SB-849 Medi-Cal. (2017-2018)

Date Published: 06/27/2018 09:00 PM

Senate Bill No. 849

CHAPTER 47

An act to amend Section 14169.53 of, to add Section 14184.90 to, and to add and repeal Section 14114 of, the Welfare and Institutions Code, relating to Medi-Cal, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 27, 2018. Filed with Secretary of State June 27, 2018.]

LEGISLATIVE COUNSEL'S DIGEST

SB 849, Committee on Budget and Fiscal Review. Medi-Cal.

(1) 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, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, an initiative measure approved as Proposition 56 at the November 8, 2016, statewide general election, increases taxes imposed on distributors of cigarettes and tobacco products and requires all revenues to be deposited into the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund, a continuously appropriated fund. Proposition 56 requires the Controller to transfer 82% of those revenues to the Healthcare Treatment Fund, to be used by the State Department of Health Care Services to increase funding for Medi-Cal and other specified health care programs and services in a way that, among other things, ensures timely access, limits geographic shortages of services, and ensures quality care. The act authorizes the Legislature to amend the provision relating to the allocation of revenues in the Healthcare Treatment Fund to further the purposes of the act with a $^{2}/_{3}$ vote of the membership of each house of the Legislature.

This bill, until January 1, 2026, would establish the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program, which would be developed by the State Department of Health Care Services to provide loan assistance payments to qualifying, recent graduate physicians and dentists that serve beneficiaries of Medi-Cal and other specified health care programs using moneys from the Healthcare Treatment Fund. By allocating revenues in that fund to the new loan repayment program, the bill would amend Proposition 56. The bill would require the department to administer separate payment pools for participating physicians and dentists, and to develop the eligibility criteria to be used to evaluate applicant physicians and dentists, including the minimum number of years a participating physician or dentist shall be a Medi-Cal enrolled provider to be eligible for loan assistance. The bill would provide that a judicial challenge to the bill's provisions establishing the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program shall be brought only within 45 days of the effective date of the bill. The bill would also provide that both the provisions establishing the program and those governing judicial challenge shall be inoperative if a single provision of either is found to be invalid.

(2) Existing law, the Medi-Cal Hospital Reimbursement Improvement Act of 2013, subject to federal approval, imposes a hospital quality assurance fee, as specified, on certain general acute care hospitals to be deposited into the Hospital Quality Assurance Revenue Fund. Existing law provides that moneys in the Hospital Quality Assurance Revenue Fund are continuously

appropriated during the first, 2nd, and subsequent program periods, as specified, and are available only for certain purposes, including, among others, paying the department's staffing and administrative costs directly attributable to implementing the quality assurance fee provisions, not to exceed $250,000, as specified. The California Constitution, pursuant to Proposition 52 as approved by voters at the November 8, 2016, statewide general election, prohibits a statute amending or adding to the provisions of the act from becoming effective unless approved by the electors, as specified, but authorizes the Legislature, by a $^2/_3$ vote in each house of the Legislature, to amend or add provisions that further the purposes of the act.

This bill would additionally make moneys in the fund available to pay for the department's staffing and administrative costs directly attributable to implementing the quality assurance fee provisions specifically incurred due to the implementation of certain federal Medicaid regulations, not to exceed $500,000, as specified. By expanding the use of moneys in the Hospital Quality Assurance Revenue Fund for additional staffing and administrative costs, this bill would make an appropriation.

This bill would declare that its provisions further the purposes of the Medi-Cal Hospital Reimbursement Improvement Act of 2013 within the meaning of a specified provision of the California Constitution.

(3) Existing law establishes the Medi-Cal 2020 Demonstration Project Act, under which the State Department of Health Care Services is required to implement specified components of a demonstration project, consistent with the Special Terms and Conditions approved by the federal Centers for Medicare and Medicaid Services. Existing law requires the department to implement the Dental Transformation Initiative (DTI), a component of the Medi-Cal 2020 demonstration project, under which DTI incentive payments are available to qualified providers who meet achievements within one or more of the project domains. Existing law authorizes the department to establish Local Dental Pilot Projects under the DTI, under which DTI incentive payments are available to approved Local Dental Pilot Projects that address certain DTI domain categories through alternative projects.

