SENATE COMMITTEE ON SENATE COMMITTEE ON BUDGET AND FISCAL REVIEW

Senator Mark Leno, Chair
2015 - 2016 Regular

Bill No:	AB 1605	**Hearing Date:**	June 13, 2016
Author:	Committee on Budget		
Version:	June 13, 2016 As amended		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Michelle Baass		

Subject: Health

Summary: This bill is the omnibus health trailer bill, and contains changes to implement the 2016-17 budget.

Proposed Law: The bill makes technical and clarifying statutory revisions necessary to implement the Budget Act of 2016. Specifically, this bill:

1. Medi-Cal: Estate Recovery. Limits estate recovery in the Medi-Cal program to only those health care services required to be collected under federal law; to make it easier for individuals to pass on their assets by using the narrower definition of "estate" in federal Medicaid law; and to allow a hardship exemption from estate recovery for a home of modest value. Budget year costs are $5.7 million General Fund; $28.9 million General Fund in out years.

2. Medi-Cal – Acupuncture. Restores acupuncture services as a covered benefit under the Medi-Cal program. This benefit was eliminated in the 2009 budget in response to the state's fiscal crisis. Budget year costs are $3.7 million General Fund; $4.4 million General Fund in out years.

3. Medi-Cal: Workers Compensation. Eliminates the sunset provision and indefinitely extends the Department of Industrial Relations authority to supply work-related injury or claim data from the Workers' Compensation Information System to the Department of Health Care Services (DHCS).

4. Medi-Cal: Emergency Medical Air Transportation. Requires the Department of Finance to report to the Legislature on the fiscal impact to Medi-Cal of, and the planned reimbursement methodology for emergency medical air transportation services after, the termination of the certain vehicle penalty assessments.

5. Medi-Cal: Electronic Health Records. Increases the annual General Fund limit, from $200,000 to $450,000, for state administrative costs associated with the implementation of the Medi-Cal Electronic Health Records Incentive Program.

6. Medi-Cal: Supplemental Drug Rebates. Makes minor technical changes to correct non-sequential lettering errors and inconsistent language to accurately preserve the intent and purpose of SB 870 (Committee on Budget and Fiscal Review), Chapter

40, Statutes of 2014, to collect supplemental drug rebate revenues for certain prescription drugs based on drug utilization from all eligible Medi-Cal programs.

7. Medi-Cal: Federal Outpatient Drug Rule. Provides DHCS authority to comply with the final federal rule related to Medicaid reimbursement for covered outpatient drugs. The final rule, issued on February 1, 2016, requires states to align pharmacy reimbursements with the actual acquisition cost of drugs and to pay an appropriate professional dispensing fee.

8. Medi-Cal: Behavioral Health Treatment (BHT) Transition Contract. Provides DHCS the authority to establish a contract to assist specified individuals with finding comprehensive health coverage. The eligible individuals are those who were receiving only BHT services from a regional center as of January 31, 2016, and will be losing eligibility for full-scope Medi-Cal without a share of cost on March 31, 2017, due to the transition of BHT services from a covered benefit under the California Home and Community-Based Waiver program for Individuals with Developmental Disabilities (DD) to a covered benefit under the California Medi-Cal State Plan.

9. Medi-Cal: Suspend County COLA for Administration. Suspends the county cost-of-living adjustment (COLA) for county eligibility administration for 2016-17. Deletes outdated language referencing the Healthy Families Program which transitioned to Medi-Cal in 2013-14.

10. Program of All-Inclusive Care for the Elderly (PACE). Makes the following changes:
    a. Standardizes rate-setting to allow DHCS to determine comparability of cost and experience between PACE and like population subsets served through long-term services and supports (LTSS) integration into managed care health plans under the Coordinated Care Initiative. Statutory change is necessary as DHCS is currently required to use a fee-for-service (FFS) equivalent cost/upper payment limit methodology to set capitation rates for PACE organizations.
    b. Removes existing statutory language that caps the number of PACE Organizations with which DHCS can contract.
    c. Removes existing statutory language to align with updated PACE federal rules and regulations.
    d. Adds new statutory language enabling DHCS to seek flexibility from the Centers for Medicare and Medicaid Services (CMS) on several issues, including the composition of the PACE interdisciplinary team, marketing practices, and development of a streamlined PACE waiver process.

11. Long-Term Care Quality Assurance Fund. Makes the Long-Term Care Quality Assurance Fund continuously appropriated without regard to fiscal year. This aligns the expenditure authority of programs supported by the Long-Term Care Quality Assurance Fund with available fee revenues. Expenditures from the fund are used to offset General Fund expenditures for long-term care provider reimbursements.

