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April 19, 2017

Dr. Richard Pan
Chair, Senate Budget Subcommittee No. 3

Dr. Joaquin Arambula
Chair, Assembly Budget Subcommittee No. 1

RE: Proposition 56 Investments in Medi-Cal

Dear Drs. Pan and Arambula:

Health Access California, the statewide health care consumer advocacy coalition working for quality, affordable health care for all Californians, respectfully requests the Legislature to invest the \$1.2 billion in Medi-Cal dollars from Proposition 56 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. We propose that about half the Proposition 56 funding be directed to access expansions and benefits and about half to provider rate increases, especially dental and others with demonstrated shortfalls in access.

Health Access was one of the organizational supporters of Proposition 56, helped to draft the initiative, and was very active in the campaign to pass the measure. Our proposal carries out both the letter and the spirit of voters' intent in passing Proposition 56: to not only discourage smoking but also make investments that will improve access to Medi-Cal in a meaningful and impactful way.

We urge the Legislature to prioritize the following investments:

- **expand eligibility for #Health4All Young Adults up to age 26** by allowing all low-income young adults up to age 26 to enroll in full-scope Medi-Cal without regard to immigration status;
- **strengthen access to Denti-Cal** through full restoration of adult dental benefits and increasing dental provider rates; and
- **increase access to FamilyPACT** and abortion services by increasing provider rates for these services.

We also suggest the remaining Proposition 56 Medi-Cal dollars be used to:

- Allow Californians in Medi-Cal's "Aged & Disabled" (A&D) program to qualify for no-cost coverage with incomes up to 138 percent of the poverty line;
- Improve Medi-Cal benefits by restoring the "optional" benefits cut in 2009;
- Investing in preventive services for asthma and diabetes; and
- Invest in additional provider rate increases using a data-driven methodology to achieve the greatest impact in improving Californians' access to Medi-Cal services.

Proposition 56: Uses of the Medi-Cal Funding

Proposition 56 dedicates most of the new revenue generated by the tobacco tax to Medi-Cal, and allows for broad use of the money to improve access. The measure was deliberately written to ensure that the revenue would not simply go to backfill existing ongoing commitments and makes clear that the funds are required to supplement, not supplant, existing General Fund spending. (Section 30130.55, paragraph a).

Proposition 56 does not earmark funds within Medi-Cal and instead requires the Legislature to consider the best ways to increase access to care in Medi-Cal through the public, policy-driven budget process. Proposition 56 calls on the Legislature to develop criteria for increasing funding support for Medi-Cal, and says the criteria “shall include, but not be limited to, ensuring timely access, limiting specific geographic shortages of services, or ensuring quality care.” (Section 30130.55, paragraph a). The options for increasing access include expanding eligibility for the program, improving benefits, and increasing provider rates, or a combination of all three.

Proposition 56: Investment Priorities

Health Access urges the Legislature to prioritize the following investments using Proposition 56’s Medi-Cal dollars:

1) Expand Eligibility for #Health4All Young Adults up to Age 26

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 Access remains committed to working with the Legislature and the Administration to cover all adults, regardless of immigration status: extending coverage to young adults to age 26 would be a step toward that goal.

Fiscal impact: We estimate expanding state-funded full-scope Medi-Cal coverage to low-income adults up to the age of 26, regardless of immigration status would cost \$80-\$90 million dollars.

2) Strengthen access to Denti-Cal through full restoration of adult dental benefits and increasing provider rates

- **Full Restoration of Adult Dental Services**

Fully restore adult dental services in Medi-Cal.

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.

These services were partially restored in the 2013-14 state budget, which has given Medi-Cal beneficiaries access to preventive care, restorations and full dentures. However, important dental services, such as gum treatment and partial dentures and implants are still not covered in Medi-Cal. The omission of these services is particularly problematic given that tooth extraction is among the most common type of service provided under the Federally Required Adult Dental Services (FRADS), by which California offered very limited dental care for adults in Medi-Cal after eliminating most dental services during the recession. Today, Medi-Cal beneficiaries continue to report having to opt for otherwise unnecessary extractions in order to obtain full dentures because partial dentures are not covered. We strongly advocate for the full restoration of adult dental services, which is essential to physical health, mental health, and employability. In addition, investing in full adult dental services will allow the state to draw down additional federal dollars that are currently left on the table.

Fiscal impact: According to the Department of Health Care Services, the 2017-2018 cost to restore all the remaining adult dental services would be \$190.7 million (\$69.5 million General Fund, \$121.2 million federal funds).

- **Increase Denti-Cal Provider Reimbursement Rates**

Increase 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.

Fiscal estimate: The state spends about \$500 million GF per year on Denti-Cal. Investing at least \$100 million toward enhancing dental provider rates will significantly improve access in the Denti-Cal program.

3) Improve Reimbursement Rates for FamilyPACT and Abortion Services

Restore the 10% cut to provider rates for Planned Parenthood, and provide a rate increase for rates frozen for over a decade.