This bill would permit the department to authorize a dental integration pilot program in San Mateo County as a component of the Medi-Cal demonstration project, subject to appropriation by the Legislature and federal approval. The bill would require the department, before the start date of the pilot program, to take specified action, including seeking input from affective stakeholders. The bill would provide that enrollees of the Health Plan of San Mateo would not receive covered Medi-Cal dental care services through the Medi-Cal fee-for-service system during the pilot program, but instead the Health Plan of San Mateo would be responsible for those services. The bill would require the department to contract for an evaluation of the pilot program, using funding provided by the Health Plan of San Mateo, to be completed and published no later than December 31 of the 6th fiscal year the pilot program is in operation.

(4) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.
Vote: 2/3 Appropriation: yes Fiscal Committee: yes Local Program: no

---

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14114 is added to the Welfare and Institutions Code, to read:

14114. (a) This section shall be known and may be cited as the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act.

(b) Notwithstanding any other law, the department shall develop and administer the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program to provide loan assistance payments to qualifying, recent graduate physicians and dentists that serve beneficiaries of existing health care programs described in Chapter 7 (commencing with Section 14000) to Chapter 8.9 (commencing with Section 14700), inclusive. To implement this section, the department shall consult with other state entities, including the Office of Statewide Health Planning and Development, and with affected stakeholders.

(c) The Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program shall be funded using moneys appropriated to the department for this purpose in the Budget Act of 2018 from the Healthcare Treatment Fund established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code. The department shall administer two separate payment pools for participating physicians and dentists, respectively, consistent with the allocations provided for in the Budget Act of 2018. To the extent authorized by subdivision (f) of Section 30130.57 of the Revenue and Taxation Code, moneys appropriated to the department to implement this section shall be available to fund the administrative costs incurred by the department and any entity contracted with pursuant to subdivision (g).

(d) The department shall develop the eligibility criteria to be used to evaluate physician and dentist participation in the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program. In developing this criteria, the department shall prioritize ensuring timely access, limiting geographic shortages of services, and ensuring quality care in the Medi-Cal program. The department shall develop separate criteria for distribution of payments from the physician and dentist payment pools. At a

minimum, the department shall establish the maximum number of years a physician or dentist may be in practice to qualify for payments pursuant to this section, and the minimum number of years a participating physician or dentist receiving payments pursuant to this section shall agree to participate as an enrolled provider in the Medi-Cal program.

(e) The selection of physicians and dentists for participation in the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program and the amount of loan repayment assistance awarded to a participating physician or dentist shall be at the discretion of the department and any entity contracted with pursuant to subdivision (g), and shall be based on the criteria developed pursuant to subdivision (d). An exercise of discretion by the department and its contractors pursuant to this subdivision shall not be subject to judicial review, except that an applicant physician or dentist who is not selected for participation in the program may file for a writ of mandate pursuant to Section 1085 of the Code of Civil Procedure to rectify an abuse of discretion by the department and its contractors.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of policy letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall consult with affected stakeholders before taking action pursuant to this subdivision.

(g) To implement this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the review or approval of a division of the Department of General Services.

(h) This section shall be implemented only to the extent that the department determines that federal financial participation under the Medi-Cal program is not jeopardized. If the department determines there is a reasonable likelihood that federal financial participation is available for expenditures pursuant to this section, it may seek the federal approvals necessary to obtain federal financial participation.

(i) The Legislature finds and declares that the expenditures authorized by this section are all of the following:

(1) Made in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Article 2 (commencing with Section 30121) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code).

(2) Based on criteria developed and periodically updated as part of the annual budget process in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(3) Consistent with the purposes and conditions for expenditures described in subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(j) The Legislature finds and declares that this section is a state law within the meaning of Section 1621(d) of Title 8 of the United States Code.

