AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

MONDAY, MAY 6, 2013

1:30 P.M. OR UPON ADJOURNMENT OF ASSEMBLY SESSION - STATE CAPITOL ROOM 4202

VOTE-ONLY CALENDAR

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ITEMS TO BE HEARD

VOTE ONLY

4150 DEPARTMENT OF MANAGED HEALTH CARE

The following three items were all heard by the Subcommittee on April 22, 2013. Please see the Subcommittee agenda for that hearing for additional detail.

ISSUE 1: HEALTH PREMIUM RATE REVIEW BCP

DMHC requests to convert 2.0 limited-term positions, set to expire June 30, 2013, to permanent and $344,000 (on an ongoing-basis) from the Managed Care Fund to address the health premium rate review workload as specified in the Affordable Care Act (ACA) and supported by SB 1163 (Statutes of 2010). The positions requested are one Senior Life Actuary and one Associate Life Actuary.

Staff Recommendation: Approve as proposed**.**

ISSUE 2: MEDI-CAL MANAGED CARE RURAL EXPANSION BCP

BCP: DMHC requests 3.5 positions and $510,000 for 2013-14 and $470,000 for 2014-15 and ongoing to address workload attributable to the expansion of Medi-Cal managed care into 28 rural counties, as mandated by AB 1468 (a 2012 budget trailer bill).

This request also includes $130,000 for consultant services to perform annual medical surveys of health plans. The proposal will be funded by 50 percent Managed Care Fund and 50 percent reimbursement from the Department of Health Care Services (DHCS) in the form of a federal match.

Staff Recommendation: Approve as proposed**.**

ISSUE 3: CONSUMER ASSISTANCE PROGRAM FEDERAL GRANT REAPPROPRIATION SFL

DMHC is requesting authority to reappropriate $1,058,000 in federal funds from 2012-13 to 2013-14, in order to extend 4.0 limited-term positions until June 30, 2014 in order to fulfill the terms of the federal Consumer Assistance Program Grant.

Staff Recommendation: Approve as proposed**.**

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: 1991-92 REALIGNMENT GROWTH—MENTAL HEALTH & CALWORKS MOE SUBACCOUNTS PROPOSED TRAILER BILL

The Administration has proposed trailer bill that would change the growth formula for mental health realignment funds, beginning in 2015-16, in order to share that growth equally between the state and counties.

This item was heard by the Subcommittee on March 18, 2013. Please see the Subcommittee agenda for that hearing for additional detail.

Staff Recommendation: Deny proposal and trailer bill**.**

ISSUE 2: ANNUAL OPEN ENROLLMENT PROPOSAL & TRAILER BILL

The DHCS is proposing trailer bill language that would change the enrollment model for Medi-Cal managed care beneficiaries who are enrolled in Two-Plan Model and Geographic Managed Care counties to an annual enrollment period; an enrollee could only change plans once a year as compared to monthly which is currently allowed. The January budget includes $2 million in savings ($1 million General Fund) as a result of this change.

This item was heard by the Subcommittee on April 8, 2013. Please see the Subcommittee agenda for that hearing for additional detail.

Staff Recommendation: Deny proposal and trailer bill**.**

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: DRINKING WATER STATE REVOLVING FUND – SMALL WATER SYSTEMS SFL

DPH is requesting 7.0 permanent positions and $3.74 million ($2,750,000 Small System Technical Assistance Account; $991,000 Safe Drinking Water State Revolving Fund) to address small community water systems that are currently not in compliance with primary drinking water quality standards.

This item was heard by the Subcommittee on April 15, 2013. Please see the Subcommittee agenda for that hearing for additional detail.

Staff Recommendation: Approve as proposed**.**

ITEMS TO BE HEARD

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 1: OFFICE OF AUDITS SFL

The Department of State Hospitals (DSH) requests $529,000 General Fund and 4.5 positions for 2013-14, and $679,000 General Fund and an additional 1.5 positions (6.0 total in combination with the 4.5 in 2013-14) in 2014-15 to staff a new Office of Audits within the Department of State Hospitals (DSH).

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

DSH currently does not have an internal audit function. Over the past five years, the department has been audited by the Department of Finance (DOF), Office of Audits and Evaluation (OSAE), and the Bureau of State Audits (BSA), and conducted its own internal review of its administrative functions in 2011. The audit findings present a need for stronger internal audit and compliance capabilities to monitor, manage, and improve department policies and procedures. Following are overviews of some of the audit findings in recent years.

In 2007, the OSAE conducted an audit of the former Department of Mental Health (DMH) budget, which included a couple of key findings: 1) the staffing model did not adequately reflect hospital workload; and, 2) funding was insufficient for annual operating expenditures. The OSAE also identified the seeds of a fiscal problem that would eventually become a major contributor to fiscal deficiencies: the DMH used salary savings to offset operating expenditures and equipment (OE&E). Over the following several years, salary savings decreased as the number of vacancies decreased, and OE&E costs rose, leading to unavoidable deficits. Per the 2012 Budget Act, the OSAE has just completed a follow-up audit that found, overall, DSH implemented 22 recommendations; implementation of nine recommendations is in progress, 46 recommendations have not been implemented, and eight are no longer applicable.

In 2011, in order to gain a clearer understanding of the causes of fiscal deficiencies, the DMH assembled a team of staff and retired annuitants, with extensive state management experience, to investigate and analyze the state hospitals' budget. The original purpose of the project was to collect information necessary to develop recommendations for the new administrative structure for the newly proposed DSH. However, ultimately the scope of the

project was widened to address the growing deficits and related fiscal challenges. Building on the 2007 OSAE audit, the 2011 report provided a similar but clearer picture of the unsustainable fiscal management of the state hospitals, which they explained as a combination of increasing costs coupled with decreasing resources. The decreasing resources occurred through a combination of budget reductions, such as a $75 million reduction between 2008-09 and 2009-10, and the decreasing availability of salary savings mentioned above. The increasing costs are complex, involving the following key issues: 1) the federal Civil Rights of Institutionalized Persons Act (CRIPA); 2) violence-related costs; 3) unfunded overtime; and, 4) lack of budget transparency.

