Call to Order.................................................................Stacey Cryer
Welcome & Introductions..................................................All
Approval of Agenda..........................................................All
Approval of Minutes ..........................................................All
Discussion of:
  • MCO Tax
  • CCS
  • 2016 Legislation: Proposed Positions
Minutes of the Meeting of the
Committee on Legislation
Wednesday July 15 2015
9:30 – 10:30 am

PRESENT: Stacey Cryer, Dick Fogg, and Rita Scardaci

ABSENT: Nancy Starck and Donnell Ewert

PHC STAFF: Robb Layne, Liz Gibboney, Patti McFarland, Amy Turnipseed, Dr. Moore and Kenzie Poncy

Welcome & Introductions
Stacey Cryer convened the meeting at 9:30 am. Ms. Cryer advised the group that the content of the meeting would include updates on topics of interest and discussion of local legislative issues.

Approval of Agenda
There were no additions or modifications to the agenda. A motion was made by Dick Fogg to approve the agenda, and seconded by Rita Scardaci.

Approval of Minutes
The minutes of the meeting on Legislation from June 3, 2015 were approved as presented to the committee. A motion was made by Mr. Fogg to approve the agenda, and seconded by Ms. Scardaci.

UPDATE – Topics of Interest

• Item 1. MCO Tax – Liz Gibboney led the discussion on the MCO Tax. She explained that the MCO Tax is an open issue in the legislature, currently CMS has concerns as to how the tax is operationalized in California. The legislature is required to propose and have approved by CMS, alternative options for the tax by the end of calendar year 2016. In its current state the MCO Tax does not have a direct fiscal impact on PHC but, could pose a threat when new alternatives are proposed if the state so chooses to back fill the tax with cuts from health plans statewide. Currently, it does not seem like the MCO Tax discussion will be a topic of the 2015 special session, we will watch for legislation in the 2016 session.

• Item 2. PPS Reform – Robb Layne led the discussion on PPS Reform. He gave an update on SB 147, this bill would have a large impact on Federally Qualified Health Centers (FQHCs). They make up a large majority of our provider network
and SB 147 would allow clinics to have their wrap around payment paid by the health plan in one check. Mr. Layne highlighted the following main concerns for clinic qualification to participate in the PPS wrap around payment.

- **Main Concern #1** - number of enrollees at each clinic site
- **Main Concern #2**
  - FQHC is in good standing with the plan
  - FQHC must not have any outstanding CAPs with PHC
  - FQHC most recent external audit must not have any large concern findings
  - FQHC must be financially secure

Mr. Layne proposed to the group that PHC sponsor SB 147 if the following conditions were met: number of enrollees' requirement be removed from the bill, alternative touches to be considered when determining network adequacy. A motion to approve sponsorship as presented was approved by Ms. Scardaci and seconded by Ms. Cryer.

- **Item 3. Special Session** – Mr. Layne led the discussion on the legislative special session. He discussed large policy concerns: timing of MCO tax and tobacco cessation.

- **Item 4. Knox Keene Legislation** – Mr. Layne led the discussion on Knox Keene Legislation. He advised the group that SB 260 would impose that COHS plans be Knox Keene Licensed through Department of Managed Health Care (DMHC) in addition to our standing contract and audits with Department of Health Care Services (DHCS). This bill would have a huge administrative financial impact on PHC with little to no value added for our members.

Mr. Layne advised the Committee that he, along with other COHS plans are building a monetary case against SB 260 to ensure that the bill is heard in Appropriations Committee so that the cost to the health plans can be recognized.

**Discussion of:**

- **Item 1. Local Legislative Issues** – Ms. Gibboney opened the discussion to allow conversation around local legislative issues. The following topics were discussed:
  - **CCS**: Amy Turnipseed advised the committee that the transition of CCS services to managed care will begin in January 2017. PHC will work closely with CCS counties whom are currently carved out to ensure realignment of work when all CCS counties become carved in beginning 2017.
  - **CPCA Bill Support**: CPCA is requesting that PHC support SB 610 which would require the department to approve rates in 90 days. At the current time PHC will not support SB 610 but will continue to watch the bill.
  - **Committee on Legislation Meetings**: Mr. Layne suggested to the group that for the 2016 Legislative Session, the Committee on Legislation meetings be aligned with key legislative dates ensuring timely recommendations and positions. The Committee agreed to date realignment.
Additional Committee on Legislation Members: Ms. Gibboney led the discussion on additional Committee on Legislation Members. Ms. Gibboney expressed to the group that additional committee members will create richer conversation and new perspectives. It was approved by the Committee to appoint additional members, not limited to PHC Commission members.

The next Committee on Legislation meeting to be announced.

**Adjournment**
The meeting adjourned at 10:30 am.
Committee on Legislation
Legislative Categorization Definitions

- **MANDATE**: A mandatory requirement under the direction of statute, regulation, or public agency as outlined in legislation

- **BENEFIT DESIGN**: The way health benefits are structured and utilized for our members

- **MENTAL HEALTH**: Provides additional benefits/parameters to guide the health plan’s ability to provide and pay for our member’s mental health services

- **PRESCRIPTION DRUGS/FORMULARIES**: Alters the capacity in which we provide, pay for, or deliver medication to our members

- **HEALTH PLAN REGULATIONS**: Affects health plan operations – reporting, delivery of benefits, health plan oversight, etc.

- **PROVIDER NETWORKS**: Directly affects our member’s ability to access to care by expanding or redefining the health plan’s provider network

- **SPOT BILL**: Placeholder bill whose contents will be replaced with meaningful provisions at a later time
LEGISLATIVE CATEGORY:
MANDATES
AB 1696 (Holden) Medi-Cal: tobacco cessation services

Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law provides for a schedule of benefits under the Medi-Cal program. Existing law requires that preventive services assigned a grade of A or B by the United States Preventive Services Task Force be provided to Medi-Cal beneficiaries without any cost sharing by the beneficiary in order for the state to receive increased federal contributions for those services, as specified.

This bill would provide that, only to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained, tobacco cessation services are covered benefits, subject to utilization controls, under the Medi-Cal program and would require those services to include all intervention recommendations, as periodically updated, assigned a grade A or B by the United States Preventive Services Task Force, and, at a minimum, 4 quit attempts per year. The bill would also require, only to the extent consistent with the recommendations of the United States Preventive Services Task Force, tobacco cessation services to include at least 4 counseling sessions per quit attempt and a 12-week treatment regimen of any medication approved by the federal Food and Drug Administration for tobacco cessation.

The bill would require the department to issue guidelines and enter into agreements to allow a specified state smoker’s helpline to furnish nicotine replacement therapy to beneficiaries participating in the helpline’s smoking cessation services, and would require the department to issue other guidelines to beneficiaries and managed care programs in connection with the provision and evaluation of tobacco cessation services pursuant to the bill. The bill would require the department to seek any federal approvals necessary to implement those provisions.

Location as of 3/2016:
Appropriations Committee

PHC Position:
Support

Sponsor:
Author

Staffer:
Victor Munoz

Fact Sheet Available:
Yes
SUMMARY

AB 1696 requires tobacco cessation medications, counseling, and assessments to be covered for Medi-Cal patients. AB 1696 also prohibits certain barriers or restrictions that hinder patients from pursuing smoking cessation treatment.

BACKGROUND

The dangers of smoking are well documented by the Surgeon General who has concluded that smoking causes cancer, respiratory and heart diseases, and birth defects. Smoking continues to be the leading preventable cause of death in the United States. The total national economic cost of tobacco use is $289 billion annually, and the cost to California is $18.1 billion a year. A 2014 Surgeon General Report says that cigarettes are more addictive than ever.

Currently, 18% of the U.S. population smokes; however among the population enrolled in Medicaid, the rates are much higher. According to the Centers for Disease Control and Prevention (CDC), 30.1% of Medicaid enrollees are smokers. In California, 19.6% of Medi-Cal (California’s Medicaid program) members were smokers and $2.2 billion was spent on treating smoking attributable illnesses. This population faces significant barriers to cessation treatments because they have limited incomes and cannot always afford over the counter smoking cessation treatments. Also, long wait times for an appointment in the Medi-Cal system leads to smokers who want to quit waiting for prescriptions or counseling.