12. Children's Continuum of Crisis Services. Establishes a one-time grant program to expand the continuum of mental health crisis services for children and youth (ages

21 and under) regardless of where they live in the state. Specifically, this bill spells out the following objectives:

a. Add child/youth-specific mobile crisis and community-based crisis stabilization support teams which can provide in-home and community-based support to the youth and family members. These teams would include clinical and paraprofessional staff who can support the youth/family until the crisis subsides or until appropriate secure alternatives are located. Essential components include:
   i. Crisis planning
   ii. Assessment of precipitant of crisis and behaviors that are accruing, and child/family safety
   iii. Stabilization of functioning
   iv. Referral and coordination
   v. Post-crisis follow-up services

b. Add triage personnel who would be available at various points of access, such as clinics and schools. These personnel could provide the following services: coordination, referral, monitoring service delivery, and providing placement service assistance.

c. Add crisis stabilization unit services lasting less than 24 hours which can provide facility-based support to children/youth who are in psychiatric crisis, as well as providing support to their family members and natural supports. The goal of crisis stabilization is to avoid the need for inpatient services during the current crisis and more importantly, to provide children/youth and the family members with the supports needed to avoid crisis in the future.

   Crisis stabilization unit programming is designed to support and assist children/youth and their caregivers to prepare for the youth's rapid return to their home and community environment. The strengths-based assessment and treatment plan will address potential barriers to this. These services must be provided at a licensed 24-hour health care facility. Essential components include:
   i. Assessment
   ii. Crisis planning
   iii. Stabilization of functioning
   iv. Referral and coordination

d. Add child/youth crisis residential services which are community-based treatment options in home-like settings that offer safe, trauma-informed alternatives to psychiatric emergency units or other locked facilities for youth under the age of 18. Child/youth crisis residential services are provided in the context of a comprehensive, multi-disciplinary, and individualized treatment plan that is frequently reviewed and updated based on the individual's clinical needs, strengths, and response to treatment. Essential components include:
   i. Therapeutic programming provided seven days a week.

ii. Facilities limited to under 16 beds with at least 50 percent of those beds in single occupancy rooms.
iii. Facilities include ample physical space for working with individuals who provide natural support to each child/youth and for integrating family members into the day-to-day care of the youth.
iv. Collaboration with each child/youth's mental health team, child and family team (CFT), and other paid and natural supports within 24 hours of intake and throughout the course of care and treatment as appropriate.

e. Add family respite care to help families and sustain caregiver health and well-being.

f. Add family support services training designed to help families participate in the planning process, access services, and navigate programs. These services will follow "a train the trainer" model which includes, at a minimum:
i. Training and education
ii. Outreach
iii. Engagement
iv. Communication
v. Advocacy

13. Office of AIDS. Makes the following changes:
a. Eliminates cost-sharing for individuals enrolled in the AIDS Drug Assistance Program with annual incomes between 400 percent and 500 percent of the federal poverty level. DPH estimates that 112 ADAP clients at this income level paid an ADAP share of cost (SOC).

b. Develops a Pre-Exposure Prophylaxis (PrEP) affordability program to cover PrEP-related copays, coinsurance, and deductibles incurred by all individuals accessing PrEP in California with annual incomes below 500 percent of the federal poverty level. The cost of this program would be capped at $1 million from the Ryan White Supplemental Drug Rebate Fund.

c. Allows the Office of AIDS' Health Insurance Premium Payment (OA-HIPP) Program to cover premiums, copays, coinsurance, and deductibles incurred by all eligible people living with HIV/AIDS in California. DPH estimates that 5,966 private insurance ADAP clients did not receive premium payment assistance from OA-HIPP Program. Consequently, this proposal would result in expenditures of $8.6 million in 2016-17 (based on calendar year 2015 data).

14. Alzheimer – Early Detection. Requires the Department of Public Health (DPH) to allocate funds to the California Alzheimer Disease Centers to determine the standard of care in early and accurate diagnosis, provide professional outreach and education, and evaluate the educational effectiveness of these efforts. (The 2016-17 budget provides funds for this purpose on a one-time basis.)

15. Hepatitis. Requires DPH to purchase and distribute hepatitis B vaccines and related materials to local health jurisdictions and community-based organizations; purchase hepatitis C test kits and related materials; train nonmedical personnel to perform hepatitis C and HIV testing; and provide technical assistance to local governments and community-based organizations regarding syringe exchange and disposal programs. (The 2016-17 budget provides funds for this purpose on a one-time basis.)

16. Naloxone. Requires DPH to award funding to local health departments, local government agencies, or on a competitive basis to community-based organizations to support or establish programs that provide Naloxone, an overdose prevention drug. (The 2016-17 budget provides funds for this purpose on a one-time basis.)

17. Covered California – Emergency Regulation Authority. Provides Covered California with emergency regulation authority in order to react to changes in federal regulations relating to notices, the special enrollment period verification process, and dental eligibility; changes related to increased enrollment in the small business exchange; and changes that may be necessary to timely implement a Section 1332 waiver.

18. California Office of Health Information Integrity. Makes technical and clarifying changes to the California Office of Health Information Integrity's duties with regard to continued compliance with the federal Health Insurance Portability and Accountability Act.

Fiscal Effect: This bill continuously appropriates the Long-Term Care Quality Assurance Fund.

Support: None on file.

Opposed: None on file.

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