These recent audits show that DSH has a critical need to ensure that all administrative policies and procedures are implemented consistently across all of its facilities. Historically, the hospitals have functioned as relatively autonomous entities. The department is now taking a system-wide approach to its hospital operations to improve the efficiency and effectiveness of its operations, ensuring that the hospitals are consistently compliant with state administrative rules and policies.

The state standards for internal audit and control review as stated in Government Code Section 1237, recommend an internal audits function be considered for departments spending $50 million or more annually. The DSH budget includes approximately $1.6 billion General Fund. The Administration sites all of the following as examples of departments that already contain audit staff to perform this type of internal audit functions: Aging, Alcohol and Drug Programs, Health Care Services, Public health, Developmental Services, Rehabilitation, Child Support Services, and Social Services.

The proposed resources would consist of 1.0 Supervising Governmental Auditor and 3.5 Associate Management Auditor staff to develop a risk assessment, audit plan, and workload analysis. Once complete in 2014-15, 1.5 full-time additional audit staff positions will allow the DSH to dedicate one auditor to each of the major areas in administrative services: accounting, budgets, contracts, purchasing and personnel. This level of staffing would allow for a representative sampling of work to be reviewed from each facility on an annual basis.

STAFF COMMENTS/QUESTIONS

In recent years, the DSH has experienced significant fiscal and operational control issues. Audits and internal reviews have noted numerous deficiencies, many of which relate to a lack of central control and oversight. The department is currently taking steps to rectify these issues. As discussed in prior Subcommittee agendas, the department is focused on moving toward a single system and establishing enhanced information tracking and sharing capabilities. This proposal is consistent with these efforts.

The Subcommittee has asked DSH to present this proposal, and to please describe how this proposed Office of Audits will be similar to audit functions in other state departments.

Staff Recommendation: Approve as proposed**.**

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

ISSUE 1: HEALTHCARE REFORM HEALTHCARE WORKFORCE DEVELOPMENT SFL

The Office of Statewide Health Planning & Development (OSHPD) is requesting $286,000 (California Health Data and Planning Funds) and authority to extend 4.0 limited term positions for one year to complete the process of proactive designation of Medically underserved Areas and Populations, and to implement OSHPD's health care reform work plan and report on its progress at the end of the 2013-14 fiscal year.

PANELISTS

- Office of Statewide Health Planning & Development
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

Of the 4.0 positions proposed to be extended, 3.0 are responsible for proactively working with communities to identify sites and acquire designations for those sites as Primary Care, Dental, and Mental health Professional Shortage Areas (HPSA), Medically Underserved Areas (MUA) and Medically Underserved Populations (MUP). This "proactive process" allows OSHPD to prepare applications for these designations on behalf of communities that qualify by identifying areas of the state that meet the federal criteria for designation. Federal law gives OSHPD the authority to process these applications; OSHPD is the only entity in California that processes federal designation applications. OSHPD receives annual federal grants to serve as a liaison for the federal government, and as the Shortage Designation Program expert for California. In 2010-11, OSHPD received three two-year limited-term positions for the purpose of conducting proactive HPSA designations. OSHPD has found that California receives almost $1.5 billion in federal, state, local, and private funding for programs for which one of the pre-requisites for participation is a HPSA, MUA, or MUP designation. Moreover, increasing the number of HPSAs, MUAs, and MUPs in California increases the ability of clinics to take advantage of the Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) status, thereby increasing federal funds to the state's clinics.

The other 1.0 position proposed for extension is responsible for implementing the Healthcare Reform work plan developed by OSHPD required by the federal Affordable Care Act (ACA). Per ACA requirements, OSHPD's role is to understand the challenges inherent in California's healthcare infrastructure and workforce, and develop program and activities that expand and equitably distribute California's health workforce. To this end, OSHPD developed a work plan, and this extension will allow for the full implementation of this work plan. The work plan seeks to increase California's primary care workforce by 10-25 percent over ten years. The work plan also includes over 125 recommendations developed by the California Workforce Investment Board, focused on five areas: stakeholder engagement; program development and evaluation; resource development; research and analysis; and policy analysis.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked OSHPD to present this proposal.

Staff Recommendation: Approve as proposed**.**

ISSUE 2: MENTAL HEALTH WORKFORCE, EDUCATION & TRAINING SFL

OSHPD requests that provisional language be added to the budget to allow funds appropriated in items related to Mental Health Workforce, Education and Training (WET) programs be available through 2017-18, in order to conform to Welfare and Institutions Code Section 5892, which allows funds for education and training to be retained for up to ten years.

OSHPD also requests that $2,217,000 in unexpended 2012-13 Proposition 63 (Mental Health Services Act/MHSA) funds be reappropriated, for WET programs and Mental Health Loan Assumption Program. OSHPD also requests budget bill language to allow for the reappropriation and for the funds to be available through June 30, 2018.

PANELISTS

- Office of Statewide Health Planning & Development
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

As discussed in detail in the Subcommittee's agenda for April 15, 2013, the MHSA WET program was transferred from the former DMH to OSHPD in 2012, as part of the elimination of the DMH. The WET program seeks to address the shortage of mental health providers in California. Particularly severe shortages exist for mental health practitioners with skills to work effectively with the following populations: children, transition-aged youth, older adults, and diverse ethnic/cultural populations. Current WET programs include stipends to mental health care students; the Mental Health Loan Assumption Program (MHLAP) that repays educational loans; grants to train Physician's Assistants in mental health via the Song-Brown program; expansions to psychiatric residency programs; a Technical Assistance Center to increase the employment of consumers and family members; identification of Health Professional Shortage Areas in mental health, and funding for county Regional Partnerships. OSHPD is in the process of developing the second 5-year WET plan, as required by the MHSA.

