HEALTH ACCESS CALIFORNIA

May 24, 2017

Budget Conference Committee
Senator Holly Mitchell
Senator Ricardo Lara
Senator John Moorlach
Senator Jim Nielsen
Senator Richard Roth
Assemblymember Phil Ting
Assemblymember Phillip Chen
Assemblymember Kevin McCarty
Assemblymember Jay Obernolte
Assemblymember Shirley Weber
Assemblymember Joaquin Arambula

RE: Budget Conference Committee – Health Issues

Dear Members of the Budget Conference Committee:

Health Access California, the statewide health care consumer advocacy coalition working for quality, affordable health care for all Californians, respectfully submits the following comments regarding health issues that will be heard in Budget Conference Committee for the 2017-2018 State Budget.

PROPOSITION 56 INVESTMENTS

We strongly support the Legislature's efforts to use the $1.3 billion in Medi-Cal dollars from Proposition 56 revenues to improve the program by expanding eligibility and coverage, restoring benefits that had previously been cut, and making targeted, data-driven increases in provider reimbursements. Health Access was one of the organizational supporters of Proposition 56, helped to draft the initiative, and actively campaigned for the measure. Proposition 56 dedicates most of the new revenue generated by the tobacco tax to Medi-Cal, and allows for broad use to of the monies to increase funding for Medi-Cal programs, treatment, and services, which includes new investments in Medi-Cal eligibility, benefits, and provider rates.

ITEMS IN CONFERENCE COMMITTEE

We urge the Legislature to include the following items in the final budget:

Expand Eligibility for #Health4All Young Adults up to Age 26

Health Access supports the Senate and the Assembly's actions to provide state-funded Medi-Cal coverage to low-income young adults up to age 26 who meet income qualifications but are currently ineligible for full-scope Medi-Cal because of their immigration status.

SB 75 (Chapter 18, Statutes of 2015) expanded full-scope Medi-Cal to all California children under age 19 regardless of immigration status. Medi-Cal should be expanded to cover young adults who age out of coverage, or whose coverage might be

impacted by a change of status of the Deferred Action for Childhood Arrivals (DACA) program. Prior to the ACA, young adults had the highest rates of uninsurance of any age group. The ACA does allow most young adults to stay on their parents' coverage--an option many undocumented youth do not have because of their parents' lack of employer coverage. A modest but significant next step would be to have Medi-Cal to cover young adults, regardless of immigration status, and expand near universal coverage to not just California children, but young adults as well. In the midst of a hostile federal environment, where immigrants are experiencing fear and anti-immigrant actions, ensuring California's young people maintain health coverage upholds California's commitment to the health and well-being of our immigrant communities.

Health for all young adults is a top priority for Health Access California, the California Immigrant Policy Center, and many other consumer, health, immigrant, and community organizations. Health Access remains committed to working with the Legislature and the Administration to cover all Californians, regardless of immigration status: extending coverage to young adults to age 26 would be a step toward that goal.

DENTI-CAL: FULL RESTORATION OF ADULT BENEFITS
Health Access supports the Senate and Assembly's actions to fully restore adult dental benefits.

Faced with a multibillion-dollar deficit in 2009, California eliminated coverage for routine dental care for adults in the Denti-Cal program beginning July 1 of that year. According to federal Medicaid law, dental services are only mandatory for children, and as part of a broad effort to eliminate the gap between revenues and spending, the optional program for adults, with a few exceptions for special populations, was defunded by the state.

We support fully restoring adult dental services, which is essential to physical health, mental health, and employability. Investing in full adult dental services will allow the state to draw down additional federal dollars that are currently left on the table.

RESTORE "OPTIONAL" BENEFITS ELIMINATED DURING RECESSION
Health Access supports the Senate and Assembly's proposals to restore the "optional" Medi-Cal benefits.

The "optional" Medi-Cal benefits were eliminated during the Great Recession for fiscal, not policy reasons. We urge the restoration of these benefits, which include audiology, chiropractic, incontinence creams and washes, optician/optical labs, podiatry, vision, and speech therapy.

DENTAL PROVIDER RATES
Health Access supports strengthening access to Denti-Cal through by increasing provider rates by at least $100M.

We also support increasing reimbursement rates for Denti-Cal providers to a level sufficient to ensure Medi-Cal beneficiaries have meaningful access. A 2014 audit of the Denti-Cal program

revealed several weaknesses that limit access to dental care, including low provider reimbursement. According to the State Auditor, California's provider reimbursement rates for the 10 most common dental procedures was only 35% of the national average in 2011, and children's utilization of dental services was the 12th worst in the nation. Furthermore, the audit revealed extreme access issues because of low reimbursement rates for dental providers, with over 50% of children going without dental care for more than 12 months.

After the audit, DHCS resumed its Annual Dental Reimbursement Rate Review and found that dental fee reimbursement fee rate varied significantly, ranging anywhere from 64-106% of similarly sized states Medicaid programs' dental fee schedule. Most alarmingly, the report found a staggering decrease in the number of Denti-Cal providers, with over 1500 providers no longer rendering Denti-Cal services. Although the state has eliminated the 10% rate reduction and the retroactive recoupment of the AB 97 rates for dental providers, there is evidence that the rates remain insufficient to ensure access.

PROVIDER RATE RESTORATIONS

Health Access supports using a substantial portion of the Proposition 56 monies to increase provider rates. The state should use publicly-reported data to direct provider rate enhancements to the geographic regions, provider types, and beneficiary populations that where the need is most acute, and where the investment would result in substantial gains in access to care and quality of care.

