROPOSAL - CONSUMER PARTICIPATION PROGRAM

PANELISTS

- **Myriam M. Valdez**, Policy and Legislative Advocate, Health Access California
- **Marta Green,** Chief Deputy Director, Department of Managed Health Care
- **Jenny Phillips,** Deputy Director, Legislative Affairs, Department of Managed Health Care
- **Mary Watanabe,** Deputy Director, Health Policy and Stakeholder Relations, Department of Managed Health Care
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

California Pan-Ethnic Health Network (CPEHN), Consumers Union, Health Access, and Western Center on Law and Poverty request trailer bill to delete the sunset on the Consumer Participation Program (CPP) at the Department of Managed Health Care (DMHC), which is currently set to sunset on January 1, 2018.

BACKGROUND

SB 1092 (Sher, Chapter 792, Statutes of 2002), created the CPP which awards reasonable advocacy and witness fees to consumer advocates who represent consumer interests in regulatory proceedings at DMHC. These include both regulation packages and other formal proceedings and decisions of DMHC such as consideration of health plan mergers and rate review. The program is funded out of the licensing fees paid to DMHC, and the CPP statute (Health and Safety Code Section 1348.9) allows the DMHC to award up to a total of $350,000 for each fiscal year.

The program at DMHC is designed to allow consumer organizations to invest substantial time, and even to retain outside experts to allow effective participation in the regulatory process, as well as to round out the perspectives and input received by DMHC to ensure sound decision-making. These advocacy organizations work with individual consumers and therefore state that they are able to represent their voices and their needs to DMHC.

The CPP had an initial sunset date of January 1, 2007, and the sunset has since been extended twice, each time in budget trailer bill and most recently in 2011 through AB 110 (Committee on Budget, Chapter 31, Statutes of 2011). The CPP has been in existence for nearly 15 years and has made it possible for nonprofit groups with few resources to represent the consumer interest in the DMHC's proceedings and ensure there is sustained oversight of managed health care plans.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Health Access to present this proposal.

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

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

ISSUE 16: MEDI-CAL ELIGIBILITY DATA SYSTEM MODERNIZATION MULTI-DEPARTMENTAL PLANNING TEAM BUDGET CHANGE PROPOSAL

PANELISTS

- **Cynthia Tocher**, Deputy Director, Project Management Division, Office Of Systems Integration
- **Rene Mollow**, Deputy Director, Health Care Benefits And Eligibility, Department Of Health Care Services
- **Tyler Woods**, Finance Budget Analyst, Department of Finance
- **Laura Ayala**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

This proposal requests $6.6 million ($727,000 General Fund) to continue support of 16.0 existing positions and other resources for an additional two years to advance the agency-wide planning effort to replace the outdated Medi-Cal Eligibility Data System (MEDS). These staffing and other resources are needed during fiscal year (FY) 2017-18 and FY 2018-19 to support completion of activities required by the State's Project Approval Lifecycle Stage Gate requirements

BACKGROUND

Since 1983, DHCS has maintained the current MEDS system to support key programmatic functions both internally and externally for its critical partners. Today, the system is used for a variety of eligibility and reporting functions specific to Californians receiving Medi-Cal benefits. MEDS and its related subsystems have been designed over many years to capture client information from a variety of different sources. Key stakeholders that manage the beneficiary eligibility data include the three county consortia (LEADER Replacement System, Consortium IV, and CalWORKs Information Network) representing all 58 counties, state and federal partners, and Covered California. MEDS also serves as the "system of record" and houses eligibility information for numerous publicly subsidized health and human services programs. Programs managed within DHCS which leverage MEDS include: Every Woman Counts, Child Health and Disability Prevention, Breast and Cervical Cancer Treatment, and the Family Planning Access Care and Treatment. Programs managed within the California Department of Social Services (CDSS), which leverage MEDS include: CalWORKs, CalFresh, Cash Aid Program for Immigrants, In-Home Supportive Services, and Refugee Cash Assistance. In addition to the state managed programs, multiple programs at the local level also leverage the system such as the County Medical

Services Program, and the County Welfare and Tribal Temporary Assistance for Needy Families. MEDS data is also used for administrative purposes such as accounting, reporting, legislation, research, and budget development. Access to the MEDS database is currently provided to over 35,000 distinct end-users in the administration of the State's health and human services programs. DHCS must ensure this access is provided in accordance with state and federal security and privacy requirements.

In FY 2014-15, the initial MEDS Modernization Planning effort began under management responsibility of DHCS. A total of 16.0 two-year limited-term positions, and approximately $3.5 million in total funds was approved in FY 2014-15 to support state staffing needs. In addition, a total of $4.9 million in funding for additional contract resources was approved in the FY 14-15 DHCS Local Assistance budget.

In FY 2015-16, a total of $3.7 million in funding was approved in the DHCS Local Assistance budget to support the project's contract resource needs.

In FY 2016-17, management responsibility for the project was transferred to the Office of Systems Integration (OSI) in order to better support the agency wide nature of the project. A total of 18.0 staffing resources and $3.7 million total funds was approved in FY 2016-17 to support the project's state staffing and other contract resource needs. Of the 18.0 staff resources, 3.0 were for DHCS, 2.0 for CDSS, and 13.0 for OSI. In addition, a total of $2.9 million was included in DHCS Local Assistance for associated spending authority by OSI.

The major accomplishments achieved to date for the MEDS Modernization Planning Project are as follows:

2016-17

- Procured consultant services and began a multi-agency alternatives analysis
- Began State Project Approval Lifecycle (PAL) Stage 2 Alternatives Analysis (S2AA)
- Obtained Department of Technology (CDT) approval of PAL Stage 1 Business Analysis (SI BA)
- Obtained approval of a Planning Advance Planning Document Update (PAPDU) for federal year
- 2017 funding participation
- Executed departmental interagency agreement between OSI and DHCS

2015-16

- Established formal Project Steering and Executive Steering Committees
- Implemented stakeholder engagement activities
- Procured new Project Planning consultant
- Executed departmental interagency agreement between DHCS and CDSS
- Completed core transition activities to move the MEDS Modernization planning effort from DHCS to OSI
- Restructured project to align with State PAL Stage Gate requirements
- Obtained approval of PAPDU for federal year 2016 funding participation

- Completed business rules extraction and annotation
- Completed As-Is Assessment of MEDS Business, Information and Technology Architecture

2014-15

- Procured Project Management Support consultant services
- Performed initial business rules extraction
- Purchased and installed business rules extraction software
- Procured Business, Information, and Technology Enterprise Architects consulting services
- On-boarded 16 new state staff
- Obtained approval of PAPDU for federal year 2015 funding participation

Continuing support for OSI's centralized management of the MEDS Modernization project will allow CHHSA to continue developing a modernization solution. OSI's project management (PM) experience and expertise can guide stakeholders to achieve desired project outcomes and improve project success. Through PM, OSI will apply best practices, engage stakeholders, and complete the required planning functions and deliverables. This comprehensive approach to planning for MEDS Modernization addresses the following issues surrounding this large and complex IT project:

1. Enterprise Approach and Stakeholder Involvement: Ensures that common business needs are addressed in a consistent and collaborative manner. Supports full inclusion and collaborative decision making on informed investment decisions through a formal governance body. Prevents a silo approach that results from stakeholders operating independently and duplicating efforts in a parallel manner. Lack of critical partners early in project planning is regularly identified as a key reason for large IT project delays and cost overruns. Identifying the program and business needs up-front, and designing the IT system to meet those needs is widely considered best practice, but requires an up-front dedication of resources from all partners to ensure that planning is done properly. This request is specifically intended to meet that critical need.