Quitting tobacco products is a difficult feat that many attempt every year but few accomplish. According to the CDC, in 2010, 69 percent of adults wanted to stop smoking, 52 percent tried and only six percent were successful. The low success rate is due to the fact that smokers often try to quit many times before they are successful and often try to quit without help. This is an ineffective way to quit for most people. According to the U.S. Public Health Service’s Clinical Practice Guideline update, the seven FDA approved tobacco cessation medications as well as counseling are very effective to get smokers to quit.

Access to these services is sometimes difficult for Medi-Cal recipients due to the many barriers to access including mandatory prior-authorization and step therapy. Prior-authorization is a requirement for written approval by physicians to prescribe medication, and limits on how long or how often a person can use smoking cessation treatments. Step therapy provisions require that a patient seek one type of treatment before moving on to another, even if that particular treatment is not effective for that particular patient. These barriers along with the inherent difficulty of quitting lead many to give up before they even get started. Currently, barriers and access to treatment varies across Medi-Cal plans.

Increasing access to smoking cessation treatments and removing barriers can ultimately lead to lower healthcare costs. Massachusetts witnessed a ten percent drop in the Medicaid patients that smoked after that state provided comprehensive smoking cessation treatments to their Medicaid members. Also, the Centers for Medicare & Medicaid Services stated that tobacco cessation treatments have a $2-3 return on every dollar spent. In the 18 months after a person quits smoking, they cost health insurers an average of $541 less per quarter than a smoker. In fact, expenditures for smoking cessation services can be offset by healthcare cost savings within three years.

The Affordable Care Act has made tobacco cessation treatments more accessible by including them in the Essential Health Benefits; these are benefits that must be included in all plans sold through Covered California and in Medi-Cal. However, tobacco cessation coverage varies between health plans because of the vague guidelines created by the federal government. This has led to confusion for health plans and while some plans provide comprehensive coverage and others’ coverage fail to meet federal guidelines.

There is hope, however, in the rate of smokers quitting tobacco. The Department of Public Health (CDPH) states that California has the second-lowest smoking rate in the nation, at 11.7% of the population. The California Tobacco Control Program, under CDPH, provides funding and assistance to the California Smokers’ Helpline. The Smokers’ Helpline has been used by 8.2% of smokers who made quit attempts in the past year. The Smokers’ Helpline offers free tips...
and counseling to smokers looking to quit or friends and relatives calling on behalf of a loved one. Telephone counseling for tobacco cessation has shown, in clinical trials, to almost double the rate of successful quitting.vii

EXISTING LAW

WIC 15814 (Applies only to the Medi-Cal Access Program, formerly the AIM program): The Department of Health Care Services shall develop protocols relating to health education for tobacco use which shall include tobacco cessation services, if appropriate.

WIC 14134(a)(9): All preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force shall be provided without any cost sharing in order for the state to receive an increased federal medical assistance percentage for these services.

The United States Preventative Services Task Force (USPSTF) recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.viii

THE SOLUTION

In order to comply with a directive from the Federal Government to states implementing Medicaid expansion, AB 1696 provides clarity to health care plans, providers and participants covered by Medi-Cal managed care and fee-for-service health plans about which tobacco cessation services are covered. It also requires that this population, which has an especially high smoking rate, has access to the federally recommended and scientifically proven standard for successful tobacco cessation treatment. The bill would require all plans to cover:

- Four quit attempts with no break required between attempts,
- All currently FDA approved medications, and
- Three types of counseling

AB 1696 also requires over-the-counter medications and at least one prescription medication to be available without prior-authorization and for other treatments to be available without step-therapy.

Finally, AB 1696 directs the Department of Health Care Services to partner with CDPH to issue guidelines to allow the California Smokers’ Helpline to provide tobacco cessation products to callers. This bill would also require the Department of Health Care Services to issue other guidelines for managed care providers to report tobacco use rates.

SUPPORT

Support: American Heart Association (Co-Sponsor)
American Cancer Society (Co-Sponsor)
American Lung Association (Sponsor)
California Black Health Network
California Optometric Association
County Health Executives Association
Health Access California
Health Officers Association of California

Opposition: California Association of Health Plans

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http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Tobacco.html


AB 1795 (Atkins) Health care programs: cancer

Existing law requires the State Department of Health Care Services to perform various health functions, including providing breast and cervical cancer screening and treatment for low-income individuals. Existing law defines “period of coverage” as beginning when an individual is made eligible for a covered condition and not to exceed 18 or 24 months, respectively, for a diagnosis of breast cancer or a diagnosis of cervical cancer.

This bill would delete that definition and, instead, provide that the treatment services be for the duration of the period of treatment for an individual made eligible for treatment due to a diagnosis of breast cancer or cervical cancer, or who is diagnosed with a reoccurrence of breast cancer or cervical cancer, as long as the individual continues to meet all other eligibility requirements. The bill would require the department to provide breast cancer screening and diagnostic services to individuals of any age who are symptomatic, as defined, and to individuals who are 40 years of age or older, who meet the other eligibility requirements.

Location as of 3/2016:
Appropriations Committee

PHC Position:
Support

Sponsor:
Susan G. Komen

Staffer:
Agnes Lee

Fact Sheet Available:
Yes
IN BRIEF

AB 1795 (1) provides that health care services under the Breast and Cervical Cancer Treatment Program (BCCTP) be covered for the duration of the treatment period after a diagnosis of breast cancer or cervical cancer, as long as the individual continues to meet all other eligibility requirements; and (2) expands eligibility for breast cancer screening under the Every Woman Counts (EWC) program to symptomatic women under age 40.

BACKGROUND

Existing law requires the State Department of Health Care Services to perform various health functions, including providing breast and cervical cancer screening and treatment for low-income individuals.

Existing law defines “period of coverage” as beginning when an individual is made eligible for a covered condition and not to exceed 18 or 24 months, respectively, for a diagnosis of breast cancer or a diagnosis of cervical cancer.

THE ISSUE

The Breast and Cervical Cancer Treatment Program (BCCTP) provides needed cancer treatment to low-income uninsured or underinsured individuals diagnosed with breast and/or cervical cancer. Currently, the state-funded BCCTP is not aligned with the federally-funded BCCTP, causing gaps in service and treatment for women diagnosed and treated through the state-funded program. Under the state BCCTP, treatment coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. It also includes a provision that denies coverage to a woman who is re-diagnosed with the same cancer in the same tissue. The state BCCTP will, however, cover a subsequent cancer diagnosis if the cancer appears in a different part of the body. The federal BCCTP, on the other hand, has no time limit of coverage and covers a re-diagnosis of cancer.

The Every Woman Counts (EWC) program provides cancer screening services to low-income uninsured or underinsured women. Currently, the EWC program provides breast cancer screening services only for women ages 40 years and older. Thus uninsured or underinsured women presenting breast cancer symptoms, who are under the age of 40, have to find care elsewhere. This makes it more difficult to receive proper diagnosis and treatment.

THE SOLUTION

AB 1795 will help ensure that women have timely access to the necessary services to detect and treat their cancers early. This bill allows low-income women in California who are uninsured or underinsured to receive complete treatment for breast and cervical cancer. It also ensures that women are not denied treatment if they are later re-diagnosed with the same cancer. Finally, it allows women under age 40 who are symptomatic for breast cancer to receive necessary screening services.
SUPPORT

Susan G. Komen (sponsor)
American Cancer Society Cancer Action Network
Black Women for Wellness
Brown Temple Christian Methodist Episcopal Church
CA Association for Nurse Practitioners
CA Health Collaborative
CA Nurses Association
Cambodian Family Community Center
Cancer Support Community Benjamin Center
Cancer Support Community San Francisco Bay Area
Central City Community Health Center
County Health Executives Association of CA
Health Access
Hope Wellness Center
Johnson Chapel African Methodist Episcopal Church
Junior Leagues of CA
North Orange County Regional Health Foundation
Planned Parenthood Orange and San Bernardino Counties
Sacramento Community Cancer Coalition
Samoan National Nurses Association
Serve the People Community Health Center
Shanti
St. Mary Medical Center Foundation
Numerous Individuals

OPPOSITION

None

FOR MORE INFORMATION

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March 9, 2016
AB 2207 (Wood) Medi-Cal: dental program

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that certain optional benefits, including, among others, certain adult dental services, are excluded from coverage under the Medi-Cal program. Existing law, beginning May 1, 2014, or the effective date of any necessary federal approvals, whichever is later, provides that only specified adult dental services are a covered Medi-Cal benefit for persons 21 years of age or older.