The full 2012-13 WET (Proposition 63) appropriation was $22.8 million, of which OSHPD has expended $20.6 million, leaving $2.2 million in yet unexpended funds which OSHPD is requesting to be reappropriated. According to OSHPD, there are a variety of program-specific reasons for the funds not being fully expended, including: 1) the MHLAP designates funding for every county, although some counties do not have professionals with qualifying educational loans in certain years; 2) sometimes students drop out of the stipend program; and, 3) OSHPD did not receive a sufficient number of applications to expend all of the Song-Brown funding.

Of the $2.2 million proposed to be reappropriated, $632,000 will be allocated to the MHLAP through 2017-18. OSHPD expects the applicant pool to increase as counties recruit provider to meet increased demand (in part associated with ACA implementation). The remaining $1.5 million will be used to implement the second 5-year WET plan, and the priorities identified in that plan.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked OSHPD to present this proposal.

Staff Recommendation: Approve as proposed, including the proposed budget bill language.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: DRINKING WATER PROGRAM -- US EPA NOTICE OF NON-COMPLIANCE

On April 15, 2013, the Subcommittee heard the Department of Public Health's proposed Spring Finance Letter regarding requesting resources to address small community water systems that are out of compliance with primary drinking water quality standards. This hearing included a discussion of broader issues and concerns that have been raised recently regarding the drinking water program at DPH. This item is a follow-up to that discussion in response to subsequent developments. On April 19, 2013, DPH received a notice of non-compliance from the United States Environmental Protection Agency stating that DPH is "in non-compliance with the Safe Drinking Water Act." This notice is described in more detail below.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

Over the past several years, the Legislature has focused oversight efforts on the provision of safe drinking water throughout the state, and in particular to small, disadvantaged communities mainly in rural areas. The 1969 Porter-Cologne Water Quality Act established the state's role in the protection of water quality and was followed by various groundwater and drinking water protection laws throughout the following decades. The Legislature, starting in 2008, has held numerous oversight hearings discussing groundwater and drinking water legislation, with a focus on providing clean drinking water, and looking at the root causes of water quality degradation. The conclusion of these hearings, as well as various reports, is that the majority of water supply in California is safe and clean. However, where there are gaps in some areas, the provision of water is a challenge, particularly in small, disadvantaged, and rural communities.

SB 1 2X (Perata), Chapter 1, Statutes of 2007-08 Second Extraordinary Session required the State Water Resources Control Board (State Board), in consultation with other agencies, to prepare a report to the Legislature outlining the causes of groundwater contamination and identifying potential remediation solutions and funding sources to recover state costs of providing clean drinking water to all communities. This report, prepared by UC Davis researchers, provides the basis for much of the groundwater and drinking water discussion this year. In addition, AB 685 (Eng), Chapter 685, Statutes of 2012 declares that it is the established policy of the state that every human have the right to water for domestic uses. The law requires state agencies to consider this as they move forward with water policies in the future.

Much discussion has gone on this year amongst various water advocacy organizations and legislative staff regarding complaints about the management of the drinking water program within DPH. Certain stakeholders have alleged that DPH is slow to make funds available to communities that needs them and is fairly inaccessible and unresponsive to stakeholder requests.

In a report entitled *Evaluating the Potential Transfer of Drinking Water Activities from DPH to SWRCB*, the Legislative Analyst's Office (LAO) further documented stakeholders concerns with regard to DPH including: its lack of integration with overall water quality management; slow distribution of financial assistance; slow rulemaking process; insufficient fee structure leading to inadequate administrative resources; and, lack of transparent decision-making. The LAO's report stated that 30 states have consolidated drinking water and water quality programs in a single state entity and that some have consolidated their revolving loan programs (CWSRF and DWSRF). The LAO concluded transferring DWP to SWRCB could have several potential advantages including greater policy integration on water issues; accelerated rulemaking; increased efficiencies and administrative capacity; and heightened transparency and greater public participation by utilizing a board that meets in public. The LAO's report also cautioned that there could be potential disadvantages, including: loss of integration with public health programs that monitor infectious diseases and incidences of birth defects and cancer; temporary disruption in the program's capacity to perform regulatory activities; and, potentially increased, mainly short-term, costs to relocate staff, reclassify positions, and integrate information technology systems.

US EPA Letter

The US EPA letter states that California has not administered the California Safe Drinking Water State Revolving Fund in accordance with applicable EPA requirements. California has received $1.5 billion in federal grants since 1998 to capitalize the California Safe Drinking Water State Revolving Fund. Specifically, the letter states:

> "States are required to make timely loans or grants using all available drinking water funds to eligible water systems for necessary projects, and California has failed to meet this standard. Additionally, the California Department of Public Health has issued loans or grants to many projects, which are not "shovel ready," resulting in funds not being paid out for years. As of October 2012, the drinking water fund had an unspent balance of $455 million in federal funds. This sum is the largest unliquidated obligation of any state in the nation."

Furthermore, the notice states that states are required to have dedicated accounting and financial staff to track commitments, calculate balances, and plan expenditures and that DPH has not met these requirements. As a result, DPH has not accurately accounted for revenue from ongoing loan repayments into the fund, amounting to $260 million in unexpended loan capacity. The EPA states that California needs $39 billion in capital improvements in order to ensure safe drinking water to all Californians through 2026.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DPH to describe the US EPA notice of non-compliance and the department's response, and to reply to the following questions:

1. What are DPH's corrective action plans?

2. What actions has DPH taken to improve financial accounting and management of the Revolving Fund?

3. How much additional resources would DPH require in order to bring the program into compliance and for it to operate more efficiently?