2. Project Approval Life Cycle: Ensures experienced PM and leadership is provided to all participating departments throughout the stage/gates of the PAL. Having dedicated PM will be critical to maintaining the schedule, and subsequently, best position the Project for control agency support and approval.

3. Federal Funding Participation (FFP) Availability: Through leveraging enhanced FFP, departments will benefit from federal funds available which minimizes the impact on the General Fund.

4. Sustaining enhanced FFP: Proper planning and implementation of MEDS Modernization will ensure that future MEDS maintenance and operations costs will continue to be reimbursed at the enhanced FFP of 75% federal and 25% state, as the modernization solution will comply with the Medicaid Information Technology Architecture (MITA) standards.

This proposal is based on a PM best practices framework which addresses all key functions conducted in the planning phase. The core planning team is a blend of PM and technical resources that will execute required activities associated with MEDS Modernization planning.

The scope of the planning efforts anticipated during FYs 2017-18 and 2018-19 are anticipated to focus on the following PAL Stage 3 and 4 requirements:

- CDT approval of the PAL Stage 2 Alternatives Analysis documentation
- Completion of PAL Stage 3 Solution Development requirements including:
    - Refinement of approved Stage 2 Mid-Level solution requirements and developing the
    - detailed solution requirements; including Functional, Non-Functional, Project/Transition,
    - Mandatory/Optional, and Administrative
    - Documentation of To-Be Process Workflows
    - Determining the specific types of vendor procurements (both primary and secondary
    - solicitations) needed to support the modernized solution's subsequent detailed design,
    - development and implementation (DD&I) phases
    - Developing the DD&I procurement(s) Statement of Work
    - Developing the proposed Procurement Planning and Development dates
    - Solicitation(s) development
    - Developing evaluation team(s) procedures
- CDT approval of PAL Stage 3 Solutions Development documentation
- Begin PAL Stage 4 Project Readiness and Approval activities including:
    - Releasing solicitation(s)
    - Selecting vendor(s)
    - Contract management readiness
    - Baseline DD&I project cost and schedule
    - Develop risk register
    - Obtain Department of Finance/Legislature approvals

STAFF COMMENTS/QUESTIONS

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

- When will the Administration be able to provide the Legislature with a comprehensive budget and timeline for this entire project?

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 17: STAKEHOLDER PROPOSAL - NEWLY QUALIFIED IMMIGRANT (NQI) WRAP ELIMINATION TRAILER BILL

PANELISTS

- **Kimberly Chen,** Government Affairs Manager, California Pan-Ethnic Health Network
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department Of Health Care Services
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Health Access, California Pan Ethnic Health Network, Western Center on Law & Poverty, California Immigrant Policy Center, and other advocacy organizations propose trailer bill to eliminate the Newly Qualified Immigrant Wrap (NQI Wrap) program by repealing W&I Code Sections 14102 and 14148.67.

BACKGROUND

Newly Qualified Immigrants (NQIs) are low-income (under 138 percent of the federal poverty level) legal immigrant adults who have been in the United States under five years. Historically, the federal government did not provide financial support through Medicaid for this population. Despite the lack of Federal Financial Participation (FFP), California's Medi-Cal program has offered this population coverage with state-only funding for many years prior to the passage of the Affordable Care Act (ACA). As a component of California's implementation of the ACA, statute was adopted to move this population (excluding parents) from Medi-Cal to Covered California, including the creation of the "NQI Wrap" which was intended to cover the additional costs that these individuals would incur with coverage through Covered California. The NQI Wrap still has not been implemented due to various implementation challenges.

The NQI Wrap for childless NQIs is authorized under W&I Code Sections 14102 and 14148.67. Per statute, NQIs who participate in the Wrap will be enrolled in one of the two lowest silver level Covered California qualified health plans (QHP) instead of receiving coverage through Medi-Cal, and will have their Covered California QHP out-of-pocket premiums, deductibles and cost-sharing up to the amount necessary to pay for that plan in his or her pricing region, paid by the State. NQIs qualify for the NQI Wrap if they would be eligible for full-scope Medi-Cal if not for the five-year bar on federal full-scope Medi-Cal eligibility.

Any Medi-Cal covered services not covered by the Covered California QHP will be provided by Medi-Cal. The combined benefit package provided by a QHP and Medi-Cal will be equivalent to full-scope Medi-Cal for new qualified immigrants at a lower overall cost to the State.

W&I Code Section 14148.65, which was enacted to implement the NQI Wrap Program for Pregnant Women, should be repealed because it cannot be implemented due to the federal Centers for Medicare and Medicaid Services' (CMS) recognition of pregnancy-related Medi-Cal as Minimum Essential Coverage (MEC). CMS also provided additional guidance in November 2014 through a State Health Official (SHO) letter 14-002 for pregnant women currently enrolled in a Covered California health plan to enroll into Medi-Cal, if eligible, or retain her current health plan from Covered California. This guidance from CMS allows pregnant women to remain in the Wrap so long as they are eligible for Medi-Cal benefits and otherwise continue to qualify.

The NQI Wrap has yet to be implemented and advocates are proposing its repeal in light of the anti-immigrant actions and hostile federal environment present today. They believe that moving NQIs from Medi-Cal to Covered California, and implementing the Wrap, will jeopardize their coverage, cause disruptions in their care and coverage, and create significant confusion for these individuals. This population has been in the United States a very short time (under five years) and many of them do not speak English. Transitioning them from one program to two programs (Covered California and the Wrap) would have to be complicated and confusing, and therefore extremely challenging for this population to navigate. Advocates have also expressed concerns regarding the risk to immigration status, including deportation, for immigrants dually enrolled in Medi-Cal and an receiving federal assistance through Covered California or who do not correctly undergo tax reconciliation.

Finally, advocates state that the repealed provisions should be replaced with a specific requirement that DHCS seek Minimum Essential Coverage certification from CMS for all full-scope state-only Medi-Cal programs for as long as there is an individual mandate requirement. Enrollees in these programs should not be needlessly incurring tax liability for lack of health insurance coverage or requiring advanced tax advice to avoid such liability when they are enrolled in full-scope Medi-Cal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the California Pan-Ethnic Health Network to present this proposal.