(k) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

SEC. 2. Section 14169.53 of the Welfare and Institutions Code is amended to read:

14169.53. (a) (1) All fees required to be paid to the state pursuant to this article shall be paid in the form of remittances payable to the department.

(2) The department shall directly transmit the fee payments to the Treasurer to be deposited in the fund. Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on deposits in the fund from the proceeds of the fee assessed pursuant to this article shall be retained in the fund for purposes specified in subdivision (b).

(b) (1) Notwithstanding subdivision (c) of Section 14167.35, subdivision (b) of Section 14168.33, and subdivision (b) of Section 14169.33, all funds from the proceeds of the fee assessed pursuant to this article in the fund, together with any interest and dividends earned on money in the fund, shall continue to be used exclusively to enhance federal financial participation for hospital services under the Medi-Cal program, to provide additional reimbursement to, and to support quality improvement efforts of, hospitals, and to minimize uncompensated care provided by hospitals to uninsured patients, as well as to pay for the state's administrative costs and to provide funding for children's health coverage, in the following order of priority:

(A) (i) To pay for the department's staffing and administrative costs directly attributable to implementing this article, not to exceed two hundred fifty thousand dollars ($250,000), except as provided in clause (ii), for each subject fiscal quarter, exclusive of any federal matching funds.

(ii) Notwithstanding any other law, during any fiscal quarter for which the department incurs staffing or administrative costs due to the implementation of the federal Medicaid pass-through payment requirements codified in Section 438.6 of

Title 42 of the Code of Federal Regulations as of March 20, 2017, or other federal requirements imposed as of the effective date of the act that added this clause, which significantly impact the implementation of this article, to pay for the department's staffing and administrative costs that are directly attributable to implementing this article, not to exceed five hundred thousand dollars ($500,000) for each subject fiscal quarter, exclusive of any federal matching funds.

(B) To pay for the health care coverage, as described in subdivision (g), except that for the two subject fiscal quarters in the 2013–14 fiscal year, the amount for children's health care coverage shall be one hundred fifty-five million dollars ($155,000,000) for each subject fiscal quarter, exclusive of any federal matching funds.

(C) To make increased capitation payments to managed health care plans pursuant to this article and Section 14169.82, including the nonfederal share of capitation payments to managed health care plans pursuant to this article and Section 14169.82 for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(D) To make increased payments and direct grants to hospitals pursuant to this article and Section 14169.83, including the nonfederal share of payments to hospitals under this article and Section 14169.83 for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)).

(2) Notwithstanding subdivision (c) of Section 14167.35, subdivision (b) of Section 14168.33, and subdivision (b) of Section 14169.33, and notwithstanding Section 13340 of the Government Code, the moneys in the fund shall be continuously appropriated during the first program period only, without regard to fiscal year, for the purposes of this article, Article 5.229 (commencing with Section 14169.31), Article 5.228 (commencing with Section 14169.1), Article 5.227 (commencing with Section 14168.31), former Article 5.226 (commencing with Section 14168.1), former Article 5.22 (commencing with Section 14167.31), and former Article 5.21 (commencing with Section 14167.1).

(3) Notwithstanding any other law, for the second program period and subsequent program periods, the moneys in the fund shall be continuously appropriated, without regard to fiscal year, for the purposes of this article and Sections 14169.82 and 14169.83.

(c) Any amounts of the quality assurance fee collected in excess of the funds required to implement subdivision (b), including any funds recovered under subdivision (d) of Section 14169.61, shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital, subject to the limitations of federal law. If federal rules prohibit the refund described in this subdivision, the excess funds shall be used as quality assurance fees for the next program period for general acute care hospitals, pro rata with the amount of quality assurance fees paid by the hospital for the program period.