This bill would require the department to undertake specified activities for the purpose of improving the Medi-Cal Dental Program, such as expediting provider enrollment and monitoring dental service access and utilization. The bill would require a Medi-Cal managed care health plan to provide dental health screenings for eligible beneficiaries and refer them to appropriate Medi-Cal dental providers. This bill would provide that those provisions shall only be implemented to the extent that the department obtains necessary federal approvals, federal matching funds, and an appropriation in the annual Budget Act for the specific purpose of implementing those provisions.

Existing law requires the department to establish a list of performance measures to ensure the dental fee-for-service program meets quality and access criteria required by the department. Existing law requires the department to annually post on October 1 the list of performance measures and data of the dental fee-for-service program for the previous calendar year on its Internet Web site. Existing law also requires the department to establish a list of performance measures to ensure dental health plans meet quality criteria required by the department. Existing law requires the department to post, on a quarterly basis, the list of performance measures and each plan’s performance on the department’s Internet Web site.

This bill, as of October 31, 2016, would eliminate the requirement that the department annually post the performance measures and program data relating to the dental fee-for-service program for the previous calendar year on October 1 and instead would require the department, commencing January 31, 2017, to post that information for the previous fiscal year on its Internet Web site on or before January 31 of each year. The bill, commencing April 30, 2017, and on specified dates thereafter, would require the department to post dental fee-for-service program performance data, the dental health plan performance measures, and each dental health plan’s performance on a quarterly basis for the preceding fiscal quarter on its Internet Web site. The bill would require the department to ensure, to the greatest degree possible, that the categories of data and performance measures selected for the dental fee-for-service program and for dental health plans are consistent with one another.

Location as of 3/2016: Assembly Health

PHC Position: Support

Sponsor: Staffer:
Tony Bui

Fact Sheet Available: Requested
SB 1361 (Nielsen) Medi-Cal: eyeglasses

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for a schedule of benefits under the Medi-Cal program, which includes eyeglasses, subject to utilization controls. Existing law provides, except as specified, that certain optional Medi-Cal benefits, including, among others, optometric and optician services, are excluded from coverage under the Medi-Cal program.

This bill, to the extent any necessary federal approvals are obtained, would restore coverage of one pair of eyeglasses provided every 2 years to an individual 21 years of age or older who is unable to meet or exceed the driver’s license vision standards established by the Department of Motor Vehicles. The bill would authorize the department to implement those provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions.

Location as of 3/2016:
Senate Health

PHC Position:
Support

Sponsor:
Author

Staffer:
Nghia Nguyen

Fact Sheet Available:
Yes
LEGISLATIVE CATEGORY:

BENEFIT DESIGN
Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income and share of cost requirements. Existing law prohibits medically needy persons or medically needy family persons from receiving health care services during any month in which their share of cost has not been met.

Existing law, for purposes of determining the share of cost for those medically needy persons or medically needy family persons, requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy individual to meet his or her basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy individual who is in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes, among other things, an amount providing for the personal and incidental needs in an amount not less than $35 while a patient, and authorizes the department, by regulation, to increase this amount as necessitated by increasing costs of personal incidental needs. This amount is also referred to as the personal needs allowance.

This bill would increase the personal needs allowance amount from $35 to $80 per month while a person is a patient as described above, and instead would require the department to annually increase this amount based on the percentage increase in the California Consumer Price Index. Because counties are required to make Medi-Cal eligibility determinations, and this bill would expand eligibility by increasing the personal needs allowance and would increase the responsibility of counties in determining Medi-Cal eligibility, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.
AB 1655 would increase the Personal Needs Allowance for Medi-Cal eligible individuals living in an institutionalized setting from $35 to $80 per month and annually adjust the personal needs allowance by the same percentage as the consumer price index.

The Personal Needs Allowance (PNA) is what a Medi-Cal eligible institutionalized individual is permitted to keep from his or her own monthly income. The remainder of the resident’s income goes to the nursing facility for their share of cost and reduces the amount the state agency pays the nursing home. California’s payment to the nursing home facility is matched by the federal government at the Federal Medical Assistance Percentages (FMAP) rate of 50%.

A nursing home resident’s income must be used to meet their share of cost for medical care, or Medi-Cal will pay for no services during that month. Eligible residents are allowed to keep only $35 for all personal needs they may have in a given month.

California’s PNA was last set in 1984, and residents in nursing facilities have not received a cost-of-living increase since then, despite the rate of inflation.

The Medi-Cal resident receives basic room and board plus medical care from the skilled nursing home. The PNA is crucial to enhancing the quality of life of residents in nursing homes by covering the costs of haircuts, clothes, shoes, personal care items, reading materials, postage and meals outside the facility. The current PNA does not adequately fund the cost of these needs.

For purposes of determining the share of cost for those medically needy persons or medically needy family persons, current law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy individual to meet his or her basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law.

In calculating the income of a medically needy individual who is in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes, among other things, an amount providing for the personal and incidental needs in an amount not less than $35 while a patient.

Existing law authorizes the department, by regulation, to increase this amount as necessitated by increasing costs of personal incidental needs.
This Bill

This bill would:
- Increase the Medi-Cal personal needs allowance from $35 to $80 per month and;
- Adjust it annually by the same percentage as the consumer price index

Support

California Senior Legislature (Sponsor)
UDW/AFSCME Local 3930
California Dialysis Council
Justice in Aging
California Long-Term Care Ombudsman Assoc.
California Advocates for Nursing Home Reform
Mountain Bears Democratic Club
San Bernardino Board of Supervisors

Opposition

None Received

Contact

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AB 2394 (Garcia, Eduardo) Medi-Cal: nonmedical transportation

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for a schedule of benefits under the Medi-Cal program, which includes medical transportation services, subject to utilization controls.

This bill would add to the schedule of benefits nonmedical transportation, as defined, subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services. The bill would specify that these provisions shall not be interpreted to add a new benefit to the Medi-Cal program. The bill would require the department to adopt regulations by July 1, 2018. Commencing July 1, 2017, the bill would require the department to provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

Location as of 3/2016:
Assembly Health

PHC Position:
Watch

Sponsor:
Author

Staffer:
Mark Rossow

Fact Sheet Available:
Yes
SUMMARY
AB 2394 would ensure low-income beneficiaries in rural areas have access to medical care by:

- Clarifying that accessible NMT service is a Medi-Cal benefit, including roundtrip transportation for covered Medi-Cal services.

BACKGROUND
Many Medi-Cal beneficiaries report difficulty accessing health care providers, specifically specialists, due to lack of adequate transportation. Some families report having to drive over 4 hours, for a one-way trip to see a provider. This issue is exacerbated by the mandatory transition into Medi-Cal managed care. There are approximately 434,000 Medi-Cal beneficiaries in 28 rural counties that have been transitioned to managed care.

Under California’s State Medicaid Plan, transportation of eligible recipients to and from health care services is assured through a variety of methods.

Medi-Cal regulations define covered medical transportation or nonemergency medical transportation as ambulance, litter van, and wheelchair van services, which are to be provided “when the beneficiary’s medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care.”

Nonmedical Transportation (NMT), defined by the Department of Healthcare Services (DHCS) as transportation of members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers, is only provided directly as a Medi-Cal benefit for children and Cal MediConnect (CMC) beneficiaries.

Unfortunately, for all other adults, questions remain regarding the basic availability of transportation as a covered plan benefit and the criteria for getting such benefits. Although most Medi-Cal plans state that they provide some help with transportation, beneficiaries report difficulty accessing transportation assistance due to wide variances in policies and procedures.

SUPPORT
Western Center on Law and Poverty

FOR MORE INFORMATION
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SB 960 (Hernandez) Medi-cal: telehealth: reproductive health care

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, as specified. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides that, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for “teleophthalmology, teledermatology and teledentistry by store and forward,” as defined to mean the asynchronous transmission of medical information to be reviewed at a later time by a licensed physician or optometrist, as specified, at a distant site.

This bill would enact similar provisions relating to the use of reproductive health care under the Medi-Cal program. The bill would provide that, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for “reproductive health care provided by store and forward.” The bill would define that term to mean an asynchronous transmission of medical information to be reviewed at a later time by a physician, nurse practitioner, certified nurse midwife, licensed midwife, physician assistant, or registered nurse at a distant site, where the provider at the distant site reviews the dental information without the patient being present in real time, as defined and as specified.