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

ISSUE 18: MAJOR RISK MEDICAL INSURANCE FUND ELIMINATION TRAILER BILL

PANELISTS

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

Public Comment

PROPOSAL

This proposal abolishes the Major Risk Medical Insurance Fund (MRMIF) and transfers the fund balance, and ongoing Managed Care Administrative Fines and Penalties Fund revenue to the newly established Health Care Services Plans Fines and Penalties Fund, which may be used to fund expenditures in the Major Risk Medical Insurance Program (MRMIP) and health care services for eligible individuals in the Medi-Cal program.

BACKGROUND

MRMIF receives revenue transferred from the Managed Care Administrative Fines and Penalties Fund for purposes of funding MRMIP expenses. Since 1991, MRMIP has provided health insurance to Californians who are unable to obtain coverage, or charged unaffordable premiums, in the individual health insurance market due to a pre-existing condition. Californians who qualify for MRMIP contribute to the cost of their health care coverage by paying monthly premiums equal to 100 percent of the average market cost of premiums (based on the Silver level coverage through the Health Benefits Exchange), an annual deductible and copayments. MRMIP has an annual benefit cap of $75,000, and a lifetime benefit cap of $750,000. MRMIP is not an income-based eligibility program.

MRMIP was originally established as a state high-risk pool. However, the need for high-risk pools such as MRMIP have reduced as a result of the passage of the Affordable Care Act (ACA). The ACA prohibits the denial of coverage to individuals due to a pre-existing condition and also prohibits charging individuals with a pre-existing condition a higher premium due to their condition. As such, enrollment in MRMIP decreased from 6,570 in 2013 to 1,332 in 2016.

The ACA has reduced the need for the high-risk pool because individuals cannot be denied coverage based on a pre-existing condition. Therefore, DHCS proposes to abolish MRMIF and transfer the fund balance, and ongoing administrative fines and penalties revenue, to a newly established fund that may be used to fund expenditures in the MRMIP and the Medi-Cal program. This proposal would not impact the level of benefits for enrollees in MRMIP.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 19: MEDI-CAL 2020 CONTRACT FUNDING BUDGET CHANGE PROPOSAL

PANELISTS

- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department Of Health Care Services
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Department of Health Care Services (DHCS) requests approval of limited-term annual contract funding of $1,960,000 ($980,000 Reimbursements (R) and $980,000 Federal Fund (FF)) beginning Fiscal Year (FY) 2017-18 to 2020-21 and $460,000 ($230,000 R and $230,000 FF) in 2021-22. The contract funding is needed to hire subject matter experts to facilitate learning collaboratives, assist participating entities by providing technical assistance, and conduct an independent evaluation. The learning collaboratives are federally required activities for all participating Public Hospital Redesign and Incentives in Medi-Cal (PRIME) entities and for all entities participating in the Whole Person Care (WPC) Pilot program. The contracts also include an independent evaluation of the Dental Transformation Initiative (DTI). Per the Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STC) of the Section 1115 Medicaid Waiver, known as MediCal 2020, this funding will be needed through the end of the demonstration.

Contract funding for WPC and PRIME is limited to four years. Specifically, $1,000,000 each year for the WPC contract and $500,000 each year for the PRIME contract.

Contract funding for DTI is limited to five years at $460,000 each year.

BACKGROUND

California's 1115 Waiver Renewal, called Medi-Cal 2020, was approved by CMS on December 30, 2015. Medi-Cal 2020 will guide DHCS through the next 5 years as DHCS works to transform the way Medi-Cal provides services to its more than 13 million members, and improve quality of care, access, and efficiency.

As mandated by the CMS STC, the State will work with each of the 54 participating PRIME entities, which are a collection of public health systems that are diverse in geography, size, population, and capacity, to lead and support regular learning collaboratives and ongoing required quality improvement activities. These activities include development of data collection and analysis systems for external evaluation and providing technical assistance to PRIME entities on program evaluation. The PRIME

program is a pay-for-performance program involving 54 public hospital health systems including 59 facilities (LA County Health System has four facilities; Alameda Health System has three facilities). PRIME participating entities will include California's 17 Designated Public Hospital Systems (DPHs) and 37 District/Municipal Public Hospitals (DMPHs). The DMPHs will be participating in the Medi-Cal 2020 waiver for the first time and have little to no experience with system transformation and health care quality improvement work of the magnitude required by the PRIME program.

The PRIME program will require increased program management and oversight as well as ongoing technical assistance related to data collection, analysis, and project interventions. Technical assistance efforts will include the creation and management of ongoing learning collaboratives that will be hosted by DHCS throughout the duration of the demonstration.

The PRIME program goals and projects, as described in the PRIME Program Funding and Mechanics Protocol, will drive the content of the learning collaboratives. These collaboratives should be facilitated and led by individuals with extensive training in health care quality improvement techniques and fundamentals who can answer practical questions about implementation and harvest ideas and best practices that they systematically spread to PRIME entities.

The State has received one-time funding approval of $500,000 for FY 2016-17 for a technical assistance contract for learning collaboratives. The Department proposes to continue this contract in budget year onward using reimbursement funding provided by participating PRIME entities as the non-federal share.

Also as mandated by the Special Terms and Conditions (STCs), the State will establish and conduct learning collaboratives for WPC pilots. Section V of Attachment HH to the STCs states the following:

a. WPC Pilot lead and participating entities shall participate in all WPC learning collaborative activities. Participation of lead and/or participating entities in any specific learning collaborative activity shall be determined by the State.

b. Learning collaborative activities shall be structured to provide information about and assist with Pilot implementation and close-out; share best practices and learnings across WPC Pilots; and for the State to provide information, discuss requirements, and report data about the Pilots.

c. A subset of WPC Pilot lead entities shall be identified to assist the State with planning and providing direction about how learning collaboratives will be structured.

d. The State shall convene a minimum of bi-weekly calls during the first year after approval of Pilot applications to discuss implementation issues, answer Pilot questions, and clarify Pilot requirements. The frequency of these calls shall be decreased following this initial year dependent on the need for them, however, shall be no less than monthly.

e. The State shall convene a minimum of two in-person learning collaboratives during each WPC program year with the exception of year 1. These meetings shall be focused on the sharing of best practices across WPC pilots; when possible, national policy and practice information will be shared; reporting of WPC Pilot performance; and to help establish working relationships across pilots to promote discussion and sharing of information amongst pilots in between meetings without direction.

Authorization for funding the WPC pilots learning collaborative is requested beginning July 2017. Learning collaborative activities will continue for the duration of the pilots – through December 2020. Learning collaborative activities will include program development and deployment, webinars, telephone-based and in-person convenings. The California Health Care Foundation has offered to provide the non-federal match for this contract funding through four years.