(d) Any methodology or other provision specified in this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance the probability that federal approval can be obtained, provided the modifications do not violate the spirit, purposes, and intent of this article and are not inconsistent with the conditions of implementation set forth in Section 14169.72. The department shall notify the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature 30 days prior to implementation of a modification pursuant to this subdivision.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14169.52 in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

(f) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt providers identified in this article as exempt from the fees specified, including the submission, as may be necessary, of a request for waiver of the broad-based requirement, waiver of the uniform fee requirement, or both, pursuant to paragraphs (1) and (2) of subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(g) (1) For purposes of this subdivision, the following definitions shall apply:

(A) "Actual net benefit" means the net benefit determined by the department for a net benefit period after the conclusion of the net benefit period using payments and grants actually made, and fees actually collected, for the net benefit period.

(B) "Aggregate fees" means the aggregate fees collected from hospitals under this article.

(C) “Aggregate payments” means the aggregate payments and grants made directly or indirectly to hospitals under this article, including payments and grants described in Sections 14169.54, 14169.55, 14169.57, and 14169.58, and subdivision (b) of Section 14169.82.

(D) “Net benefit” means the aggregate payments for a net benefit period minus the aggregate fees for the net benefit period.

(E) “Net benefit period” means a subject fiscal year or portion thereof that is in a program period and begins on or after July 1, 2014.

(F) “Preliminary net benefit” means the net benefit determined by the department for a net benefit period prior to the beginning of that net benefit period using estimated or projected data.

(2) The amount of funding provided for children’s health care coverage under subdivision (b) for a net benefit period shall be equal to 24 percent of the net benefit for that net benefit period.

(3) The department shall determine the preliminary net benefit for all net benefit periods in the first program period before July 1, 2014. The department shall determine the preliminary net benefit for all net benefit periods in a subsequent program period before the beginning of the program period.

(4) The department shall determine the actual net benefit and make the reconciliation described in paragraph (5) for each net benefit period within six months after the date determined by the department pursuant to subdivision (h).

(5) For each net benefit period, the department shall reconcile the amount of moneys in the fund used for children’s health coverage based on the preliminary net benefit with the amount of the fund that may be used for children’s health coverage under this subdivision based on the actual net benefit. For each net benefit period, any amounts that were in the fund and used for children’s health coverage in excess of the 24 percent of the actual net benefit shall be returned to the fund, and the amount, if any, by which 24 percent of the actual net benefit exceeds 24 percent of the preliminary net benefit shall be available from the fund to the department for children’s health coverage. The department shall notify the Joint Legislative Budget Committee and the fiscal and appropriate policy committees of the Legislature of the results of the reconciliation for each net benefit period pursuant to this paragraph within five working days of performing the reconciliation.

(6) The department shall make all calculations and reconciliations required by this subdivision in consultation with the hospital community using data that the department determines is the best data reasonably available.

(h) After consultation with the hospital community, the department shall determine a date upon which substantially all fees have been paid and substantially all supplemental payments, grants, and rate range increases have been made for a program period, which date shall be no later than two years after the end of a program period. After the date determined by the department pursuant to this subdivision, no further supplemental payments shall be made under the program period, and any fees collected with respect to the program period shall be used for a subsequent program period consistent with this section. This subdivision does not affect the department’s authority to collect quality assurance fees for a program period after the end of the program period or after the date determined by the department pursuant to this subdivision. The department shall notify the Joint Legislative Budget Committee and fiscal and appropriate policy committees of that date within five working days of the determination.

(i) Use of the fee proceeds to enhance federal financial participation pursuant to subdivision (b) shall include use of the proceeds to supply the nonfederal share, if any, of payments to hospitals under this article for services provided to individuals who meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described in Section 1905(y) of the federal Social Security Act (42 U.S.C. Sec. 1396d(y)) such that expenditures for services provided to the individual are eligible for the enhanced federal medical assistance percentage described in that section.

SEC. 3. Section 14184.90 is added to the Welfare and Institutions Code, to read:

14184.90. (a) Subject to appropriation by the Legislature, beginning no sooner than July 1, 2019, and consistent with Section 14184.20, the department may authorize a dental integration pilot program in San Mateo County as a component of the Medi-Cal 2020 demonstration project established by this article, or any extension or amendment to the Medi-Cal 2020 demonstration project pursuant to subdivision (j) of Section 14184.20. The pilot program shall be designed to test the impact to oral care access, quality, and utilization, as well as medical cost impacts by the delivery of covered dental care services as a managed care benefit under the operation of the Health Plan of San Mateo.