Health Access is committed to ensuring access to care: Over the last three decades, Health Access has worked to ensure consumers get the care they need when they need it. We have sponsored numerous bills to increase reporting and accountability within the Medi-Cal program (and in managed care in general), including establishing clear standards for network adequacy and timely access to care. These bills include SB 137 (2015), which requires health plans to regularly update their provider directories, and SB 964 (2014), which requires health plans to report on their compliance with timely access standards and do separate reporting for Medi-Cal managed care networks. The bill also required Medi-Cal managed care plans to be subject to routine medical surveys every three years, like their commercial counterparts.

State Audits and academic studies highlight access concerns: Several state audits and studies have found access challenges in Medi-Cal. In 2014, the California State Auditor found that DHCS had, among other things, weak oversight over whether health plans have adequate provider networks. As a result, the state did not have reliable health plan data to understand which consumers have challenges accessing care. DHCS has been working on improving its oversight over health plans, and the Legislature should look to DHCS' data to inform where access challenges exist.

Medi-Cal Managed Care Access Assessment is underway: DHCS is conducting an Access assessment in Medi-Cal Managed Care as part of the requirements of the Special Terms and Conditions of California's 1115 Wavier renewal. This one-time assessment will evaluate primary, core specialty, and facility access to care for managed care beneficiaries based on the

current health plan network adequacy requirements set forth in the Knox-Keene Act, Medicaid managed care contracts, and reporting on the number of providers accepting new patients. The Assessment will look at access to care using a variety of network performance measures. The results of the Access Assessment will be available by mid-2018. We believe the information gained from this Access Assessment, coupled with the SB 964 timely access data and other information collected by DHCS would provide information to understand where access challenges exist and how to best target investments in provider reimbursement.

Furthermore, several recent studies highlight access challenges in Medi-Cal. An October 2016 study conducted by UCSF and supported by the California Health Care Foundation found that the percentage of California physicians accepting new Medi-Cal patients varies substantially across major physician specialties.[1] Fewer than half of specialists in general internal medicine and psychiatry were accepting new patients. In addition, the northern part of the state had the lowest percentage of primary care physicians accepting new Medi-Cal patients. Another study by UC Davis researchers on access in the 8-county region around Sacramento found that Medi-Cal beneficiaries had limited access to primary care providers and that Sacramento County had the worst access to PCPs in the region.[2]

We urge the Legislature to direct provider rate increases toward specific providers, services, or geographic regions that will yield *substantial, demonstrable gains* in patients' access to care and improve the quality of care provided to Medi-Cal beneficiaries.

AGED & DISABLED ELIGIBILITY LEVEL INCREASE

Health Access supports the Assembly's action to increase the amount of income that is disregarded in calculating elibility for the Medi-Cal aged and disabled (A&D) program.

The A&D program provides no-cost, comprehensive Medi-Cal services to seniors and people with disabilities. When this program was created nearly a dozen years ago, the income limit was set at 133 percent of the poverty line. However, this limit has declined to 123 percent of the poverty line because the program's "income disregards" — which help to determine individuals' eligibility — have not been adjusted for inflation. A&D enrollees whose incomes exceed this limit must pay a share of their health care costs, potentially amounting to hundreds of dollars per month, before Medi-Cal begins to pay for services. The income disregards should be adjusted in order to increase the limit for no-cost Medi-Cal to 138 percent of the poverty line, the same threshold that applies to other adults. This action would decrease the number of low-income seniors with a high Medi-Cal share of cost, allowing them to use their Medi-Cal coverage.

[1] Janet Coffman, Physician Participation in Medi-Cal: Is Supply Meeting Demand? (October 2016) Available at: http://www.chcf.org/publications/2016/10/physician-participation-medical

[2] Joy Melnikow, et al., Medi-Cal Enrollee Access to Primary Care Providers: A Secret Shopper Study (July 2016).

DIABETES PREVENTION PROGRAM MODEL PILOTS

Health Access supports the Assembly action to approve $5M to cover diabetes prevention through Medi-Cal and supports funding for the Diabetes Prevention Program Model Pilots, which will improve health outcomes and save Medi-Cal money.

The Diabetes Prevention Program (DPP) is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are prediabetic. DPP is covered under Medicare and was recently approved by CMS as a cost savings program that reduced net Medicare spending. Evaluation of DPP has demonstrated that participants cut their risk of developing type 2 diabetes by 58%. This outcome was achieved by helping people lose 5 - 7% of their body weight through healthier eating and 150 minutes of physical activity a week.5 Starting in 2018, DPP will be a covered expense by Medicare based on studies showing an ROI of $2,650 per person after 15 months. Public Health Advocates estimates that California spends $15 billion annually on health care costs for diabetes. Although $15 billion is the amount of all healthcare costs, not just Medi-Cal, it is important to note that diabetes rates are highest in low-income populations, and therefore it can be assumed that over half of all Californians with diabetes are enrolled in Medi-Cal and therefore the Medi-Cal program likely bears more than half of the cost of our diabetes epidemic.

Health Access California looks forward to working with you to finalize a state budget that invests in the health and well-being of all Californians and protects the gains that California has made. Please contact Tam Ma, Legal and Policy Director (tma@health-access.org or (916)497-0923 x.808), or Myriam Valdez, Legislative and Policy Advocate (mvaldez@health-access.org or (916) 794-0923 x.804), if you have any questions about our position on the state budget.

Sincerely,

Anthony Wright
Executive Director

CC: Senate President pro Tempore Kevin de León
Assembly Speaker Anthony Rendon
Donna Campbell, Office of Governor Jerry Brown