Within the Medi-Cal 2020 Waiver, the DTI represents a critical mechanism to improve dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. More specifically, these strategies aim to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

The extension of contract funding beyond FY 2016-17 is critical for DHCS to meet the provision of specialized clinical and quality improvement-related expertise and ongoing specialized technical assistance to the pilot WPC programs throughout the state and the 54 hospitals/health systems participating in the PRIME program. This type of specialized clinical and quality improvement expertise and expansive capacity is exceedingly rare through civil service classifications. The funding for this proposal will enable the execution of a multi-year contract to support the achievement of the WPC and PRIME program goals. It is estimated that a multi-disciplinary team of approximately 5 individuals, one full-time, and four 50% time, will be needed to support the PRIME program along with dedicated state staff. The team would include competencies in: large-scale, health system management; Medicaid programs and policies; clinical and population health quality improvement; performance monitoring using standardized quality metrics; and strong, scientific communication skills.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 20: FEDERAL MANAGED CARE REGULATIONS BUDGET CHANGE PROPOSAL

PANELISTS

- **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
- **Jacob Lam**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Department of Health Care Services (DHCS) requests the establishment of 15.0 permanent positions and the associated expenditure authority, detailed below, to support the implementation of the Medicaid and CHIP Managed Care Final Rule CMS-2390-P.

Total funding request:

Fiscal Year	Total Funds	General Fund	Federal Fund
2017-18 to 2020-21 (per FY)	**$8,920,000**	**$4,460,000**	**$4,460,000**
Permanent:	*$2,590,000*	*$1,295,000*	*$1,295,000*
4-Year LT:	*$6,330,000*	*$3,165,000*	*$3,165,000*
2021-22 and ongoing (per FY)	**$2,590,000**	**$1,295,000**	**$1,295,000**
Permanent:	*$2,590,000*	*$1,295,000*	*$1,295,000*

Released in May 2016, Final Rule 2390-P changed the Medicaid managed care regulations to reflect the increased utilization of managed care as a delivery system. It aligns the rules governing Medicaid managed care with those of other major sources of coverage, including Qualified Health Plans and Medicare Advantage Plans; implements statutory provisions; changes actuarial payment provisions; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also strengthens beneficiary protections and policies related to program integrity. This rule requires states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries.

The final rule requires states to develop and implement a transparent data-driven process to evaluate whether provider payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with section 1902(a)(30)(A) of the Social Security Act. The monitoring system developed must provide information necessary to address issues raised by the monitoring process. Implementation of the Final Rule must be executed no later than July 1, 2018.

The following chart identifies the positions/resources requested and organizationally where they are located within DHCS:

LOCATION WITHIN DHCS	RESOURCES REQUESTED
Managed Care Quality and Monitoring Division	4.0 4-year limited term
Managed Care Operations Division	7.0 4-year limited term
Medi-Cal Dental Services Division	7.0 4-year limited term
Enterprise Innovation and Technology Services	5.0 4-year limited term
Information Management Division	2.0 4-year limited term
Office of HIPAA Compliance	5.0 4-year limited term
Office of Legal Services	2.0 4-year limited term
Mental Health Services Division	11.0 permanent positions & 3.0 4-year limited term
Substance Use Disorder Division	4.0 permanent positions & 1.0 4-year limited term
Administration Division	4.0 4-year limited term

Contract Funding:

MHSD External Contract(s): Permanent funding.
FY 2017-18: $471,000 ($235,000 GF and $236,000 FF)
FY 2018-19 and ongoing: $606,000 ($303,000 GF and $303,000 FF)

Director's Office External Contract(s): 4-Year Limited-Term
FY 2017-18 only: $538,000 ($269,000 GF and $269,000 FF)
FY 2018-19 to FY 2020-21: $763,000 ($382,000 GF and $381,000 FF)

BACKGROUND

Managed Care Regulations
Since 1965, Medicaid has financed health care coverage for certain categories of low income individuals. States administer the program within broad federal guidelines and have considerable flexibility in designing certain aspects of the program, including eligibility, covered services, and provider payment rates. States generally cover Medicaid services for beneficiaries through two major financing approaches: traditional fee-for-service (FFS), in which the Medicaid program directly reimburses providers for care provided to beneficiaries, and capitated managed care, in which the state pays Managed Care Organizations (MCOs) a fixed monthly per member per month (capitation) payment for covered health care services. Managed care is a health care delivery system organized to manage cost, utilization, and quality.

States design, administer, and oversee their own Medicaid managed care programs within the requirements set forth in federal Medicaid law and further elaborated in regulation. These federal regulations, previously updated in 2002, set forth state responsibilities and requirements in areas including enrollee rights and protections, quality assessment and performance improvement (including provider access standards), external quality review, grievances and appeals, program integrity, and sanctions. The 2002 regulations (67 Fed. Reg. 40989, June 14), were a response to the Balanced Budget Act of 1997 (Pub. L. 105-33).

The Centers for Medicare and Medicaid Services (CMS) released its Medicaid managed care proposed revision to the 2002 rule on May 26, 2015; it was published in the Federal Register on June 1, 2015. CMS issued Final Rule CMS-2390-P on May 6, 2016. The final rule primarily amends and expands the requirements of Title 42, Code of Federal Regulations, Part 438, pertaining to managed care. CMS proposes to modernize the Medicaid managed care regulatory structure to facilitate and support delivery system reform initiatives resulting in improved health outcomes and the beneficiary experience, while effectively managing costs. The Center for Medicare and Medicaid Services (CMS) additionally seeks to align managed care with other sources of coverage such as Medicare Advantage and Exchange plans.

The rules have multiple, direct purposes with respect to: the accountability of rates paid in the Medicaid managed care program; beneficiary protections in the areas of provider networks, coverage standards, and treatment of appeals; and program integrity safeguards. In so doing, the rule seeks to balance greater regulatory oversight and accountability of both state and industry practices with wider deference to states in how they choose to design managed care and utilize contractors.

The new rulemaking expands the detail and scope of existing oversight activities and requires states to substantially expand oversight and monitoring of Managed Care Plans (MCP), Mental Health Plans (MHP), Prepaid Inpatient Hospital Plan (PIHP), and Dental Managed Care (Dental MC) activities by requiring greater detail in oversight activities and verification of information reported by MCPs and Dental MCs, including data on provider networks according to a specified range of provider types, cultural and language standards, and quality improvement projects. The new rules also require states to demonstrate their willingness to issue sanctions to MCPs that repeatedly fail to comply with program requirements. (CMS-2390-P Part I, Section A).

Mental Health Specialty Mental Health Services
Pursuant to the terms of a 1915(b) waiver, specialty mental health services (SMHS) in California are provided to Medi-Cal beneficiaries of each county through a Mental Health Plan (MHP). DHCS' Mental Health Services Division (MHSD) contracts with 56 county MHPs who are responsible for providing, or arranging for the provision of, SMHS to beneficiaries who meet medical necessity criteria in a manner consistent with the beneficiaries' mental health treatment needs and goals as documented in the beneficiary's treatment plan.

One of CMS' primary goals with the revised rule is to align Medicaid managed care with other federal health care programs. However, California's SMHS program is unique in its design and delivery system. As such, the effort it will take to achieve CMS's goal of alignment will have a significant impact on MHSD and the overall SMHS delivery system.