4. Does DPH have an update on the amount of unexpended funds cited in the letter of non-compliance?

Staff Recommendation: Informational item; no action recommended**.**

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: AFFORDABLE CARE ACT – FISCAL ESTIMATE ON MANDATORY EXPANSION

The following is an overview of the administration's cost estimate for the Medi-Cal simplification provisions of the Affordable Care Act, which the administration refers to as the "mandatory" expansion of Medi-Cal.

PANELISTS

- Department of Health Care services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

On March 23, 2010, President Obama signed the federal Patient Protection and Affordable Care Act (ACA). Amongst the many provisions of the ACA that collectively change the health care landscape in the United States and extend coverage to many millions of people, the ACA requires states to simplify their Medicaid (Medi-Cal in California) programs. When Medicaid programs are simplified, the result is that it becomes easier for people to enroll and remain enrolled, thereby increasing the size of the enrolled population. Therefore, upon implementation of these ACA-mandated simplifications, along with various other aspects of the ACA discussed below, the administration justifiably anticipates a fairly significant increase in enrollment and retention of individuals who are eligible for Medi-Cal already, but not enrolled. Hence, the administration refers to this as a "mandatory Medi-Cal expansion." The primary simplifications include:

- Establishing a new standard for determining income eligibility, based on Modified Adjusted Gross Income (MAGI), consistent with the standard used to determine eligibility for premium tax credits.

- Eliminating the asset test for individuals whose eligibility determination is based on MAGI.

- Conducting an "ex parte" review when making a redetermination of eligibility. Redeterminations must be made based on available information with a primary reliance on electronic data.

In addition to Medi-Cal simplifications, full implementation of the ACA will increase enrollement in Medi-Cal as a result of the requirement that most individuals obtain coverage (individual mandate) and marketing and outreach activities conducted by California's Health Benefit Exchange (Covered California).

The Governor convened an extraordinary session that began on January 28, 2013, to consider and act upon legislation necessary to implement the ACA. AB 1X 1 (Speaker Perez) and SB 1X 1 (Hernandez and Steinberg) have been introduced to implement the ACA's Medi-Cal simplification provisions discussed above as well as the state-based expansion of Medi-Cal to low-income adults with incomes up to 138 percent of the federal poverty level (FPL), referred to as the "optional expansion." These bills are identical as the Legislature is working collaboratively on these vehicles.

The administration has put forth proposed language on just the mandatory expansion (i.e., Medi-Cal simplifications), first in the form of amendments to SB 28, and more recently in the form of proposed amendments to AB 1X 1 and SB 1 X1.

January Budget and Revised Estimate

The 2013-14 Governor's January Budget includes $350 million General Fund as a placeholder for the costs of the increase in Medi-Cal caseload as a result of the changes described above.

In February, the Administration provided a revised and more detailed estimate for the mandatory expansion. Per this revised estimate, the Administration estimates that the General Fund costs of the mandatory expansion will be $188.7 million in 2013-14, $659.6 million in 2014-15, and $729.1 million in 2015-16, when costs are fully phased in.

Reduced Disenrollments

The Administration's estimate is premised on the notion that the redetermination simplification provisions of the ACA will dramatically reduce the disenrollment rate and, consequently, individuals will retain coverage at a higher rate. It finds that 525,601 individuals, who would have been disenrolled will retain coverage.

The Administration classified individuals who discontinue enrollment into three categories of leavers and assumes a certain rate of retention for each of these categories:

1. Short-term leavers – Individuals who disenroll from Medi-Cal and return within one to six months are considered "short-term" leavers. The Administration assumes that 100 percent of these individuals will retain continuous coverage. (265,508 individuals)

2. Longer-term leavers – Individuals who disenroll from Medi-Cal and return within seven to 12 months are considered "longer-term" leavers. The Administration assumes that 75 percent of these individuals will retain continuous coverage. (126,508 individuals)

3. Non-returners - Individuals who disenroll from Medi-Cal and return within 13 to 18 months are considered "non-returners." The Administration assumes that 40 percent of these individuals will retain continuous coverage. (133,435 individuals)

New Enrollment

The total base caseload is also adjusted by 33 percent to attempt to capture currently eligible but unenrolled individuals, given that marketing and outreach activities conducted by Covered California and the requirement that most individuals obtain health coverage are likely to result in additional enrollment among this population. (200,506 individuals)

The Administration also assumes that about 82,000 children in families with incomes up to 150 percent of the federal poverty level (FPL) who are eligible for Healthy Families, but not enrolled would enroll into Medi-Cal.

Based on these assumptions, the estimate projects that Medi-Cal enrollment would increase by a total of about 809,000. This increase in caseload would be fully phased in by September 2014, or just nine months after these ACA provisions are effective.

Summary of Administration's Caseload Increase Estimate	
Category of Individual	**Projected Increase**
Individuals enrolled who would have discontinued coverage, but instead retain it.	525,601
Currently eligible individuals, but never enrolled	200,506
Eligible children with incomes under 150% FPL, but not yet enrolled.	81,994
Total estimated increase within 9 months	**808,101**

LAO Findings and Estimate

The following table below shows the LAO's range of estimated costs for these additional enrollees under three different scenarios. The LAO finds that the moderate-cost scenario is most likely. Under this scenario, it estimates that the General Fund costs associated with this population would be $104 million in 2013-14, about $290 million in 2014-15, and $359 million in 2015-16. Under the moderate scenario, the LAO estimates that average monthly enrollment will increase by 154,016 in 2013-14 and 410,447 in 2014-15.