This bill would also provide that, to the extent federal financial participation is available and any necessary federal approvals are obtained, telephonic and electronic patient management services, as defined, provided by a physician or nonphysician health care provider acting within his or her scope of licensure shall be a benefit under the Medi-Cal program in fee-for-service and managed care delivery systems, as specified. The bill would authorize the department to seek approval of any state plan amendments necessary to implement these provisions.

Location as of 3/2016:
Senate Health

PHC Position:
Support

Sponsor:
Author

Staffer:
Melanie Moreno

Fact Sheet Available:
Requested
SB 997 (Lara) Health care coverage

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law extends eligibility for full-scope Medi-Cal benefits to individuals under 19 years of age who do not have, or are unable to establish, satisfactory immigration status, commencing after the Director of Health Care Services determines that systems have been programmed for implementation of this extension, but in no case sooner than May 1, 2016.

Existing law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the director makes the above-described determination to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, as specified. Existing law requires an individual who is eligible pursuant to these provisions to enroll in a Medi-Cal managed care health plan, where available, but does not preclude a beneficiary from being enrolled in any other children’s Medi-Cal specialty program that he or she would otherwise be eligible for.

This bill, until January 1, 2019, authorizes the enrollment of eligible children who, as of May 1, 2016, were enrolled in comprehensive, low-cost coverage provided by a health care service plan with a total enrollment in excess of five million lives, in full-scope Medi-Cal with the same health care service plan, notwithstanding any other law or existing Medi-Cal managed care contract. The bill would prohibit the child from being enrolled in fee-for-service Medi-Cal or another Medi-Cal managed care plan unless a responsible adult seeks enrollment in fee-for-service Medi-Cal or another Medi-Cal managed care plan after the child obtains full-scope Medi-Cal benefits. The bill would require the department to provide notice to the family before the child’s transition to full-scope Medi-Cal, as specified.

Location as of 3/2016:
Senate Health

PHC Position:
Watch

Sponsor:
Health Access California

Staffer:
Lawrence Cooper

Fact Sheet Available:
Yes
Summary:
Senate Bill 997 will ensure a seamless transition to full-scope Medi-Cal coverage for eligible children who were already enrolled in a comprehensive, low-cost health plan prior to the enactment of SB 4.

The intent of this legislation is to ensure continuity of coverage and limit disruption of services as those children transition to full Medi-Cal coverage.

Background:
Last year’s historic enactment of SB 4 (Lara) Health4All Kids, allows all low-income California children, regardless of immigration status, to enroll in Medi-Cal. Starting in May, all income-eligible children will have access to comprehensive, zero-cost or low-cost Medi-Cal benefits, including dental and mental health coverage as well as the full array of health benefits (doctors, hospitals, prescription drugs, and more).

Currently, over 120,000 undocumented children are enrolled in restricted scope, emergency-only Medi-Cal and an additional 70,000 undocumented children have comprehensive health coverage through Kaiser Permanente. That coverage was provided well before the passage of SB 4, when families with undocumented children had very limited options for health care.

The children on restricted scope Medi-Cal will be automatically shifted to full-scope Medi-Cal when Health4All Kids is implemented in May 2016. Families will have an option to select a health plan, or transition directly into a default coverage option.

Under current rules, the children enrolled in Kaiser coverage will have to reapply for Medi-Cal eligibility.

Problem:
Requiring children to reapply for coverage can cause unnecessary disruptions, limit access to care, and may even result in children losing coverage.

It is in the best interest of patients and their families to minimize these challenges and make the process as streamlined as possible, especially for vulnerable populations.

Solution:
SB 997 creates a limited exception to Medi-Cal enrollment rules to allow the undocumented children covered by Kaiser to maintain their Kaiser coverage, if they choose to do so.

Like any other enrollee, those children will also have the option to change their coverage plan once they are enrolled.

Staff Contact: Lawrence Cooper, 651-4033 lawrence.cooper@sen.ca.gov

Sponsor: Health Access California Beth Capell (916) 497-0923
LEGISLATIVE CATEGORY:
MENTAL HEALTH
AB 847 (Mullin) Mental Health: community based services

Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The act provides that it may be amended by the Legislature by a 2/3 vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law provides for a schedule of benefits under the Medi-Cal program and provides for specified services, including various mental health services. Existing federal law, the Protecting Access to Medicare Act of 2014, requires the United States Secretary of Health and Human Services to, among other things, select, no later than September 1, 2017, select from among those states awarded a planning grant, the states that may participate in a time-limited demonstration program that is designed to improve access to community mental health and substance use treatment services provided by certified community behavioral health clinics.

This bill would require the department to develop and submit a proposal to the United States Secretary of Health and Human Services to be selected as a participating state in the time-limited demonstration program described above to receive enhanced federal matching funds for mental health services provided by certified community behavioral health clinics to Medi-Cal beneficiaries. The bill would appropriate $1,000,000 from the Mental Health Services Act Fund to the State Department of Health Care Services to develop that proposal. The bill would make findings and declarations of the Legislature, including that the changes the bill would make are consistent with and further the intent of the act.

This bill would declare that it is to take effect immediately as an urgency statute.

Location as of 3/2016: Governor's Desk
Fact Sheet Available: Yes

PHC Position: Support

Sponsor: Author

Staffer: Hugh Bower
AB 847: Accessing Federal Mental Health Grants
By Assemblymembers Kevin Mullin and Sebastian Ridley-Thomas

PURPOSE
AB 847 directs the State Department of Health Care Services (DHCS) to develop a proposal to compete to become a designated state to receive significantly enhanced federal mental health funds under the Excellence in Mental Health Act - enacted as Section 223 of the Protecting Access to Medicare Act of 2014.

SUMMARY
Federal law would enable successful states to nearly double federal funds to support community mental health and alcohol and drug services with no additional state or county cost. Estimates are that the benefit to the state could be in the range of $1 billion. The law currently allowed for eight states to be selected for two years to have the federal share of costs increased for outpatient mental health and alcohol and drug services increased from the current level of 50% to at least 65%. This would mostly affect people who are disabled due to a severe mental illness.

California is one of 24 states that received a $1 million grant to compete to become one of the designated states to receive the enhanced funding starting in January 2017, with proposals due in October 2016.

California’s planning grant proposal request was for $2 million, but only received $1 million. DHCS asserts it cannot complete the application process without the full $2 million.

DHCS has indicated it will return the $1 million federal grant unless it receives full $2 million funding.

CURRENT LAW
Existing law establishes the State Department of Health Care Services and prescribes the department’s powers and duties, including with respect to mental health services. Existing federal law, the Protecting Access to Medicare Act of 2014, establishes criteria for the certification of federally qualified community behavioral health centers, and requires the administrator of the federal Substance Abuse and Mental Health Service Administration to certify centers that meet those criteria. The act also authorizes the Secretary of Health and Human Services to award matching grants to states to expend funds for the construction or modernization of facilities used to provide community-based mental health and substance abuse services. The grants must be awarded no later than January 1, 2016.

THIS BILL
This bill would require DHCS to develop and submit a proposal to the United States Secretary of Health and Human Services to be selected as a participating state in the time-limited demonstration program described above to receive enhanced federal matching funds for mental health services provided by certified community behavioral health clinics to Medi-Cal beneficiaries. The bill would appropriate $1,000,000 from the Mental Health Services Act Fund to the State Department of Health Care Services to develop that proposal (Proposition 63). The additional $1 million would bring the total to $2 million, which DHCS indicates is necessary to complete the application.
SUPPORT

- Steinberg Institute
- Mental Health America of California
- California Council of Community Mental Health Agencies
- Disability Rights California
- American Association for Marriage and Family Therapy – California Division
- California Youth Empowerment Network
- California Coalition for Mental Health
- American College of Emergency Physician’s – California Chapter

STAFF CONTACT

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Assembly Speaker pro Tempore Kevin Mullin
SB 1291 (Beall) Medi-Cal: specialty mental health: children and youth

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including specialty mental health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Under existing law, specialty mental health services are provided by mental health plans and the department is responsible for conducting investigations and audits of claims and reimbursements for expenditures for specialty mental health services provided by mental health plans to Medi-Cal eligible individuals.

