

DEPARTMENTAL UPDATES

Lesley Cummings, Executive Director, Managed Risk Medical Insurance Board

- Regarding the Healthy Families Program, MRMIB implemented a waiting list that had to be maintained for a couple of months, for children, due to inadequate funding provided by the budget. The First Five Commission granted EMSA \$81 million, which enabled MRMIB to reopen the Healthy Families Program, which serves children, who are presently up to 250% of the Federal poverty level. The Healthy Families Program provides coverage where Medicaid coverage ends. This is a separate program from Medi-Cal. EMSA charges premiums and co-payments for services and they have similar, but slightly different practices from Medi-Caid Managed Care.
- MRMIB programs are affected since the Governor has proposed for a reduction in program eligibility from 250% of the Federal poverty level to 200% of the Federal poverty level. The Governor has also called for increased premiums for people between 150% and 200% of the Federal poverty level and elimination of division benefits. These proposals are being addressed in a special session and the deadlines for legislative action have not occurred.
- An area that MRMIB has always been delighted to provide funding for is related to the Healthy Families Program, the Rural Health Demonstration projects. There is no funding to continue these projects next year, but MRMIB is still in the process of administering 42 projects that have been funded in the past.
- MRMIB continues to provide a program that serves persons who frequently relocate for their job, particularly migrant workers, foresters, etc. and they can be enrolled in a plan that allows coverage wherever they may be living without having to re-enroll each time they move. This will be challenging in the budget year since funds are not budgeted for plan rate increases.

Bonnie Sinz, RN, BS, Chief, EMS Systems, Emergency Medical Services Authority **(Representing Director Steven Tharratt, MD, Emergency Medical Services Authority)**

- There are 58 counties in California; EMS has 31 local agencies. EMSA has regional agencies in rural areas where multiple counties create an EMS agency. There are 7 of those and the remaining 24 are single county agencies.
- EMSA is divided into 3 divisions: EMS Systems, Personnel, and the Disaster Divisions. The Systems Division is very active with a key project developing a State Trauma System. The State is divided into 5 regions, known as Rural Trauma Coordinating Committees and they are: Northern Region, in Sacramento; the Bay Area; Central California; Southern California has 2: the Southwest Region, and the Southeast Region.
- Current efforts are underway to implement a regional approach to trauma systems, dealing with resources, using available resources, needs assessment and trying to

standardize some of the triage criteria for the delivery of trauma patients to trauma hospitals. Part of the State trauma system development is the development of a State trauma plan, which hopefully there will be a draft form available by the December Trauma Summit in San Francisco.

- EMS Systems Division has started a new data project, referred to as CEMSIS, which is the California EMS Information System. The Office of Traffic Safety provided funding for CEMSIS, which provides a data system for all trauma patients that go to trauma centers to have data records. All EMS records, which are pre-hospital care records, are also in that system.
- The Poison Center was saved from the fiscal crisis cuts thanks to MRMIB funding.
- EMSA is working on the development of STEMIE and stroke systems within the State and is working in conjunction with the American Heart Association, the American Stroke Association, and the California Department of Public Health.
- Another project to resurface on July 1st is in regards to the first central registry in California for paramedics and EMT's. Certification will be standardized to allow pre-hospital care personnel to provide services in different areas of the State.
- EMSA worked closely with the DPH and DHCS on the H1N1 issues, which are concluding soon.

David Maxwell-Jolly, PhD, Director, Department of Health Care Services

- DHCS is focusing on efforts to increase the level of Federal financial support for the program and we want to ensure that people are aware of the efforts in Washington of trying to convince the Federal government to increase support for California. Request was made to extend the stimulus package increase, the Federal matching rate that we get under ARRA, for at least an additional 6 months. It's part of the President's budget and seems to have a good chance of passing.
- DHCS is also trying to make a case for the inadequacy of the existing formula for calculating the financial participation in the Medicaid program, the so called FMAP. It's based on an average per capita income, and while California has a relatively high per capita income compared to other states, we believe the formula doesn't take into account California's relatively high poverty rate and relatively high level share of the population that's included in the Medicaid program. We would like to suggest that the formula be reconsidered. Additional Federal revenues will be critical to putting together the final package of benefits in the Medicaid program. DHCS spends 15% of the General Fund expenditures and in any case where there's a significant shortage of the General Fund, we have to be at the table and contributing to those reductions.
- Another issue is the planning of the renewal of the 1115 waiver. On the DHCS website, there's a waiver renewal button that will lead to an extensive set of

documentation and a journey through an extensive stakeholder process that we have initiated to discuss how we are planning to move forward with the new waiver. There are a lot of people within the State who are participating in the process. It can be followed on the phone or anybody can attend the stakeholder meetings and participate in the discussions. The waiver offers a great opportunity for us to rethink how we are delivering Medi-Cal services, reorganize deliveries to help reduce the rate of growth in the Medi-Cal program, and to get us in a better budget position for the future.