Range of Estimated Annual Medi-Cal Costs for Health Care Services to Currently Eligible but Unenrolled Population Under the ACA[a]

(In Millions)

State Fiscal Year	Low-Cost Assumptions			Moderate-Cost Assumptions			High-Cost Assumptions		
	Total Cost	Federal Funds[b]	State Funds	Total Cost	Federal Funds[b]	State Funds	Total Cost	Federal Funds[b]	State Funds
2013-14	$65	$35	$30	$222	$118	$104	$540	$286	$254
2014-15	180	98	83	618	328	290	1,517	804	714
2015-16	222	120	102	765	407	359	1,897	1,005	893
2016-17	245	145	101	849	482	367	2,127	1,198	929
2017-18	259	157	103	901	522	379	2,279	1,309	970
2018-19	274	165	109	958	554	404	2,447	1,404	1,043
2019-20	289	174	115	1,015	587	429	2,620	1,501	1,119
2020-21	305	184	122	1,080	623	457	2,814	1,610	1,204
2021-22	323	194	129	1,150	663	487	3,027	1,731	1,297
2022-23	341	205	136	1,222	703	518	3,248	1,855	1,393

Key Assumptions

Eligible population in 2014	2.4 million	2.5 million	3.1 million
Average take-up rates[c]	8%	20%	33%
Annual average cost per new enrollee in 2014	$1,169	$1,440	$1,694

[a] Estimates do not include administrative costs, such as additional costs for eligibility determinations.

[b] Applicable federal matching rate depends on whether the enrollee is currently eligible for the Medicaid matching rate or currently eligible for the Children's Health Insurance Program matching rate.

[c] The "take-up rate" is the percent of eligible individuals who actually enroll. Estimates assume take-up is complete by July 1, 2016.

ACA = Patient Protection and Affordable Care Act.

Overall, the LAO find the administration's enrollment estimate to be plausible, though likely too high. The LAO finds that the short– and long–term costs from additional enrollment among the currently eligible Medi-Cal population under the ACA are subject to uncertainty. Some of the major areas of uncertainty include: 1) the size of the eligible, but not enrolled population; 2) the percent of the eligible population that will enroll (take–up rate); and 3) the cost of providing services to each additional enrollee.

CalSIM

In addition to the Administration and LAO's estimates, under the CalSIM model, which was created by the UCLA Center for Health Policy and Research and UC Berkeley Labor Center for Labor Research and Education, it is estimated that the total General Fund costs associated with this population would be between $143 million and $378 million in 2014, between $125 million and $380 million in 2016, and between $134 million and $407 million in 2019.

The CalSIM model is being used by Covered California to produce enrollment estimates and the California Health Benefits Review Program (CHBRP) to simulate and project the effects of the ACA in California. (CHBRP provides the Legislature with independent analysis of proposed legislation related to health insurance benefits. Policy makers consult CHBRP reports for guidance on issues of health benefits policy design.)

Concerns Raised Regarding Administration's Estimate

Stakeholders have raised various concerns about the Administration's estimate and its assumptions, including the following:

- **Caseload Too High.** The biggest concern with the Administration's estimate is its projected enrollment. The Administration's estimated caseload is substantially larger than any of the other estimates.

- **Take-Up Rate Questionable.** The Administration's estimate for when all persons who are eligible, but not enrolled, would enroll in Medi-Cal is considerably more ambitious than the other estimates. The Administration projects that all individuals who are eligible but not enrolled would enroll by September 2014. This is almost two years earlier than other estimates. This estimate also assumes that all redeterminations occur in nine months instead of 12, between January and September 2014, but provides no explanation on how to complete this expedited redetermination process.

- **Estimate Does Not Account for Natural Attrition.** The Administration's estimate does not account for the natural attrition of people leaving the program (because they have moved out of state or have a change in employment, for example). The estimate assumes that almost all individuals will remain on the program because of the redetermination simplification provisions.

- **Enrollment of This Population May Reduce Costs in the Long-Term.** The Administration acknowledges that individuals that are eligible but unenrolled are likely healthier and could reduce the overall cost of care. However, since DHCS cannot develop its actuarially-based rates on this assumption (because it does not have utilization data for this population), it recognizes that in the long-term, overall costs may be reduced as a result of this healthier population.

STAFF COMMENTS/QUESTIONS

The Subcommittee has requested DHCS respond to the following questions.

1. Please provide an overview of the Administration's estimate.

2. Please provide the basis for the assumptions used to develop this estimate.

3. Please comment specifically on the research and data used to justify the caseload estimates.

Staff Recommendation: Hold open**.**

ISSUE 2: AFFORDABLE CARE ACT – PROPOSAL ON THE REMAINING UNINSURED

Advocacy organizations have put forth the following proposal to extend health coverage to the population of individuals who can be expected to remain uninsured even after implementation of the Affordable Care Act. This proposal would extend county Low-Income Health Programs (LIHPs) as the primary vehicle to offer coverage to this population, while requiring counties to share realignment funds with the state based on each county's LIHP enrollment numbers. The proposal is described in detail below.

PANELISTS

- Legislative Analyst's Office
- Department of Health Care Services
- Department of Finance
- Public Comment

BACKGROUND

Implementation of the federal Affordable Care Act (ACA), signed by President Obama on March 23, 2010, will result in a dramatic reduction in the number of uninsured Americans, primarily as a result of expansions to state Medicaid programs as well as subsidized commercial coverage facilitated through state Health Benefits Exchanges. However, despite the substantial strides in coverage that are anticipated, some portion of the uninsured will remain uninsured. In California, estimates of the size of the remaining uninsured population vary, but most fall within the range of approximately 2-4 million. Health Access, with the support of several other health advocacy organizations, has put forth a proposal for extending access beyond the ACA in order to reduce the number of uninsured even further. This proposal also seeks to create a fair and rational cost sharing arrangement between the state and counties, in order to address the concerns and goals expressed by the administration related to the Governor's proposal to implement the "optional" Medi-Cal expansion in his proposed January budget.