(b) Before the start date of the approved pilot program, the department shall do all of the following:

(1) Seek input from affected stakeholders including, but not limited to, the Health Plan of San Mateo, currently enrolled Medi-Cal dental providers, other dental providers, and consumer advocates.

(2) Establish objectives for improving dental utilization through the pilot program.

(3) Establish objectives for improving access to oral health care through the pilot program.

(4) Determine that the Health Plan of San Mateo meets the department's readiness requirements, including, but not limited to, the demonstration of an adequate network of dental care providers.

(c) Under the approved pilot program, covered Medi-Cal dental care services currently provided under the Medi-Cal fee-for-service system to enrollees of the Health Plan of San Mateo shall be made the responsibility of the Health Plan of San Mateo, including covered dental care services provided through safety net clinics, such as federally qualified health centers. For the duration of the approved pilot program, enrollees of the Health Plan of San Mateo will no longer receive covered Medi-Cal dental care services through the Medi-Cal fee-for-service system.

(d) To minimize interruptions in ongoing dental care, enrollees impacted by the approved pilot program who have been in treatment with a specific Medi-Cal dental provider for more than 12 months shall be permitted to continue to receive covered dental services from that provider, if all of the following are met:

(1) The provider is willing to continue to treat the enrollee at existing Medi-Cal fee-for-service rates, or at another rate or rate methodology as agreed upon by the plan and provider.

(2) The provider remains an eligible provider of dental services in Medi-Cal.

(3) The Health Plan of San Mateo has not identified a significant quality issue with the provider.

(e) The pilot program described in this section shall be authorized for no more than a period of six years.

(f) Pursuant to subdivision (e) of Section 14184.20, and to the extent the department obtains federal approval for the pilot program described in this section, the department shall contract with an external entity to conduct an evaluation of the pilot program to be completed and published no later than December 31 of the sixth state fiscal year the pilot program is in operation. The evaluation shall include all of the following:

(1) Assessment of the pilot program's ability to meet the utilization objectives established in this section.

(2) Assessment of the pilot program's ability to meet the improved access objectives established in this section.

(3) Assessment of overall dental utilization and changes in utilization compared to utilization in the fee-for-service system that occurred prior to the pilot program.

(4) Assessment of the medical cost impacts of the pilot program, if any, such as reductions in emergency room visits.

(5) Assessment of the impacts to the available provider network for dental services in the pilot program compared to the provider network available in the fee-for-service system before the pilot program.

(g) The funding for the evaluation described in subdivision (f) shall be provided by the Health Plan of San Mateo to the department. The department shall seek federal matching funds if available.

(h) The department shall consult with the Health Plan of San Mateo no later than six months before the start date of the approved pilot program regarding any necessary adjustments to its capitation rates developed pursuant to Section 14301.1 and methods required to integrate dental care services for plan enrollees.

(i) (1) This section shall not be implemented until all necessary federal approvals have been obtained.

(2) This section shall be implemented only to the extent the department determines federal financial participation is available and is not otherwise jeopardized.

SEC. 4. (a) A judicial action or proceeding to challenge, review, set aside, void, or annul the provisions of Section 14114 of the Welfare and Institutions Code, as added by this act, may proceed only by application or complaint filed within 45 days of the effective date of this act.

(b) It is the intent of the Legislature to simultaneously enact each provision of Section 14114 of the Welfare and Institutions Code and this section of the bill. If any provision of Section 14114 of the Welfare and Institutions Code or this section is held unconstitutional, unenforceable, or otherwise invalid, both Section 14114 of the Welfare and Institutions Code and this section shall become inoperative.

SEC. 5. The Legislature finds and declares that the amendments made to the Medi-Cal Hospital Reimbursement Improvement Act of 2013 by this act further the purposes of the act within the meaning of Section 3.5 of Article XVI of the California Constitution.

SEC. 6. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.