Stephen W. Mayberg, PhD, Director, Department of Mental Health

- The positive news at DMH is that Proposition 63, the Mental Health Services Act, continues to be a viable source of funding and we have plans submitted to begin implementing many of our prevention and early intervention programs starting in July, with several hundred million dollars being infused into the system.
- There is more focus on integration with other entities than have been in the past. Two very critical areas that have been addressed are the integration with physical health care and the realization that you cannot separate the mind and the body, and that there are interesting programs that are being suggested to start addressing those issues. The Department of Health Care Services is looking at the needs for this vulnerable population to be able to provide better care, including how to control costs.
- Another area being looked at is the issue with co-occurring disorders, substance use, and mental health issues which are not addressed accordingly and the end result is people end up in the emergency room and physical health care system.

Michael S. Cunningham, Department of Alcohol and Drug Programs
Representing Director Renée Zito, LMSW, CASAC

- A primary area of focus is in unifying ADP's workforce development by having State licensure and certification for our alcohol and other drug counselors throughout the State, including those who practice in the private sector, as well as those who work in the programs. For the first time, this also includes the establishment of a tiered system, which will have counselors, as well as clinical supervisors. The purpose is to look at how to best include the quality of care throughout ADP's system and how to create workforce opportunities.
- We are also focusing on re-engineering the entire ADP system of services and to establish, through the State, a recovery oriented system of care. The current focus is primarily on acute care. ADP is trying to orient the system, recognizing that alcohol and other drug problems, and dependency, are chronic disorders and, as such, the need is there to focus not only on acute services, but also to engage in recovery management and continuing care.

- ADP has a core set of treatment standards for the first time and for improving quality of care. These treatment standards are based on work by the National Quality Forum and the focus is on how ADP can best establish the types of standards within ADP's system. This will facilitate ADP programs and will continue to improve the quality of services and implementation of evidence-based practices. Pilot programs are being established; 2 of which are in smaller rural counties and ADP will be looking at both the impact of these standards in the large urban counties, as well as in smaller rural counties.
- Another area being looked at is how ADP can best screen all participants who go through not only ADP programs, but also all of healthcare, and so that there's early identification of alcohol and other drug problems.

Stephanie Clendenin, Chief Deputy Director (Acting), OSHPD

Representing Director David M. Carlisle, MD, PhD

- OSHPD is the recipient of 2 grants funded by the American Reinvestment and Recovery Act (ARRA). These grants are designed to increase access to healthcare services provided in the healthcare shortage areas. The first grant is a \$2 million National Health Service core grant to support the State Loan Repayment Program. These grants provide up to \$120,000 to primary care physicians, dentists, dental hygienists, physician assistants, nurse practitioners, certified nurse midwives, and mental health providers who practice in defined health professions shortage areas. To qualify for these funds, providers must commit to practice in medically underserved areas in the public or nonprofit entities for a minimum of 2 years, up to a maximum of 4 years. OSHPD is now accepting applications for these opportunities, which are taken on a first-come, first-served basis. The awards will go through September 29th or until all funds have been depleted.
- The second of our stimulus grants of \$193,000 was awarded in partnership with the California Area Health Education Center and the California Primary Care Association, to implement the California Student Resident Experiences and Rotations in Community Health Program, also known as the Cal-SRERCH program. This program is designed to support 75 health professions students and residents who will receive 4 to 6 week clinical rotation opportunities in California clinics and community health centers. The students and residents, as well as clinic and community health centers who host the students and residents, will receive stipends for participating in the Cal-SRERCH program. The student stipends are \$665 and the clinic and community health centers will receive \$1,000 for each student they host. The targeted disciplines are medical students, residents in family medicine, internal medicine, pediatrics, OB-GYN, dentistry, nurse practitioners, and physician assistants. We encourage people to share this information to aspiring health providers who can benefit from these new programs.

- Regarding the Legislative changes resulting from SB 499, a Ducheny bill that was passed last year, this bill relates to seismic safety compliance for hospitals and will now require that hospitals with buildings located in seismic performance Category 1 submit data to OSHPD on an annual basis, starting this November. Templates are being developed and the goal is to make them available to hospitals online. A penalty of \$10 per day, per bed will be assessed for each SPC1 building that is not reported by the deadline, up to a maximum of \$1,000 per day, per building.
- OSHPD's Cal-Mortgage Loan Insurance Program remains a viable source for the financing of construction projects for district and nonprofit hospitals. This program has approximately \$1.3 billion of loan insurance capacity and has been very active during these times of diminished credit availability.