Health Access, with the support of the California Immigrant Policy Center, California Pan-Ethnic Health Network, Latino Coalition for a Healthy California and Western Center on Law and Poverty, proposes the following elements of a solution for the remaining uninsured, and ACA implementation in general:

1) Implement a statewide Medi-Cal expansion, under the Affordable Care Act, coupled with an aggressive effort to enroll as many Californians as possible.

2) Preserve the state realignment dollars for the first three years, in which the federal government is funding the expansion at 100%, which would allow for capacity building to meet the needs of the newly insured as well as the remaining uninsured during this peak.

3) Allow counties to keep those state dollars contingent on a maintenance of effort requirement to assure counties continue to spend at least what they are spending now, including their own county dollars, on the remaining uninsured, public health and related health needs.

4) Encourage counties to redirect existing Low Income Health Programs to serve the remaining uninsured; Counties would be encouraged to maintain their LIHP-like or Healthy San Francisco-type programs using these state realignment dollars.

5) Ensure, after three years, half of state realignment funds continue to go to counties to perform public health functions, as envisioned in the original 1991 realignment, as well as base 17000 safety-net responsibilities.

6) Link the remaining portion of this funding stream to LIHP enrollment, so counties are funded in line with the demand and their commitment. The first three years provide time when counties have the opportunity to build their enrollment back up, but then the state can yield savings as the ACA is implemented and overall demand goes down.

7) Allocate some state savings to support safety-net institutions through a state funding stream.

8) Institute accountability and transparency into the state-county relationship going forward.

STAFF COMMENTS/QUESTIONS

The Subcommittee had a hearing on the ACA optional Medi-Cal expansion on March 6, 2013, and much discussion took place regarding both the timing of implementation and the overall structure (in light of the Governor's proposal to either adopt a state-based or a county-based expansion). In general, strong opposition was voiced to a county-based expansion and many individuals expressed great concern about the administration's approach to timing, which some perceive as lacking a sense of urgency. A state-based expansion is contained in AB 1X 1 and SB 1X 1. The administration has stated consistently that California should not move forward without addressing the counties-to-state cost shift that will occur as a result of an expansion to Medi-Cal. Several issues are at stake:

- The cost of the expansion is fully federally supported for three years, after which the maximum state responsibility goes to ten percent.

- County health care and public health services have been woefully underfunded for many years, and the state's recent recession likely had an equal or greater impact on county budgets as on the state's budget.

- As individuals shift out of county-supported services and into Medi-Cal, many remaining individuals can be expected to take their places, if offered, thereby sustaining county costs, as is addressed by this proposal.

- Implementing a Medi-Cal expansion requires complex changes both for the state and counties, and therefore will take a substantial amount of time to implement. It is unknown precisely how much time will be necessary, however many stakeholders have expressed concern and pessimism about the prospect of a January 1, 2014 start date. Should it become impossible to begin enrollment into a Medi-Cal expansion on January 1, 2014, the state will begin losing federal funds and will delay the opportunity to extend coverage to approximately a million Californians. Finally, the approximately 550,000 Californians currently covered through LIHPs will once again join the ranks of the uninsured, rather than transitioning to Medi-Cal.

The Subcommittee has asked the LAO to present this proposal and requests DHCS to provide reactions to the proposal, and respond to the following:

1) How much time is needed from the day the Governor signs a bill to expand Medi-Cal until the state and counties are ready to begin enrolling individuals?

2) Does the administration have a proposal for covering the remaining uninsured?

3) Is the administration planning to put forth a fully developed state-based expansion proposal? If so, when?

4) Please describe any objections or reservations that the administration has to this proposal.

Staff Recommendation: Hold open**.**

ISSUE 3: AFFORDABLE CARE ACT – PROPOSAL TO FUND MEDI-CAL ASSISTORS

The California Endowment (TCE) Board of Directors has approved providing $26.5 million to the state for the purpose of Medi-Cal in-person enrollment assistance payments and targeted outreach and enrollment grants to community-based organizations. These funds could be used to draw down a federal match, thereby providing $53 million (total funds) for these purposes.

PANELISTS

- Legislative Analyst's Office
- Department of Health Care Services
- Department of Finance
- Public Comment

BACKGROUND

An effective and targeted outreach and enrollment strategy will maximize Medi-Cal enrollment under the ACA. The Governor's Budget does not include any funds earmarked for this purpose.

Specifically, TCE has committed to providing:

- ***Medi-Cal Enrollment Assistance - $14 million*****.** This funding would be used for Medi-Cal in-person enrollment assistance payments of $58 per approved Medi-Cal application.

- ***Medi-Cal Outreach and Enrollment Grants to Community-Based Organizations- $12.5 million*****.** This funding would be used to target outreach and enrollment strategies aimed at persons with behavioral health needs; homeless persons; young men of color; persons who are in county jail or state prison, on state parole or county probation, and post-release community supervision; families of mixed-immigration status; school-age children through their educational institutions; and persons with limited English proficiency.

Covered California has received a federal grant and TCE funding for outreach and enrollment activities targeted at those individuals with incomes over 138 percent of the federal poverty level that could qualify for Covered California's health coverage programs. However, these outreach and enrollment strategies may not target individuals who would qualify for Medi-Cal and would not pay for enrollment into the Medi-Cal program.

STAFF COMMENTS/QUESTIONS

The Subcommittee has requested the LAO to present this proposal and has asked DHCS to respond to the proposal.

Staff Recommendation: Adopt placeholder trailer bill language to require DHCS to accept these contributions and seek matching federal funds for these purposes**.**

The following is proposed trailer bill language to implement this proposal.

Medi-Cal Assister Language

Medi-Cal General Fund and Federal Fund Items

Of the amount appropriated in this item, $14 million shall be used for Medi-Cal in-person enrollment assistance payments of $58 per approved Medi-Cal application and payment processing costs.