The revised MMC rule establishes new requirements for managed care organizations (MCOs), Pre-paid Inpatient Health Plans (PIHPs), Pre-paid Ambulatory Health Plans (PAHPs), Primary Care Case Managers (PCCMs) and PCCM Entities. The 56 MHPs are classified under the federal Medicaid managed care (MMC) rule as PIHPs. Unlike traditional Medicaid managed care plans, MHSD does not pay MHPs a capitated rate

under the Specialty Mental Health waiver program. Rather payment is made through non-risk contracts in a FFS payment structure. MHPs must comply with all MMC rules applicable to PIHPs in non-risk contracts. In addition to establishing new requirements, the revised MMC rule expands the scope and applicability of many existing federal regulations which did not previously apply to PIHPs.

The Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) established licensing and regulatory authority for the oversight of California's health plans. Knox-Keene set rules for mandatory basic services, financial stability, availability and accessibility of providers, review of contracts, administrative organization and consumer disclosure, and grievance requirements. Knox-Keene has been amended over time to include a series of additional benefits and to provide mandates regarding new provider contracting, claims payment requirements, and changes to coverage and contract requirements. Knox-Keene effectively introduced control mechanisms to help make sure Medi-Cal managed care plans were able to comply with the existing federal Medicaid managed care rule. Since the MHPs are not regulated by Knox-Keene, the standards do not apply. Therefore, the MHPs lack this foundation for compliance with the final MMC rule.

As a result, the final MMC rule will have a significant impact on the SMHS delivery system and MHSD is now charged with new workload directly related to the provision of SMHS and oversight of the 56 MHPs.

Medi-Cal Dental Services

In the State of California, there are two types of dental managed care: geographic managed care wherein participation is predominately mandatory which is located in Sacramento County; and Prepaid Health Plan which is located in Los Angeles county and is accomplished by the opt-in process. Each of these managed care delivery systems is currently contracted with three separate insurance plans.

The Medi-Cal Dental Services Division (MDSD) houses the Department's Medi-Cal Dental Program and is responsible for gathering and analyzing dental fee for service (FFS) and Dental MC data so program expenditures are based on complete, accurate, reasonable, and timely encounter data and that each beneficiary has timely access to high quality health care services provided by an appropriate provider type in the right location. MDSD monitors the quality, timeliness, and access of services provided by 6 Medi-Cal Dental MC contracts and the FFS delivery system, each operating in one or more of the state's 58 counties and serving over 13.3 million Medi-Cal beneficiaries. Approximately 946,797 of these beneficiaries are enrolled in a Dental MC plan in Sacramento and Los Angeles counties.

In 2011, Assembly Bill 97 was signed into law, mandating that certain Medi-Cal provider reimbursement rates be reduced by up to 10 percent. Before allowing DHCS to implement the reductions, CMS required DHCS to develop a FFS access monitoring plan so that payment reductions would not adversely impact beneficiaries' access to health care services.

In November 2015, CMS amended the requirements for states' documentation of access to care found in 42 CFR Part 447. These new requirements necessitate the design and development of a new access monitoring plan, and list specific measures for separate analyses. CMS requires that both the monitoring plan and analyses be revised and updated periodically as new information is evaluated. These new requirements represent an increase in workload beyond DHCS' current monitoring efforts. For example, new requirements call for the inclusion of pediatric and adult dental provider specialty types. Since the Medi-Cal program has many dental provider specialty types, this change increases the scope and complexity of current reporting. Such changes increase the number of datasets relied upon, data linkages that must occur, development of analytic files, calculation of statistics, overall analyses, and research writing. These efforts can only be completed through the addition of skilled research staff. Finally, pursuant to 42 CFR Part 447, CMS requires states to incorporate provider rate reviews into their access monitoring plans and analyses. These reviews examine Medi-Cal services and providers, and must include a comparison of Medi-Cal payment rates to those of other public and private payers. Reimbursement rate comparisons are included as part of DHCS' current dental rate monitoring process through state legislative mandate. However, the complexity of the new requirements set out by CMS will increase the complexity of DHCS' reports.

Transformed-Medicaid Statistical Information System (T-MSIS)

Enterprise Innovation and Technology Services (EITS) is responsible for architecting, building and delivering secure, innovative solutions and services that drive health care quality and for information technology strategy formulation, enterprise architecture, enterprise portfolio management, and enterprise governance. EITS establishes information technology policy and standards and confirms compliance with state and federal laws and regulations regarding the use of information technology and the safeguarding of electronic information. In doing so, EITS manages a complex portfolio of program systems, including the Medi-Cal Eligibility Data System (MEDS), Behavioral Health Systems, and the Management Information System/Decision Support System (MIS/DSS). EITS provides quality application and data services to DHCS programs; facilitates the successful completion of business and information technology projects undertaken by DHCS; and manages the design, installation, upgrade, and support of a complex technology infrastructure, including network, servers, desktops, network devices, messaging systems, websites, web applications, and databases.

EITS is directly responsible for the technical implementation of the Medicaid Statistical Information System (MSIS) and the Behavioral Health Systems, which are essential to the implementation of the final rule. Section 4753 of the federal Balanced Budget Act of 1997 (Public Law 105-33), requires DHCS to provide data to the CMS in the format prescribed for the MSIS. The claims data format for MSIS electronic transmission is specified in the State Medicaid Manual, Part 2, §2700 as may be updated by the Secretary from time to time. DHCS has been reporting the MSIS data quarterly for approximately two decades. In 2012, CMS initiated a 10-state pilot to develop a Transformed Medicaid Statistical Information System (TMSIS), of which California was one of the states. In March 2013, CMS approved an Implementation Advanced Planning Document (lAPD) for T-MSIS for total project costs of $506,189. In September 2014, CMS approved an Implementation Advanced Planning Document Update (lAPDU) for

$1,626,450 which increased the budget for software and staffing and revised the project schedule.

Drug Medi-Cal Organized Delivery System (DMC-ODS)
The DMC-ODS program was authorized and financed under the authority of the State's 1115 Medi-Cal 2020 Waiver approved by CMS in August, 2015. The DMC-ODS is a Medi-Cal benefit provided by, and within, participating counties through a county operated PIHP as defined by CMS in 42 CFR 438.2. Counties that opt into a DMC-ODS contract with DHCS will be creating a continuum of care for eligible beneficiaries with substance use disorders while decreasing other system health care costs. The Substance Use Disorders Compliance Division (SUDCD) and the Substance Use Disorders Program, Policy & Fiscal Division (SUDPPFD) are responsible for licensing, certification, program integrity, regulatory and contractual oversight, and technical assistance to County and treatment providers. These responsibilities encompass the current State Plan Drug Medi-Cal services, federal block grant funded services, and DMCODS services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal.