Assembly Bill 97 (Chapter 3, Statutes of 2011) reduced Medi-Cal provider rates by 10%. The rate cut has been dire for Planned Parenthood and other family planning providers, which provides critical primary care and reproductive health services to over 850,000 low-income men and women in California. About 90 percent of Planned Parenthood patients are Medi-Cal beneficiaries, which means the bulk of Planned Parenthood’s funding is from reimbursement for services provided to Medi-Cal beneficiaries. The Family PACT program is critical for individuals who are not eligible for Medi-Cal. Currently, almost 50% of eligible individuals are served, indicating a still huge unmet need for services across California. Ninety-seven percent of services in California are for non-abortion services, such as annual exams, including breast exams, STD screenings, and contraception. Family planning services offered through providers like Planned Parenthood and other providers help prevent unintended births and help all Californians obtain access to critical care in their geographic region. Provider rates for FamilyPACT and other fee-for-service reproductive services had been frozen for years prior to the 10% rate cut, compounding the impact of the 10% provider rate cut. Enhancing reimbursement rates for reproductive services will ensure that Planned Parenthood and other family planning providers can continue to serve the consumers who rely on them for critical reproductive and other health care services.

Fiscal impact: We estimate that improving reimbursement rates for Planned Parenthood and other family planning providers would cost \$50-\$60 million dollars.

Proposition 56: Additional Investments to Improve Access

The following investments would further expand eligibility to Medi-Cal, enhance benefits provided to beneficiaries, and improve provider reimbursement rates in a targeted manner:

Remove gaps in Medi-Cal coverage for Californians in Medi-Cal’s “Aged & Disabled” program.

Allow Californians in Medi-Cal’s “Aged & Disabled” (A&D) program to qualify for no-cost coverage with incomes up to 138 percent of the poverty line.

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.

Fiscal impact: The Legislature previously estimated this would cost \$30 million.

Restore “Optional” Medi-Cal Benefits

Restore critical Medi-Cal benefits eliminated during the state’s fiscal crisis in 2009, including audiology, chiropractic, incontinence creams & washes, optician/optical lab, podiatry, vision, and speech therapy.

These services were eliminated for budgetary, not fiscal reasons. Providing these services for a modest cost saves the Medi-Cal program more money in the long run because providing these services can avoid more expensive health care costs.

Fiscal Impact: The Legislature previously estimated it would cost a mere \$9.3 million to restore these services.

Fund Asthma Preventative Services

AB 391 (Chiu), pending in the Legislature, authorizes the Department of Health Care Services (DHCS) to permit Medi-Cal to utilize qualified professionals that may fall outside of the state’s clinical licensure system, if recommended by a licensed practitioner, to provide asthma education and home environmental asthma trigger assessment services. Over 5 million Californians have been diagnosed with asthma -- nearly 1 in 7 state residents. In 2010, Medi-Cal beneficiaries represented 50% of asthma hospitalizations and 42% of asthma emergency department visits, even though they represented only 30% of Californians. Asthma is of particular concern for low-income Californians enrolled in Medi-Cal. Low-income populations have higher asthma severity, poorer asthma control, and higher rates of asthma emergency department visits and hospitalizations.

AB 391 enacts a reimbursement mechanism that will expand access to these highly effective, long-standing preventative strategies, which will help improve health outcomes for all Californians suffering from asthma.

Fiscal impact: Unknown, but likely modest.

Support Diabetes Prevention Program Model Pilots

Provide 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.

Fiscal Impact: Unknown at this time, but likely modest.

Invest in Data-Driven Provider Rate Restorations

The aforementioned requests are relatively modest, leaving over half of the new tobacco tax revenues for additional provider rate increases. 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. The Legislature should take advantage of the data that is forthcoming from both the Department of Managed Health Care and Department of Health Care Services to make informed decisions on how to prioritize investments in provider rates. Because some of this data will not be available for another year, we suggest the Legislature develop a process and methodology for assessing the forthcoming data.

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.

Improving DMHC Timely Access Reports: We are beginning to get the timely access reports generated by SB 964, and may need another cycle or two to have that data be reported in a way that could be most useful--to identify specific geographic regions or specialists or other categories where a specific investment in provider rates is needed. While we are deeply disappointed by the abject failure of the health plans to comply with SB 964 thus far, we must not let the delay in getting quality data be an impediment to taking measurable steps to improving access to care. We suggest using a small fraction of the Proposition 56 money to require the Department of Managed Health Care to hire an independent entity to validate the

SB 964 data and reporting so that all of us may have accurate data on the networks and timely access for those plans with Medi-Cal managed care contracts.

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 Waiver 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.

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.

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

Health Access recommends the Legislature to utilize 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.

In summary, Health Access urges the Legislature to make these targeted investments in Medi-Cal to expand coverage, improve access and enhance services for Medi-Cal beneficiaries. This investment in Proposition 56's Medi-Cal dollars will allow California to make significant progress toward covering the remaining uninsured, restoring critical benefits like dental that had been

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).

eliminated during the Great Recession, increasing provider reimbursement rates where access has been a demonstrated challenge, and support prevention efforts that will improve health outcomes and save the state money in the long-run. Please contact Tam Ma, Legal and Policy Director, at tma@health-access.org or (916) 497-0923 x. 808 if we can answer any questions for you.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Anthony Wright', is enclosed in a light gray rectangular box.

Anthony Wright
Executive Director

CC: Senate President pro Tempore Kevin de León
Assembly Speaker Anthony Rendon
Senator Holly Mitchell, Chair, Senate Budget Committee
Assemblymember Phil Ting, Chair Assembly Budget Committee
Members, Senate Budget Subcommittee No. 3
Members, Assembly Budget Subcommittee No. 1