(a) Entities and persons that are eligible for this fee shall be those trained and eligible for in-person enrollment assistance payments by the CA Health Benefits Exchange. The payments may be made by the State Department of Health Care Services or through the California Health Benefits Exchange in-person assistance payment system.

(b) The Department shall accept contributions by private foundations in the amount of at least $14 million for this purpose and shall immediately seek an equal amount of federal matching funds.

(c) Enrollment assistance payments shall be made only for Medi-Cal applicants newly eligible for coverage pursuant to the federal Patient Protection and Affordable Care Act or those who have not been enrolled in the Medi-Cal program during the previous 12 months prior to making the application.

(d) The commencement of enrollment assistance payments shall be consistent with those of the California Health Benefits Exchange.

(e) The department or the California Health Benefits Exchange shall provide monthly and cumulative payment updates and number of persons enrolled through in-person assistance payments on their website.

Medi-Cal CBO Grant Language

Medi-Cal General Fund and Federal Fund Items

Of the amount appropriated in this item, $12.5 million shall be used for Medi-Cal outreach and enrollment grants to community-based organizations (CBOs).

(a) The grants shall be apportioned geographically according to the estimated number of persons who are eligible for Medi-Cal but not enrolled and who will be newly Medi-Cal eligible as of January 1, 2014. The department may determine the number of grants and the application process.

(b) The department shall give special consideration to outreach and enrollment proposals targeting the following populations:

1) persons with behavioral health needs;

2) homeless persons;

3) young men of color;

4) persons who are in county jail or state prison on state parole or county probation and post-release community supervision;

5) *families of mixed-immigration status;*
6) *school-age children through their educational institutions; and*
7) *persons with limited English proficiency.*

(c) *The Department shall accept contributions by private foundations in the amount of at least $12.5 million for this purpose and shall immediately seek an equal amount of federal matching funds.*

(d) *The department shall begin the payment for the CBO grant outreach program by January 1, 2014.*

(e) *Grantees may not receive in-person assister payments for potential Medi-Cal enrollees assisted under the terms of this grant.*

(f) *Data shall be collected and made publicly available by the department that identifies outreach, enrollment, retention and utilization activities from CBO grantees using a web- based reporting system that would compile, by grantee, demographic and geographic information of population assisted with enrollment, outreach activity numbers by type of strategy, enrollment applications completed, successful enrollment in Medi-Cal and assistance with retention of coverage at annual renewal.*

ISSUE 4: COORDINATED CARE INITIATIVE UPDATES

Enacted as part of the 2012 budget, the Coordinated Care Initiative (CCI) integrates medical, behavioral, long-term supports and services (LTSS), and home- and community-based services through a single Medi-Cal health plan for persons eligible for both Medicare and Medi-Cal (dual eligibles) in eight demonstration counties. Additionally, it integrates LTSS into Medi-Cal managed care for Medi-Cal-only individuals.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

SB 208 (Statutes of 2010) requires DHCS to establish a demonstration program to begin enrolling persons who are eligible for both Medi-Cal and Medicare (dual eligible) into coordinated health care delivery models in up to four counties. During the 2010 Bridge to Reform Section 1115 waiver negotiations, CMS requested that California pursue the dual eligible pilots through a new federal initiative rather than as part of the waiver. California was one of 15 states to receive a $1 million design contract from CMS in April 2011.

SB 1008 (a 2012 budget trailer bill) and SB 1036 (a 2012 budget trailer bill) modified the original authority in SB 208 and created the Duals Demonstration Project/Coordinated Care Initiative (CCI). Under the CCI:

- Up to eight counties can participate in the Duals Demonstration Project. These counties are: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

- Long-term supports and services (LTSS), such as In-Home Supportive Services, are shifted into Medi-Cal managed care for Medi-Cal-only individuals.

Under the CCI, the state and CMS will jointly contribute to managed care rates that are designed to lower total Medicare and Medi-Cal spending for dual eligibles. The rates will be determined based on the assumption that by integrating LTSS under managed care, demonstration plans can prevent and substitute nursing facility stays for their members with less costly LTSS.

The rates also assume a reduction in hospital inpatient services under managed care. In future years, when the CCI is fully implemented, General Fund savings are expected to result from both: 1) LTSS integration, which mainly lowers Medi–Cal costs; and, 2) reduced hospitalizations for dual eligibles, which mainly lowers Medicare costs.

SB 1008 contains a "poison pill" in that it requires that if a six-month stable enrollment period is not obtained in the project or the level of savings estimated in the 2012 budget act is not achieved, then the entire CCI project becomes inoperative.

MOU Signed. On March 27, 2013, DHCS announced that it had entered into a Memorandum of Understanding (MOU) with the federal CMS regarding the state's Duals Demonstration, a component of the CCI. The MOU reflects the procedures under which CMS and the state plan will implement and operate "Cal MediConnect," the name of the demonstration project. The project will begin no sooner than October 1, 2013 and continue until December 31, 2016.

Key provisions in the MOU that have changed since the 2012 budget include:

- **Shared Savings.** The CCI, as reflected in the 2012 budget, assumes that the state and the federal government will share the CCI savings equally (50:50). The MOU defines the state's minimum savings percentages as 1 percent in the first year, 2 percent in the second year, and 4 percent in the third year. Payment rates to the health plans will be determined by applying these savings percentages to the baseline spending amounts. The Administration has not yet provided fiscal estimates explaining how these savings percentages affect the total estimated savings from CCI.

- **Timeline.** The MOU calls for implementing Cal MediConnect no earlier than October 2013. This means that the first notices any beneficiaries would receive about these transitions would come no earlier than July 2013. This is a change from the 2012 budget that had a launch date of March 2013.