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

ISSUE 21: DELAY OF FEDERALLY QUALIFIED HEALTH CENTERS ALTERNATIVE PAYMENT METHODOLOGY PILOT (SB 147)

PANELISTS

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

Public Comment

PROPOSAL

In order to manage and prioritize workload, DHCS is proposing (or announcing) delays to the implementation of six bills. As indicated below, three of these require legislative authorization, and DHC has proposed trailer bill for this purpose, while the other three can be delayed under the current authority of the administration. This issue today covers just number six in the list below; the other five have been heard already as indicated. The six proposals are:

1. Implementation of the Whole Child Model for CCS in COHS counties (SB 586) to no sooner than July 1, 2018. *This proposal does not require legislative authorization. This issue was heard by the Subcommittee on* ***March 27, 2017****.*

2. Implementation of the palliative care program (SB1004) to no sooner than July 1, 2018. *This proposal does not require legislative authorization. This issue was heard by the Subcommittee on* ***March 27, 2017****.*

3. Implementation of the inclusion of marriage and family therapists as billable FQHC providers (AB 1863) to no sooner than July 1, 2018. *This proposal requires legislative authorization (trailer bill). This proposal was heard by the Subcommittee on* ***April 3, 2017****.*

4. Issuance of regulations for out-of-county foster care presumptive transfer (AB 1299) to July 1, 2020. *This proposal requires legislative authorization (trailer bill). This proposal was heard by the Subcommittee on* ***April 3, 2017***.

5. Issuance of evaluation report for Assisted Outpatient Treatment (AB 59) to no sooner than July 1, 2018. *This proposal requires legislative authorization (trailer bill). This proposal was heard by the Subcommittee on* ***April 3, 2017***.

6. Implementation of the FQHC alternative payment methodology pilot (SB 147) to no sooner than January 1, 2018. *This proposal does not require legislative authorization. This proposal is being heard today on* ***May 1, 2017***.

The Administration announced its intention to implement SB 147 (Hernandez, Chapter 760, Statutes of 2015) no sooner than January 1, 2018.

BACKGROUND

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

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

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

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

(or an APM, discussed below) for each face-to-face encounter between a Medicaid beneficiary and one of the FQHCs billable providers for a covered service.

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

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

SB 147 calls for a pilot project using an APM where FQHCs would receive per-member per month (PMPM) payments from the health plan, and would no longer receive a "wrap around" payment from DHCS. CMS has indicated a state may accept an FQHCs written assertion that the amount paid under the APM results In payment that at least equals the amount to which the FQHC is entitled under the PPS.

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

In 2016, DHCS requested three-year, limited-term expenditure authority of $240,000, to support the implementation, administration, and evaluation of an alternative payment methodology (APM) pilot for select California Federally Qualified Health Centers (FQHCs) pursuant to the requirements of SB 147. One-time contract authority of $300,000 was requested in FY 2017-18, to prepare an evaluation of the pilot. The contract was to be funded 50 percent Federal Funds (FF) and 50 percent reimbursement from a foundation. FY 2016-17 expenditure authority requested: $240,000 (50% General Fund (GF)/ 50% FF). FY 2017-18 expenditure authority requested: $540,000 ($120,000 GF/ $270,000 FF/ $150,000 reimbursement). These resources were approved and included in the 2016 Budget Act.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal and to clarify the status of the resources provided for implementation of SB 147 in the 2016 Budget Act.

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

ISSUE 22: STAKEHOLDER PROPOSAL - HOME UPKEEP ALLOWANCE

PANELISTS

- **Curtis L. Child**, Legislative Director, Disability Rights California
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department Of Health Care Services
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Disability Rights California (DRC) proposes trailer bill to codify and increase the home upkeep allowance (HUA) and a transitional needs fund (TNF) for up to six months for a long-term care (LTC) facility resident who intends to leave the facility and return or establish a home in a community.

BACKGROUND

The Assembly Appropriations Committee provided the following fiscal analysis of AB 286 (Gipson) which is identical to this proposal:

Any additional money the state allows individuals to keep as a HUA or a transitional fund results in a commensurate increase in Medi-Cal costs. It increases costs because it reduces the amount an individual enrolled in the "Share of Cost" (SOC) Medi-Cal program would otherwise pay as their share of cost. This bill would allow an individual to exclude an additional $4,800 of income over 6 months.

The HUA would be available only to a portion of the 42,000 SOC Medi-Cal enrollees in long-term care in any given month. Federal law restricts the HUA to situations there is not a spouse or family member living in the individual's home. Costs are estimated as follows:

1. For every 1,000 Medi-Cal enrollees in long-term care (LTC) facilities that make use of the expanded HUA or transitional fund per month, and assuming the additional amount excluded is 80% of the maximum allowable, the increased cost will be about $9 million annually (50% GF, 50% federal). Data is not available on what percentage of Medi-Cal enrollees would be both eligible to use and would use the HUA, but it would likely be a small portion of total discharges given the restrictions on eligibility explained above.

2. Unknown, significant costs associated with increased usage as a result of outreach related to the availability of the HUA (GF/federal). According to organizations familiar with advocacy for long-term care residents, utilization and knowledge of the current program is quite low. According to DHCS, only $607,000 statewide was set aside for HUAs under existing rules.

3. Unknown, likely significant costs associated with a higher number of persons who could become eligible for full scope Medi-Cal due to the higher income exclusion (GF/federal). The bill excludes income that would otherwise be counted when determining program eligibility. In some cases, applying the exclusion would make an applicants' income low enough to qualify for full-scope Medi-Cal, and the applicant would no longer share in the cost of their care. In those cases, the state would pay the full cost of their care.

4. Unknown, significant cost savings, to the extent this higher HUA allows individuals, who otherwise would have difficulty maintaining or establishing a home in the community in the absence of this higher HUA, to be discharged from institutional care. Because the HUA is restricted to individuals with no spouse or family, allowing these individuals to maintain a home would likely allow them to be discharged more readily.

BACKGROUND

The Assembly Health Committee provided the following background in their analysis of AB 286:

Long-term care in California
According to the U.S. Census Bureau, in 2015 California was home to over 5 million persons age 65 and older, representing 13.3% of the population, an almost 2% increase from 2010. According to a report by the Public Policy Institute of California, California's over-65 population is expected to be 87% higher in 2030 than in 2012, an increase of more than four million people. Because of this faster growth, there will be fewer adults of prime working age relative to the senior population. As a result, a greater share of the state's human and economic resources will be used to provide LTC and other types of support for this group.

LTC services generally address an individual's health, social, and personal needs, and are provided in institutional care settings (for example, skilled nursing facilities) and through community-based providers ranging from nonmedical residential care facilities to services such as transportation and meals to help individuals remain in their homes instead of being placed in an facility. LTC services are provided not only to the elderly (age 65 and older), but also to younger persons with developmental, mental, and/or physical disabilities. Many of the persons eligible for LTC services use multiple services provided by a variety of programs operated by many state departments. Within California, the Departments of Aging, Health Care Services, Social Services, Developmental Services, Mental Health, Rehabilitation, and Veterans Affairs directly administer LTC programs.

Current standards of the HUA

Maintaining or establishing a home in the community is a major obstacle for Medi-Cal beneficiaries who want to return home after admission to an institution. Medicaid eligibility rules give states the flexibility to support this goal and allow states to exempt income to maintain a home. The HUA is a Medi-Cal deduction for qualifying Medi-Cal beneficiaries who are living in, or will be living in, a nursing home or other medical facility. The HUA currently allows beneficiaries to keep $209 per month of their monthly income for maintenance and upkeep of their homes while they are temporarily residing in the nursing home other medical facility. The HUA can be allowed for up to a six month period from the date the beneficiary enters the nursing home. To qualify for the HUA, a beneficiary must meet all of the following requirements:

a. Intend to leave the nursing facility and to return home within six months of the date the individual begins living in the nursing home;
b. Obtain a written medical statement from the individual's doctor certifying that he or she will be able to return home within six months;
c. The spouse or family of the individual must not live in the home; and,
d. The home must be maintained for the individual's return.