This bill would require each mental health plan, annually on or before July 1 of each year, to submit a foster care mental health service plan to the department detailing the service array, from prevention to crisis services, available to Medi-Cal eligible children and youth under the jurisdiction of the juvenile court and their families. The bill would require annual mental health plan reviews to be conducted by an external quality review organization (EQRO) and to include specific data for Medi-Cal eligible children and youth under the jurisdiction of the juvenile court and their families, including the number of Medi-Cal eligible children and youth under the jurisdiction of the juvenile court served each year.

This bill would require the department to review the plans and the EQRO reviews and post them on its Internet Web site. The bill would also require the department to notify the mental health plan of any deficiencies and would require the mental health plan to provide a written corrective action plan to the department. The bill would also authorize the director, if he or she believes that a mental health plan is substantially failing to comply with any provision pertaining to the administration of specified benefits for children and youth under the jurisdiction of the juvenile court, to take specified action, including bringing an action for injunctive relief or imposing certain sanctions.

Location as of 3/2016:
Senate Health

PHC Position:
Watch

Sponsor:
Author

Staffer:
Sunshine Borelli

Fact Sheet Available:
Requested
LEGAL CATEGORY:

PRESCRIPTION DRUGS/FORMULARIES
AB 73 (Waldron) Patient Access to Prescribed Antiretroviral Drugs for HIV/AIDS Treatment Act

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law specifies the benefits provided pursuant to the program, including the purchase of prescribed drugs that are covered subject to utilization controls. Utilization controls include a requirement that the treatment provider obtain prior authorization for providing medical treatment, as specified.

This bill would, bill, to the extent permitted by federal law, and would provide that drugs in specified therapeutic drug classes that are prescribed by a Medi-Cal beneficiary’s treating provider are covered Medi-Cal benefits. The bill would require, except as specified, that a Medi-Cal managed care plan cover the drug if the treating provider demonstrates that the drug is medically necessary, not on the Medi-Cal managed care plan formulary, and consistent with federal rules and regulations for labeling and use, under which circumstances if medically necessary antiretroviral drugs used in the treatment of HIV/AIDS is prescribed by a Medi-Cal beneficiary’s treating provider for that purpose, and coverage for that prescribed drug is denied by a Medi-Cal managed care plan in which the beneficiary is enrolled, that denial shall be reviewed in accordance with the bill. This bill would provide that if the treating provider demonstrates, consistent with federal law, that in his or her reasonable, professional judgment, the drug is medically necessary and consistent with the federal Food and Drug Administration’s labeling and use rules and regulations, as specified, the beneficiary would be entitled to an automatic urgent appeal, as defined.

Location as of 3/2016:
Senate Health

PHC Position:
Watch

Sponsor:
Author

Staffer:
Andrea Gutierrez

Fact Sheet Available:
Requested
AB 2084 (Wood) Medi-Cal: comprehensive medication management

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for a schedule of benefits under the Medi-Cal program, which includes outpatient prescription drugs, subject to utilization controls and the Medi-Cal list of contract drugs.

This bill would provide that comprehensive medication management (CMM) services, as defined, are a covered benefit under the Medi-Cal program, and would require those services to include, among other things, the development and implementation of a written medication treatment plan that is designed to resolve documented medication therapy problems and to prevent future medication therapy problems. The bill would require the department to evaluate the effectiveness of CMM on quality of care, patient outcomes, and total program costs, as specified.

Location as of 3/2016:
Assembly Health

PHC Position:
Watch

Sponsor:
California Pharmacists Association

Staffer:
Tony Bui

Fact Sheet Available:
Requested
AB 2810 (Eggman, Wolk) Aid-in-dying prescription drugs: coverage for Medi-Cal beneficiaries.

Under the End of Life Option Act, an adult who meets certain qualifications and who has been determined by his or her attending physician to be suffering from a terminal disease, as defined, is authorized to make a request for a drug prescribed pursuant to these provisions for the purpose of ending his or her life. The act is repealed on January 1, 2026.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which qualified low-income persons receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for a schedule of benefits under the Medi-Cal program, which includes prescription drugs, as specified.

Existing federal law prohibits the expenditure of funds appropriated by Congress for the provision of health care services under the Medicaid Program from being used (1) to provide or pay for any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, as specified; or (2) to pay for health benefit coverage that includes any coverage of the item or service or of any expenses relating to the item or service.

This bill would declare the intent of the Legislature to enact legislation relating to health care coverage and payment for aid-in-dying prescription drugs. It would add to the schedule of benefits under the Medi-Cal program coverage for aid-in-dying drugs, as defined. The bill would require coverage for an aid-in-dying drug prescription to be provided to a Medi-Cal beneficiary who meets the qualifications of the End of Life Option Act and who requests a prescription in accordance with that act, and would require the cost for those services to be provided with state-only funds. The bill would authorize the department to implement, interpret, or make specific its provisions by all-county letters or similar instructions, without taking regulatory action, until the time regulations are adopted, as specified. The bill’s provisions would be repealed on January 1, 2026.

Location as of 3/2016:
Assembly Floor

PHC Position:
Watch

Sponsor:
Author

Staffer:
Gustavo Medina

Fact Sheet Available:
Requested
SB 1335 (Mitchell) Medi-Cal benefits: federally qualified health centers and rural health centers: drug Medi-Cal and specialty mental health services

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits, including specialty mental health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal), under which the department is authorized to enter into contracts with each county for various alcohol and drug treatment services, including substance use disorder services, narcotic treatment program services, naltrexone services, and outpatient drug-free services, to Medi-Cal beneficiaries. Specialty mental health services and Drug Medi-Cal Services and provided pursuant to waivers from the federal Centers for Medicare and Medicaid Services.

Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. Existing law authorizes FQHCs and RHCs to elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services and requires those costs to be adjusted out of the FQHC’s or RHC’s clinic base rate as scope-of-service changes.

This bill would authorize FQHCs and RHCs to elect to have Drug Medi-Cal and specialty mental health services reimbursed on a fee-for-service basis, according to the same criteria as applied to pharmacy and dental services.

Location as of 3/2016:
Senate Health

PHC Position:
Support

Sponsor:
California Primary Care Association

Staffer:
Myri Valdez

Fact Sheet Available:
Yes
SB 1335 will help community clinics more easily provide substance use disorder treatment and medically necessary specialty mental health services to our most vulnerable communities by allowing federally qualified health centers (FQHCs) and rural health clinics (RHCs) to elect reimbursement on a fee-for-service (FFS) basis instead of the prospective payment system (PPS) basis, thereby expanding the services offered and provider types available at FQHCs and RHCs.

**BACKGROUND**

Health centers are paid through an all-inclusive bundled rate called PPS. Current law permits FQHCs and RHCs to carve out of their PPS rates pharmacy and dental services, providing these services at FFS rates instead. SB 1335 would add DMC and MHP services to the elective carve-out.

**What is Drug Medi-Cal?**

The DMC Treatment Program provides medically necessary substance use disorder treatment services. Last year, the federal Centers for Medicare and Medicaid Services (CMS) approved California’s Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver amendment, which provides a continuum of care for substance use disorder treatment services. The DMC-ODS Waiver allows for local control of the DMC provider network and administration, and greatly expands DMC services.

**What are Specialty Mental Health Services?**

DHCS distinguishes between specialty mental health care (defined in the state’s 1915b Mental Health Services Consolidation Waiver) and general mental health care needs (those needs which could be met by a general health care practitioner). Specialty mental health care is under the purview of county MHPs, which contract with DHCS to provide medically necessary specialty mental health services. MHPs select and credential provider networks, negotiate rates, authorize services and pay for services rendered by specialty mental health providers. General mental health care remains under DHCS purview through managed care or fee for service Medi-Cal (MC/FFS).

**Current Payment for Behavioral Health Services**

All FQHCs provide behavioral health services, either directly or through contract. Most FQHCs provide behavioral health services by building the service costs into their PPS rates. A patient can come in for a medical visit or a behavioral health visit, and as long as the rules for PPS
reimbursement are followed, the FQHC will receive the same PPS reimbursement no matter which type of service is provided.

**ISSUE**

Under the Medi-Cal expansion and new DMC-ODS waiver, FQHCs are critically needed in the behavioral health continuum of care, but find it difficult to contract with counties, even when the counties want to contract with health centers.

This contracting is important to better integrate FQHCs into the county specialty mental health plan or Drug Medi-Cal System.

Such contracting also allows FQHCs to provide different types of services with different types of providers (i.e. peer support specialists; group counseling; drug abuse counselors) which may be more limited under the FQHC PPS system.