PUBLIC TESTIMONY

Karyn Karp, past President of the California Association of Nurse Anesthetists

- CANA is pleased to announce that California is now exempted from the Federal CMS Condition of Participation for supervision of nurse anesthetists. As there is no supervision required by State or Federal regulations, rural and urban hospitals are now unencumbered by restrictions regarding CRNA practice. Six California counties are served solely by nurse anesthetists and 80% of California counties utilize CRNA service independent of physician anesthesiologists in a variety of practice settings. The exemption assures access to care and affords healthcare facilities the flexibility to staff their anesthesia departments and deliver services in a manner that best suits their communities.

Raymond Hino

- Regarding expansion of Medi-Cal Managed Care into the counties that have not yet experienced Medi-Cal Managed Care, a plan has been established to expand into Mendocino and Lake Counties, which only have a total of 5 rural hospitals in the 2 counties; 4 of those are CAH's, which are cost-based. There's a concern that expansion of Medi-Cal Managed Care into those 2 counties would result in additional discounting of services beyond what those hospitals are currently providing and would be detrimental to the care provided in those rural areas. Is it possible to reconsider expansion of Medi-Cal Managed Care into the rural counties? I would urge you to consider that Mendocino and Lake Counties are rural counties. Hopefully Managed Care would not be set up with competitive discount contracting in mind, as this may result in covered lives being moved out of our counties into a larger county, such as Sonoma County, to save money. If a system is set up having contracts go to the lowest bidder and perhaps that lowest bidder might be an urban hospital, the result may be in covered lives being moved out of Mendocino and Lake Counties in order to achieve cost savings for the State. This would have a devastating affect with people essentially being shut out of utilizing their local

physicians and local facilities. These small areas don't have a large county hospital to take care of patients in our area and there's little room for cutting.

Mickey Richie, Regional Center of Rural Counties (RCRC)

- I'm on a task force with county representatives and Department of Corrections and Rehabilitation representatives regarding the mental health, physical health, and substance abuse needs of prisoners and parolees that are to be released early from State prisons (including medical releases). Is the impact on county mental health, physical health and substance abuse, and social services being discussed at the Health and Human Services Agency level? Or is this just a County Corrections issue? This would include DHCS programs, since Medi-Cal programs would be needed.

Gail Nickerson, California Association of Rural Health Clinics (CARHC)

- CARHC is a fairly new organization with approximately 270 rural health clinics in California and 40 out of 58 counties have at least one.
- Regarding the Cal-SRERCH program, are rural health clinics included? If nonprofit is an issue, about half of rural health clinics are nonprofit. I hope that some of those Cal-SRERCH people end up in rural health clinics, according to the California definition, because it makes kind of two worlds of clinics and we don't really need that. We're trying to take care of the same people, who are underserved in medically underserved areas.
- Also, CARHC is sponsoring its annual meeting in Sacramento on June 23rd and all State employees who wish to learn more about rural health clinics are invited to attend for free.

Kurt Hahn, North Sonoma County Healthcare District

- We are involved in 2 endeavors regarding telemedicine, with 6 hospitals participating, and a group of intensivists that provide 24/7 support for our ICU's on the North Coast. This has facilitated the reopening of a number of ICU's and has strengthened the safety backbone on the North Coast by providing the intensivist support that none of us individually could afford to have on site.
- We also participate in a stroke program that is supported by Cal Pacific Medical Center, neurology support on a 24/7 basis, utilizing telemedicine, and it has dramatically increased the stroke survival rate amongst people that would otherwise not make it to a regional trauma center or to other locations. Despite the fact that the Federal Communications Commission and other entities have funded the expansion of the telemedicine network in California for Critical Access Hospitals connecting to major teaching hospitals, CMS has gone in the opposite direction in cutting funding. This is not something that requires State money. Senator Feinstein's office has made the point that the President has,

on 3 occasions, in discussing healthcare reform, mentioned telemedicine, yet the bureaucrats at CMS are not supportive of telemedicine and are cutting away at the reimbursements, including all consults. Senator Feinstein and Congressman Rangel, two powerful Congress members, need a full briefing and active advocacy on behalf of State government to support another State program that's underway now, with the expansion of internet services connecting Critical Access Hospitals and teaching hospitals. I encourage State staff to remember that this is an important part of our safety net in California and if we don't have support from CMS for issues the President is advocating, his words are somewhat worthless.

- Secondly, Dr. Carlisle and OSHPD's efforts are appreciated regarding the process of construction project reviews and the staffing that he has provided. But the current furlough process is being utilized by some OSHPD bureaucrats as an excuse to delay things more than the 3 furlough days. I understand a waiver is being considered, which I encourage you to support for the furlough, especially since OSHPD is a fee-supported entity and it has no impact on the State's General Fund at all. There is a lot of pending construction that would help generate jobs in California and anything that can be done to expedite those jobs should be supported by everybody, from the Governor on down.

Meeting adjourned at 8:45 a.m.