DRC states that the $209 HUA has been in place since the 1970's, the availability of the allowance is widely unknown, and the HUA does not help people who have lost their homes while in a facility but want to find a new home and leave the facility. DRC asserts that the benefits of this proposal will far outweigh the costs as people are able to leave facilities and use community-based services. According to DRC, this proposal is necessary to increase the HUA for Medi-Cal recipients in nursing facilities to have greater opportunity to transfer back into their homes and communities from a nursing facility. The current allowance of just over $200 is not enough to sustain a rent/mortgage and utilities, and results in many people staying in nursing facility indefinitely because they are unable to transition back into their homes or prior community. In 2009, the California Health and Human Services Agency commissioned an independent study to identify ways that California could improve its aging and LTC infrastructure and support services and the report recommended an increase in the HUA as a critical way to improve lives and save money for the state.

STAFF COMMENTS/QUESTIONS

According to the Medi-Cal Estimate, the estimated average cost for an aged person in long-term care is $52,791 per year ($26,395 General Fund) and for a disabled person it is $63,368 per year ($31,684 General Fund). This is net of share of cost, Medicare payments, and other third party coverage. Therefore, if the state were to allow up to $1,005 per month to be kept by the beneficiary for non-institutional housing and related costs, that represents a per person cost of approximately $12,060 ($6,030 General Fund) as compared to $26,395 General Fund for this individual to stay in a long-term care facility. Hence, it is unclear how this proposal would have any cost, as compared to significant savings for the state.

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

- Please explain how this proposal would result in higher costs, rather than savings, for the state, given that the state would be paying the HUA instead of the full cost of long-term care.

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

ISSUE 23: STAKEHOLDER PROPOSAL - ROBERT F. KENNEDY MEDICAL PLAN (SB 145) TRAILER BILL

PANELISTS

- **Patrick Johnston**, Representative, Robert F. Kennedy Medical Plan
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department Of Health Care Services
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Robert F. Kennedy (RFK) Medical Plan requests trailer bill to move the sunset date in SB 145 (Pan, Chapter 712, Statutes of 2015) from January 21, 2021 to January 1, 2026.

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

BACKGROUND

SB 145:

1) Requires DHCS to annually reimburse the RFK Medical Plan for claim payments that exceed $70,000 made by the plan on behalf of an eligible employee or dependent for a single episode of care on or after September 1, 2016.
2) Limits reimbursement to the RFK Medical Plan by the state to no more than $3 million.
3) Requires the RFK Medical Plan, commencing after September 1, 2017, and annually thereafter, to submit to DHCS completed data, verified by an independent certified public accountant, for claims paid by the plan for services during the preceding year.
4) Requires DHCS to analyze the data to determine the aggregate amount of claims that exceed $70,000 paid the plan on behalf of an eligible employee or dependent for any separate episode of care, and reimburse the plan that amount, up to $3 million, within 60 days.
5) Sunsets on January 1, 2021.

RFK Medical Plan

Taft-Hartley plans are subject to the federal Employee Retirement Income Security Act of 1974, and thus are exempt from state insurance laws. The RFK Medical Plan is a self-funded, self-insured Taft-Hartley Plan that is subject to a collective bargaining agreement between the United Farm Workers (UFW) and multiple agricultural

employers. According to the UFW, the RFK Medical Plan provides health insurance to more than 13,000 people living in California farm worker families.

The ACA sets forth new standards for employer-sponsored health coverage, including a prohibition on annual and lifetime benefit limits. The RFK Medical Plan had previously imposed annual limits on benefits at $70,000. The purpose of the limit was to protect the financial solvency of the plan against high claims costs that exceeded $70,000. In light of the ACA's prohibition on annual limits, the RFK Medical Plan is no longer allowed to keep the $70,000 limit in place.

The RFK Medical Plan obtained a federal waiver allowing it to keep the $70,000 limit in place until 2014. In addition to the federal waiver, the RFK Medical Plan took other steps to sustain the plan in light of the financial risk associated with the high-cost claims. Specifically, the plan worked with both union and employer partners to increase employer and employee contributions to the RFK Medical Plan within the maximum allowable limits for grandfathered Taft-Hartley plans. Additionally, the RFK Medical Plan searched the market to try to purchase stop-loss insurance in the private market, and is building financial reserves through increasing the number of beneficiaries, increasing contributions within allowable limits, modifying benefits, and maintaining administrative costs below 5% within the goal of eventually withstanding larger claims.

Stop-loss Insurance and Previous Budget Actions

Stop-loss insurance is commonly sold to employers that self-insure their employee's health coverage. Self-insurance involves greater risk to the employer since employee health care costs could exceed expected estimates. In order for employers to minimize the risk involved with self-insurance, insurance carriers sell stop-loss insurance which covers claims in excess of a maximum dollar amount of liability incurred by an employer for health care expenses.

The 2014-15 state budget included $3.2 million (special fund) appropriation to the RFK Medical Plan for the purchase of stop-loss insurance for any claims over the amount of $70,000. Another one-time appropriation of $2.5 million was included in the 2015-16 budget for the same purpose. The RFK Medical Plan argued that there would be off-setting savings in the Medi-Cal program. These arguments were based on an assumption that the plan would not be financially viable and dissolve without financial assistance to purchase stop-loss insurance. If this occurred, the RFK Medical Plan's consultants assumed 50% of its members would be eligible for Medi-Cal at an estimated state cost of $4.7 million. Additionally, the RFK Medical Plan argued that if it were to cease operating, those insured by the plan not eligible for Medi-Cal would become uninsured.

Rather than appropriating state funds to the RFK Medical Plan for the purchase of stop-loss insurance, SB 145 instead requires the state to reimburse the plan for the claims that exceed $70,000 for an individual employee or dependent for a single episode of care up to a total of $3 million. In other words, the state acts as the stop-loss insurer for the RFK Medical Plan. In the 2014 plan year (September 2014 to August 2015), 17 cases exceeded the $70,000 threshold. The total payments made for these 17 cases were $1.4 million, far less than the cost of a stop-loss insurance plan.

The RFK Medical Plan explains that SB 145 is allowing the Plan to achieve one month's worth of savings per year, which the Plan is placing in their reserves. The Plan now has 3 months of savings in their reserve, and their actuaries recommend that they maintain a reserve of 12 months of savings. Hence, they are proposing to delay the SB 145 sunset by 5 years in order to achieve the additional 9 years of savings that they believe they need for a healthy reserve.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the RFK Medical Plan to present this proposal.