It’s important to note that the FQHC does not receive its PPS rate when they separately contract with DMC or county MHP. They receive a normal contracted rate like any other provider.

Under the change proposed by this bill, legal certainty would clarify that FQHCs and RHCs can provide these important behavioral health services outside of the PPS rate.

**SOLUTION**

SB 1335 will add the Drug Medi-Cal Program (DMC) and county specialty mental health plan (MHP) services to the types of services for which federally qualified health centers (FQHCs) and rural health clinics (RHCs) may elect reimbursement on a fee-for-service (FFS) basis instead of the prospective payment system (PPS) basis.

**SUPPORT**

- California Primary Care Association (sponsor)
- Community Clinic Association of Los Angeles County (CCALAC)

**OPPOSITION**

None on file

**STATUS OF BILL**

Introduced

**FOR MORE INFORMATION CONTACT**

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LEGISLATIVE CATEGORY:
HEALTH PLAN REGULATIONS
Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care health plans, including through a county organized health system and geographic managed care.

This bill would require the State Department of Health Care Services to annually administer the Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan surveys, which are developed by the federal Agency for Healthcare Research and Quality, for all Medi-Cal managed care plan populations, and would require the CAHPS survey to be administered for all Medi-Cal managed care plan models, including county organized health systems and geographic managed care. The bill would require the department to translate the CAHPS survey in all Medi-Cal threshold languages, and administer the CAHPS survey in each county in all Medi-Cal threshold languages in that county. The bill would require the department to stratify the results of the CAHPS surveys by specified factors, including geographic region and primary language, as specified. The bill would require the department to annually prepare and make publicly available a report on the results of the CAHPS surveys on the department’s Internet Web site, and would require the report to include specified information.

Location as of 3/2016:
Assembly Health

PHC Position:
Watch

Sponsor:
California Pan-Ethnic Health Network

Staffer:
Taylor Jackson

Fact Sheet Available:
Yes
AB 2670 – Health Care Quality & Consumer Experience Survey
For Medi-Cal Enrollees

SUMMARY
Assembly Bill 2670 requires the Department of Health Care Services (DHCS) to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on an annual basis in all Medi-Cal threshold languages, for all Medi-Cal beneficiaries.

EXISTING LAW
The CAHPS survey is a federally developed consumer assessment tool that polls patients on their actual experience receiving care. Currently DHCS conducts the CAHPS survey once every three years, and only in two languages, English and Spanish. DHCS publishes the results on its website and uses them as part of its Medi-Cal Managed Care Program Quality Strategy.

The Department of Health Care Services is charged with monitoring, evaluating, and improving the quality of care provided by Medi-Cal managed care plans. DHCS’s oversight is critical to ensuring patients receive appropriate services based on recommended guidelines and in accordance with their needs and preferences.

RATIONALE
California’s Medi-Cal program has grown tremendously in enrollment since implementation of the Affordable Care Act (ACA). Medi-Cal covers approximately 12 million enrollees, up from seven million in 2013. 78% of enrollees belong to a community of color, and more than a third’s primary language is not English. For consumer survey data to be useful in quality improvement strategies, the views and experiences of California’s diverse enrollees must be collected consistently, reported on annually, and incorporated into DHCS quality reports and activities.

Many communities of color face disproportionate rates of chronic disease. With these groups comprising a majority of Medi-Cal enrollees, the long term success of the Affordable Care Act rests on how the health system will improve the care experience of California’s diverse population.

AB 2670 gives us the opportunity to better assess these groups and their different health care needs. Medi-Cal’s quality measures must be consistent and reflect the experience of California’s most diverse populations.

SUPPORT
California Pan-Ethnic Health Network (Sponsor)

OPPOSITION
None

CONTACT INFORMATION
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SB 1174 (McGuire) Medi-Cal: children: prescribing patterns

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including early and periodic screening, diagnosis, and treatment for any individual under 21 years of age. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law establishes a statewide system of child welfare services, administered by the State Department of Social Services, with the intent that all children are entitled to be safe and free from abuse and neglect.

This bill would require the State Department of Health Care Services and the State Department of Social Services to, on an ongoing basis, conduct an analysis of data regarding Medi-Cal prescribers and their prescribing patterns for all children enrolled in and receiving services pursuant to the Medi-Cal program. The bill would require the analysis to include a breakdown of data by specified population categories, including children in foster care. Commencing July 1, 2017, the bill would require the State Department of Health Care Services and the State Department of Social Services to report quarterly to the Medical Board of California and to the Legislature of the ongoing analysis. The bill would require the Medical Board of California to review the analysis in order to determine if any potential violations of law or departures from the standard of care exist and conduct an investigation, if warranted, and would require the board to take disciplinary action, as specified.

Location as of 3/2016:
Senate Health

PHC Position:
Watch

Sponsor:
Author

Staffer:
Kelly Burns

Fact Sheet Available:
Yes
SUMMARY

Over the past fifteen years, the rate of foster youth prescribed psychotropic medication has increased 1,400 percent.

Nearly 1 in 4 California foster teens are prescribed psychotropic drugs; of those nearly 60 percent were prescribed an anti-psychotic – the powerful drug class most susceptible to debilitating side effects.

While the Child and Family Services Improvement and Innovation Act of 2011 requires each state to oversee and monitor the use of psychotropic medications with children in care, there are currently no requirements to identify those who are over prescribing medication to foster youth.

The State of California has not been monitoring over prescribing because the data collection and data sharing system is not in place.

Given the State has a responsibility to monitor the administration of these drugs and to ensure the health and well-being of foster children, we should implement a process that provides the appropriate oversight for these powerful medications.

SB 1174 will establish a formal process for the Medical Board of California to responsively review and confidentially investigate psychotropic medication prescription patterns among California children.

BACKGROUND

Psychotropic drugs are potent medications that have documented well-known side effects that include serious lifelong and irreversible effects. Moreover, California spends more on psych drugs for foster children than on any other kind of medication. In the last decade, the state spent more than $226 million on psych meds for foster children, an astounding 72 percent of total spending.

PROBLEM

While the vast majority of doctors prescribing medication are doing so appropriately, California still needs an oversight mechanism (among other reforms including funding robust trauma care services). Currently, we have no system for evaluating the medical soundness of high rates of prescribing; and no way to measure the efficacy of these practices.

Last year, the Department of Health Care Services (DHCS) and the Medical Board of California adopted a one-year trial Data Use Agreement that allows for the sharing of prescriber data in order to identify the outlying prescribers.

With the data from DHCS, the medical board will have regular, reliable information to work from instead of depending on the current individual complaint process that very few foster children are able to access. SB 1174 will alleviate the alarming data disparity between private and foster care system complaint rates.

Such data sharing practices should not be on a one-time basis, but rather an ongoing process for improving the quality of prescribing for our children.

SOLUTION

This bill enables the Medical Board of California to confidentially collect and analyze data, and, when warranted, conduct investigations of physicians who frequently prescribe over the recognized safety parameters for children.

Specifically, SB 1174 requires:

• The Department of Health Care Services (DHCS) to share prescribing patterns and prescriber information with the Medical Board of California.

• The Medical Board of California to analyze prescribing patterns and identify outlying prescribers or widespread practices that could be improved.

• Investigators for the Medical Board of California, staffed within the Attorney General’s office, to be able to conduct investigations and take other actions where warranted as a result of the analysis.

SB 1174 will enable California to implement what is already standard oversight practice in Washington, Illinois, and Ohio. These state initiatives have shown a 25% decrease in dangerous prescribing practices and have improved the overall prescription frequency for medically acceptable reasons.

CONTACT

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SB 1436 (Bates) Local agency meetings: local agency executive compensation: discussion of final action taken

The Ralph M. Brown Act requires that all meetings of a legislative body of a local agency be open and public, except that closed sessions may be held under prescribed circumstances. Existing law authorizes the legislative body to hold a closed session to consider the appointment, employment, evaluation of performance, discipline, or dismissal of a public employee, but generally prohibits the closed session from including discussion or action on proposed compensation. Existing law authorizes the legislative body to hold a closed session with the local agency’s designated representatives regarding the salaries, salary schedules, or compensation paid in the form of fringe benefits of its represented and unrepresented employees, but prohibits the closed session from including final action on the proposed compensation of one or more unrepresented employees. Existing law prohibits the legislative body from calling a special meeting regarding the salaries, salary schedules, or compensation paid in the form of fringe benefits, of a local agency executive, as defined.

This bill would require the final action on the salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive to be made a separate discussion item and not placed on a consent calendar. The bill would define, for these purposes, “discussion item” as an item that is given time in a meeting for discussion separate from any other item and “consent calendar” as a list of 2 or more items that the legislative body has agreed to vote on as a group at once without a separate debate for each item.

By imposing new requirements on cities, counties, cities and counties, and special districts, this bill would impose a state-mandated local program.

The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Location as of 3/2016:
Senate Health

PHC Position:
Watch

Sponsor:
Author

Staffer:
Frank Prewoznik

Fact Sheet Available:
Yes
SB 1436: Local Agency Compensation: Discussion of Final Action Taken

Senator Patricia C. Bates

IN BRIEF
SB 1436 ensures that the decisions of local elected officials regarding executive compensation are open and public by requiring the final action on salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive to be made a separate discussion item and not placed on the consent calendar.

THE ISSUE
There is a public interest in ensuring that decisions made by legislative bodies of local agencies regarding local agency executive compensation are open and transparent. Local agency executives such as agency CEOs and city managers are offered fringe benefits including health care coverage and pensions in amounts that can have a significant long-term impact on the budget and that deserve particular scrutiny by the public.

Local agencies generally designate representatives to negotiate with employees. In negotiations with a local agency executive, a local agency often designates members of the legislative body of the local agency to act as the representatives.

A legislative body of a local agency may hold closed sessions with the local agency’s designated representatives to review its position and instruct its designated representatives, but it is otherwise generally prohibited from including the discussion of or action on proposed compensation in closed session. The law’s intent for openness is not achieved if the final action on local agency executive compensation is placed on the consent calendar, with no prescribed or required discussion.

EXISTING LAW
Existing law generally prohibits the legislative body of a local agency from including the discussion or action on proposed compensation in closed session, but authorizes a legislative body of a local agency to hold closed sessions with the local agency’s designated representatives regarding the salaries, salary schedules, or compensation paid in the form of fringe benefits of its represented and unrepresented employees, for the purpose of reviewing its position and instructing the local agency’s designated representatives. Existing law prohibits final action on the proposed compensation of one or more unrepresented employees in closed session. (Government Code §§ 54957(b)(1), 54957(b)(4), and 54957.6(a))

Existing law requires the legislative body of any local agency to report publicly, orally or in writing, any action taken in closed session and the vote or abstention on that action of every member present, as specified. (Government Code § 54957.1)

Existing law requires after any closed session the legislative body to reconvene into open session prior to adjournment and make any required disclosures of action taken in closed session. (Government Code § 54957.7)

Existing law prohibits a legislative body from calling a special meeting regarding the salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive, as defined. (Government Code § 54956(b))

THE SOLUTION
To ensure that the final action of a legislative body of a local agency on the salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive is open and public, this measure requires that action be made a separate discussion item and not placed on the consent calendar.

FOR MORE INFORMATION
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Bill text and status can be found at:
www.leginfo.ca.gov
LEGISLATIVE CATEGORY:

PROVIDER NETWORKS
AB 1863 (Wood) Medi-Cal: federally qualified health centers: rural health centers

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. “Visit” is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals. Existing law allows an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services it provides.

This bill would include a marriage and family therapist within those health care professionals covered under that definition. The bill would require an FQHC or RHC that currently includes the cost of services of a marriage and family therapist for the purposes of establishing its FQHC or RHC rate to apply to the department for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, would require the FQHC or RHC to bill these services as a separate visit, as specified. The bill would require an FQHC or RHC that does not provide the services of a marriage and family therapist, and later elects to add these services, to process the addition of these services as a change in scope of service.

Location as of 3/2016:
Assembly Health

PHC Position:
Support

Sponsor:
Author

Staffer:
Tony Bui

Fact Sheet Available:
Requested
AB 2053 (Gonzalez) Primary care clinics

Under existing law, the State Department of Public Health licenses and regulates primary care clinics, as defined. A violation of those provisions is a crime under existing law. Existing law provides that no application for licensure is required if a licensed primary care clinic adds a service that is not a special service, as defined, or remodels or modifies an existing primary care clinic site, but requires the clinic to notify the department of these events, as specified.

This bill would, among other things, expand that exception from licensure, and that notice requirement, to include a licensed primary care clinic that adds an additional physical plant maintained and operated on separate premises. The bill would require the department, upon written notification by a primary care clinic, to issue a single consolidated license to a primary care clinic that includes more than one physical plant maintained and operated on separate premises or that has multiple licenses for a single health facility on the same premises, as specified. Because the bill would create a new crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Location as of 3/2016:
Assembly Health

PHC Position:
Support

Sponsor:
California Primary Care Association

Staffer:
Andrea San Miguel

Fact Sheet Available:
Yes
IN BRIEF

AB 2053 will help community health centers meet the growing demand for medical care by allowing them to add an additional facility that is maintained and operated by the same health center under its existing license.

THE PROBLEM

The growing need for primary health care continues to go unmet even though coverage has been expanded under the Affordable Care Act. Community health centers are working to increase access, but have encountered problems when expanding.

Today, if a licensed health center expands their services into a facility that is located next door, across the street, around the corner, or a few stops down the bus line, it will be required to obtain a new license to operate independently of the original health center. This requires duplication of effort for practice management, administrative licensing processes, annual utilization reports, reimbursement rate setting process, and more. This does not make sense for cutting-edge integrated care models championed by community health centers.

There is also no specific process that a licensed health center can follow to consolidate two facilities under a single license. In limited circumstances, the California Department of Public Health (CDPH) may issue consolidated licenses for health centers under their waiver authority. In several cases, however, the lack of a definitive process for consolidation has led to confusion within CDPH regarding how licensure and reporting should be handled. This has created unintended consequences such as delays in opening new facilities and providing patient care. In one example, a licensed health center that attempted to obtain a consolidated license for a new facility constructed across the street waited one full year for determination by CDPH.

THE SOLUTION

Facilities operating within the same health center corporation, under a central Board of Directors, administrative leadership, and medical leadership, should have the option to be licensed as a single entity when it is appropriate to their system of care.

AB 2053 creates that option and eases the current practice of licensing every facility independently, regardless of their proximity to one another or how they coordinate care. This legislation also provides surety and guidance to CDPH and its field offices by allowing for a streamlined and consistent process for both the Department and the health center seeking to expand. Additionally, AB 2053 provides an avenue for CDPH District Office staff to gain a better understanding of the care team relationships between facilities that are consolidated under a single license and system of care.

Like independently licensed facilities, new facilities under AB 2053 would be required to meet robust building standards, fire and life safety standards, and Americans with Disabilities Act standards that are currently applicable to licensed health centers.

SUPPORT

California Primary Care Association (Sponsor)

Co-Authors

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FOR MORE INFORMATION

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SB 1401 (McGuire) Home health care pilot projects

Existing law provides for the licensure and regulation of home health agencies by the State Department of Public Health. Existing law requires all private or public organizations that provide or arrange for skilled nursing services to patients in the home to obtain a home health agency license. Existing law also provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. Existing law provides that home health care services are covered Medi-Cal benefits, subject to utilization controls.

This bill would require the department, on or before January 1, 2017, to develop at least 3 regional pilot projects in counties located in designated areas of the state. The pilot projects would be targeted to increase access to in-home, private duty nursing care for children receiving Medi-Cal benefits who are eligible for in-home, shift nursing care services. The bill would require, for a period of at least 2 years, an increased reimbursement rate for participating licensed home health agencies that are currently providing private duty nursing. The bill would require that the pilot project be implemented only to the extent that federal financial participation is available, and would require the department to submit any state plan amendment, waiver, or waiver amendment application necessary for federal approval.

This bill would authorize the department to establish reasonable provider eligibility standards and participation requirements and also would require the department, or an entity contracting with the department, to report to specified committees of the Legislature an evaluation of the effectiveness of the pilot projects, with input from specified stakeholders. The bill’s provisions would become inoperative on July 1, 2019, and would be repealed as of January 1, 2020.