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

ISSUE 24: STAKEHOLDER PROPOSAL - MEDI-CAL COVERAGE UP TO AGE 26

PANELISTS

- **Ronald Coleman**, Government Affairs Director, California Immigrant Policy Center
- **Tam Ma**, Legal and Policy Director, Health Access California
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department Of Health Care Services
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Health Access, California Immigrant Policy Center (CIPC), California Pan-Ethnic Health Network (CPEHN) and other advocacy organizations propose trailer bill and Proposition 56 revenue to provide state-funded Medi-Cal coverage to low-income young adults up to age 26 who meet income qualifications but are currently ineligible for full-scope Medi-Cal because of their immigration status.

Advocates estimates expanding state-funded full-scope Medi-Cal coverage to low-income adults up to the age of 26, regardless of immigration status, would cost $80-$90 million dollars.

BACKGROUND

SB 75 (Committee on Budget, Chapter 18, Statutes of 2015) expanded full-scope Medi-Cal to all California children under age 19 regardless of immigration status. Advocates argue that Medi-Cal also should be expanded to cover young adults who age out of coverage, or whose coverage might be impacted by a change of status of the Deferred Action for Childhood Arrivals (DACA) program. Prior to the Affordable Care Act (ACA), young adults had the highest rates of uninsurance of any age group. The ACA allows most young adults to stay on their parents' coverage up to age 26--an option many undocumented youth do not have because of their parents' lack of employer coverage.

Advocates state that a modest but significant next step would be to have Medi-Cal to cover young adults, regardless of immigration status, and expand near universal coverage to not just California children, but young adults as well. Advocates also state that in the midst of a hostile federal environment, where immigrants are experiencing fear and anti-immigrant actions, ensuring California's young people maintain health coverage upholds California's commitment to the health and well-being of immigrant communities.

Covering this population up to age 26 would be consistent with both ACA coverage (through parents' plans) as well as with Medi-Cal coverage for former foster youth.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CIPC and Health Access to present this proposal.

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

ISSUE 25: STAKEHOLDER PROPOSAL - FAMILY PACT RATE INCREASE

PANELISTS

- **Jodi Hicks**, Legislative Representative, Planned Parenthood Affiliates of California
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department Of Health Care Services
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Health Access and Planned Parenthood Affiliates of California propose to dedicate $50 million in Proposition 56 revenue to restore the 10 percent cut to provider rates for Family PACT, and provide a rate increase for rates frozen for over a decade for family planning visit fees and surgical abortion services.

BACKGROUND

AB 97 (Committee on Budget, Chapter 3, Statutes of 2011) reduced Medi-Cal provider rates by 10 percent. Advocates state that the rate cut has been dire for Planned Parenthood and other family planning providers, which provides critical primary care and reproductive health services to over 850,000 low-income men and women in California. About 90 percent of Planned Parenthood patients are Medi-Cal beneficiaries, which means the bulk of Planned Parenthood's funding is from reimbursement for services provided to Medi-Cal beneficiaries. Moreover, the Family PACT program provides services for low-income individuals who are not eligible for Medi-Cal. Advocates state that, currently, not quite 50 percent of eligible individuals are served, indicating a still significant unmet need for services across California.

97 percent of services in California are for non-abortion services, such as annual exams, including breast exams, STD screenings, and contraception. Family planning services offered through providers like Planned Parenthood and other providers help prevent unintended births and help all Californians obtain access to critical care in their geographic region. Provider rates for Family PACT and other fee-for-service reproductive services had been frozen for years prior to the 10 percent rate cut, compounding the impact of the 10 percent provider rate cut.

In recent years, Planned Parenthood has come increasingly under attack. After the illegally-taped videos surfaced in the summer of 2015, Planned Parenthood's health centers and providers experienced a nine-fold increase in attempted violence. Planned Parenthood has spent more than $9 million in California alone to improve security so its patients, providers and staff can access care safely; defend itself in investigations; recruit and retain staff frightened by the attacks; and repair vandalized health centers.

Planned Parenthood also has spent substantial resources fending off repeated attempts by Congress to strip it of all federal reimbursement for the services it provides. If those attempts succeeded, more than 850,000 Californians would lose their ability to choose Planned Parenthood as their health care provider, which for many, is their only option.

Advocates point out further that the costs of providing services have continued to climb while reimbursement rates have stayed flat and, in some cases, decreased. Family planning costs per visit have risen 40 percent since 2008, the last time rates were increased. Family planning visit fees are now less than half the costs of providing these services. As a result**,** Planned Parenthood lost more than $60.5 million in providing family planning visits last year. Similarly, the Medi-Cal reimbursement rates for surgical abortion do not cover the costs of providing that service. Annually, Planned Parenthood loses at least $4 million for providing that service to its low-income patients.

The California Medical Association (CMA) also supports this proposal, which is a component of their overall Proposition 56 spending proposal. CMA states that they have long recognized the need to increase rates for these particular services in order to ensure access to them, particularly at this time.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Planned Parenthood to present this proposal.

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

ISSUE 26: STAKEHOLDER PROPOSAL - AGED & DISABLED POPULATION ELIGIBILITY

PANELISTS

- **Linda Nguy**, Policy Advocate, Western Center on Law & Poverty
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department Of Health Care Services
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Western Center on Law and Poverty, Disability Rights California, Congress of California Seniors, and at least 28 organizations request increasing the Medi-Cal Aged and Disabled Program income level to 138 percent of the Federal Poverty Level (FPL), at a cost of $30 million General Fund.

BACKGROUND

The Medi-Cal Aged and Disabled (A&D) program is a critical part of the Medi-Cal program that provides free, comprehensive coverage to persons over the age of 65 and those with disabilities. The A&D program was implemented in 2001, with an income eligibility standard of 100% FPL plus income disregards of $230 and $310 for individuals and couples, respectively. When the program was established, the income standard was equivalent to 133% FPL, the same level as many other people enrolled in Medi-Cal. However, the disregards lose real value every year, with the resulting income standard today at 123% FPL. When a senior has even a small increase in their income that puts them over 123% FPL, they are forced into the Medi-Cal Medically Needy program with a high share of cost.

A share of cost is the difference between a beneficiary's countable income and the Maintenance Need Income Level (MNIL). The MNIL is a fixed monthly amount that is supposed to be sufficient to cover basic living expenses, such as rent, food, and utilities. The MNIL in California is $600 for an individual and was established in 1989; it has not changed since then. Anything an individual earns over $600 in a month becomes that individual's share of cost. So for example, a 67 year old beneficiary with a monthly income of $1,250 would have to pay $650 for his or her health care before Medi-Cal begins paying for services.

In 2014 California expanded and streamlined Medi-Cal eligibility raising the income threshold to 138% FPL for most adults. Yet, seniors remain in the A&D Program and will continue to be held to the 123% income threshold. WCLP explains that while millions of Californians are now able to qualify for free Medi-Cal services because the income threshold was raised, it is inequitable to require a person to pay hundreds of dollars

monthly simply due to their age. The anticipated fiscal cost would be $30 million General Fund.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Western Center on Law and Poverty to present this proposal.

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