Location as of 3/2016:
Senate Health

PHC Position:
Support

Sponsor:
Author

Staffer:
Kelly Burns

Fact Sheet Available:
Requested
LEGISLATIVE CATEGORY:
SPOT BILL
AB 1568 (Bonta) Medi-Cal: demonstration project - SPOT BILL

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits and services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for a demonstration project under the Medi-Cal program until October 31, 2015, to implement specified objectives, including better care coordination for seniors and persons with disabilities and maximization of opportunities to reduce the number of uninsured individuals.

This bill would require the State Department of Health Care Services to implement a waiver or demonstration project authorized under a specified federal waiver that, among other things, includes a delivery system transformation and alignment incentive program for designated public hospital systems and district municipal hospitals. The bill would require the department to consult with interested stakeholders and the Legislature in implementing this waiver or demonstration project.

This bill would declare that it is to take effect immediately as an urgency statute.

Location as of 3/2016:
Assembly Floor

PHC Position:
Discard

Sponsor:
Author

Staffer:
Evan Corder

Fact Sheet Available:
Requested
Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for the reimbursement of providers under the Medi-Cal program.

The Lanterman Developmental Disabilities Services Act requires the State Department of Developmental Services to contract with regional centers to provide services and supports to individuals with developmental disabilities. Under existing law, the regional centers purchase needed services for individuals with developmental disabilities through approved service providers or arrange for those services through other publicly funded agencies. Existing law establishes specified rates to be paid to certain service providers and the rates to be paid for certain developmental services. Existing law requires that rates to be paid to other developmental service providers either be set by the department or negotiated between the regional center and the service provider.

This bill would state the intent of the Legislature to enact legislation to stabilize funding for the Medi-Cal program and to provide rate increases for Medi-Cal and developmental services providers.

**Location as of 3/2016:**
Senate Rules

**PHC Position:**
Discard

**Sponsor:**
Author

**Staffer:**
Evan Corder

**Fact Sheet Available:**
None available
(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing law, until July 1, 2016, imposes a sales tax on sellers of Medi-Cal managed care plans. This bill, on July 1, 2016, and until July 1, 2019, would establish a new managed care organization provider tax, to be administered by the State Department of Health Care Services. The tax would be assessed by the department on licensed health care service plans, managed care plans contracted with the department to provide Medi-Cal services, and alternate health care service plans (AHCSP), as defined, except as excluded by the bill. The bill would require the department to determine for each health plan using the base data source, as defined, specified enrollment information for the base year. By October 14, 2016, or within 10 business days following the date upon which the department receives approval for federal financial participation, whichever is later, the bill would require the department to commence notification to the health plans of the assessed tax amount due for each fiscal year and the dates on which the installment tax payments are due for each fiscal year.

This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–17, 2017–18, and 2018–19 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. The bill would require the department to request approval from the federal Centers for Medicare and Medicaid Services as necessary to implement this bill. The bill would authorize the department to implement its provisions by means of provider bulletins, all-plan letters, or similar instructions, and to notify the Legislature of this action.

This bill would establish the Health and Human Services Special Fund in the State Treasury, into which all revenues, less refunds, derived from the taxes imposed by the bill would be deposited into the State Treasury to the credit of the fund. Interest and dividends earned on moneys in the fund would be retained in the fund, as specified. The bill would continuously appropriate the moneys in the fund to the State Department of Health Care Services for purposes of funding the nonfederal share of Medi-Cal managed care rates for health care services furnished to specified persons, thereby making an appropriation.

(2) Existing law imposes a gross premiums tax of 2.35% on all insurers, as defined, doing business in this state, as set forth in the California Constitution. For purposes of the Corporation Tax Law, existing law sets forth items specifically excluded from gross income. This bill would provide that the qualified health care service plan income, as defined, of health plans that are subject to the managed care organization provider tax would be excluded from the definition of gross income for purposes of taxation under the above provisions, as specified. The bill would reduce the gross premiums tax rate from 2.35% to 0% for those premiums received on or after July 1, 2016, and on or before June 30, 2019, for the provision of health insurance paid by health insurers providing health insurance that has a corporate affiliate, as defined, that is a health care service plan or health plan that is subject to the managed care organization provider tax imposed under the bill, as specified. The bill would require the State Department of Health Care Services to annually report specified information to the Franchise Tax Board with regard to these provisions. The bill would authorize the board to implement these provisions and would exempt the board from the administrative rulemaking process.
Existing law provides that when the laws of another state or foreign county impose certain taxes or other amounts on California insurers, or their agents or representatives, the same taxes or other amounts are imposed in this state upon the insurers, or their agents or representatives, of the other state or country doing business in this state.

The bill would prohibit the Insurance Commissioner from considering the reduction of the gross premiums tax rate under this bill in any determination to impose or enforce a tax under those retaliatory tax provisions.

The bill would provide that these provisions become operative on the later of July 1, 2016, or on the date the Director of Health Care Services certifies in writing that federal approval necessary for receipt of federal financial participation has been obtained.

(3) This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of 2/3 of the membership of each house of the Legislature.

**Location as of 3/2016:**
Assembly Public Health and Developmental Services

**PHC Position:**
Discard

**Sponsor:**
Author

**Staffer:**
Evan Corder

**Fact Sheet Available:**
None Available
SBX2 15 (Hernandez) Medi-Cal: managed care organization tax – SPOT BILL

(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing law, until July 1, 2016, imposes a sales tax on sellers of Medi-Cal managed care plans.

This bill, on July 1, 2016, and until July 1, 2019, would establish a new managed care organization provider tax, to be administered by the State Department of Health Care Services. The tax would be assessed by the department on licensed health care service plans, managed care plans contracted with the department to provide Medi-Cal services, and alternate health care service plans (AHCSP), as defined, except as excluded by the bill. The bill would require the department to determine for each health plan using the base data source, as defined, specified enrollment information for the base year. By October 14, 2016, or within 10 business days following the date upon which the department receives approval for federal financial participation, whichever is later, the bill would require the department to commence notification to the health plans of the assessed tax amount due for each fiscal year and the dates on which the installment tax payments are due for each fiscal year.

This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–17, 2017–18, and 2018–19 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. The bill would require the department to request approval from the federal Centers for Medicare and Medicaid Services as necessary to implement this bill. The bill would authorize the department to implement its provisions by means of provider bulletins, all-plan letters, or similar instructions, and to notify the Legislature of this action.

This bill would establish the Health and Human Services Special Fund in the State Treasury, into which all revenues, less refunds, derived from the taxes imposed by the bill would be deposited into the State Treasury to the credit of the fund. Interest and dividends earned on moneys in the fund would be retained in the fund, as specified. The bill would continuously appropriate the moneys in the fund to the State Department of Health Care Services for purposes of funding the nonfederal share of Medi-Cal managed care rates for health care services furnished to specified persons, thereby making an appropriation.

(2) Existing law imposes a gross premiums tax of 2.35% on all insurers, as defined, doing business in this state, as set forth in the California Constitution. For purposes of the Corporation Tax Law, existing law sets forth items specifically excluded from gross income.

This bill would provide that the qualified health care service plan income, as defined, of health plans that are subject to the managed care organization provider tax would be excluded from the definition of gross income for purposes of taxation under the above provisions, as specified. The bill would reduce the gross premiums tax rate from 2.35% to 0% for those premiums received on or after July 1, 2016, and on or before June 30, 2019, for the provision of health insurance paid by health insurers providing health insurance that has a corporate affiliate, as defined, that is a health care service plan or health plan that is subject to the managed care organization provider tax imposed under the bill, as specified. The bill would require the State Department of Health Care Services to annually report specified information to the Franchise Tax Board with regard to these provisions. The bill would authorize the board to implement these provisions and would exempt the board from the administrative rulemaking process.
Existing law provides that when the laws of another state or foreign county impose certain taxes or other amounts on California insurers, or their agents or representatives, the same taxes or other amounts are imposed in this state upon the insurers, or their agents or representatives, of the other state or country doing business in this state.

The bill would prohibit the Insurance Commissioner from considering the reduction of the gross premiums tax rate under this bill in any determination to impose or enforce a tax under those retaliatory tax provisions.

The bill would provide that these provisions become operative on the later of July 1, 2016, or on the date the Director of Health Care Services certifies in writing that federal approval necessary for receipt of federal financial participation has been obtained.

(3) This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $2/3$ of the membership of each house of the Legislature.

**Location as of 3/2016:**
Senate Public Health and Developmental Services

**PHC Position:**
Discard

**Sponsor:**
Author

**Staffer:**
Health Committee

**Fact Sheet Available:**
None Available