- **Enrollment Strategies.** Eight counties will implement the Cal MediConnect program: Alameda, Los Angeles, San Bernardino, San Diego, San Mateo, Santa Clara, Orange, and Riverside. Originally, all counties would phase-in enrollment over 12 months. The MOU lays out enrollment strategies for each county. Specifically, assuming an October 2013 start, San Mateo County enrollment will complete enrollment in January 2014 and Los Angeles County enrollment will happen over a 15-month period.

- **No Stable Enrollment Period.** The 2012 budget included an initial six-month stable enrollment period, during which eligible beneficiaries would remain in the same health plan. The MOU contains no language regarding a stable enrollment period. Beneficiaries enrolled in Cal MediConnect can opt out at any time.

- **Home and Community Based (HCBS) Waiver.** The original proposal called for closing most of California's HCBS waivers. Those waivers will now remain open.

- **Size of the Demonstration.** The total number of enrollees allowed under the MOU is estimated at 456,000. This is almost half the size of the number of enrollees (800,000) estimated in the 2012 budget.

- **Number of Participants in Los Angeles County.** The MOU sets a cap of no more than 200,000 enrolled beneficiaries in Los Angeles County. The 2012 budget had no such cap.

Other provisions included in the MOU are:

- **Quality Withhold Measures.** Under the demonstration, CMS and the state will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to the health plan's performance, consistent with established quality thresholds. These thresholds are based on a combination of certain core quality withhold measures, as well as state-specified quality measures including behavioral health coordination and planning, and ensuring physical access to buildings, services, and equipment.

- **Risk Corridors.** Limited risk corridors will be established in order to provide a level of protection to the health plan and payers against uncertainty in rate-setting that could result in either overpayment or underpayment.

- **Additional Home and Community Based Services.** Health plans participating in the project will have the ability to provide additional HCBS, including supplemental personal care services, respite care, and nutritional supplements.

- **Dental, Vision, and Transportation Benefits Required.** The benefit package offered under this project must include preventative, restorative, and emergency oral health and vision benefits and must include non-emergency, accessible medical transportation.

- **Evaluation.** CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of this project. The evaluator will assess how the project operates, how it transforms and evolves over time, and beneficiaries' perspectives and experiences.

Budget Impact. The budget proposes the following related to CCI:

- **Increased General Fund Savings in Current Year.** As a result of delaying the start date until the budget year, General Fund savings in the current year is $642 million, an increase of $34 million compared to the 2012 Budget Act. This is because the state does not have to pay overlapping Medi-Cal fee-for-service payments and Medi-Cal managed care rates for the dual eligibles that would have transitioned in the current year. This current year savings is not impacted by the MOU.

- **Decreased General Fund Savings in Budget Year and Ongoing.** The Governor's budget includes $171 million General Fund savings in 2013-14 and ongoing General Fund savings of $535 million starting in 2015-16 (when enrollment will be complete in all demonstration counties). At the time the 2012 budget was enacted, it was estimated that 2013-14 and ongoing General Fund savings would be $880 million.

According to the Administration, the revised savings estimates more accurately reflect the number of people eligible for the CCI.

The MOU will have an impact on the estimated budget year and ongoing savings. Consequently, these estimates will change at May Revise.

STAFF COMMENTS/QUESTIONS

The Subcommittee has requested DHCS respond to the following:

1. Please provide an overview of the MOU and next steps regarding the project.

2. Please explain how CMS and the state will share the savings from this project.

3. What is the Administration's timeline for sharing updated fiscal estimates and proposed trailer bill language regarding this project?

Staff Recommendation: Informational item; no action recommended**.**

ISSUE 5: COORDINATED CARE INITIATIVE BCP

DHCS's Long-Term Care Division requests the extension of one full-time limited-term position (a Health Program Manager III) for a three-year term. This position would continue work related to the implementation of the Duals Demonstration Project/Coordinated Care Initiative (CCI). The cost for this position is $150,000 ($75,000 General Fund and $75,000 federal funds).

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

As described in more detail in the prior issue, SB 208 (Statutes of 2010) directed DHCS to establish pilot projects in up to four counties to develop effective health care models to provide services to persons who are dually eligible under both the Medi-Cal and Medicare programs (the Dual Demonstration). SB 1008 (a 2012 budget trailer bill) authorized the CCI, expanded the Dual Demonstration to an additional four counties, and included the integration of long-term supports and services (LTSS), including the Multi-Purpose Senior Services Program and In-Home Supportive Services, into a Medi-Cal managed care benefit.

The position requested to be extended in this proposal would help facilitate LTSS integration into managed care health plans participating in the Duals Demonstration. In addition, this position would work with the California Department of Aging and the California Department of Social Services, on developing the universal LTSS assessment process and tool.

In response to questions asked at a prior Subcommittee hearing regarding overall CCI resources, the Department of Finance provided the following chart:

CCI Resources

	2012-13	2013-14	Vacancy Rate
	Positions	BCP Requested positions	
DHCS [1/]	(31)	1	7.0%
DMHC [2/]	13	16.5	17.0%
DSS [3/]	(1)	7	12.7%
Total	13	24.5	

1/ DHCS notes the position requested for 2013-14 is related to the Dual Eligibles Demo, not CCI per se.
DHCS positions in 2012-13 are redirected internally.
DHCS vacancy rate is as of December 2012.

2/ DMHC positions in 2012-13 are one-year limited term.
DMHC vacancy rate is as of April 2013.
Without limited-term positions that are hard-to-fill, DMHC vacancy rate is 7%.

3/ DSS position in 2012-13 is redirected internally.
DSS vacancy rate is as of March 2013.
Requested positions in BY are limited term.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DHCS to present this proposal.

Staff Recommendation: Hold open**.**

ISSUE 6: BIOTERRORISM/EMERGENCY PREPAREDNESS OFFICE AUDITS BCP

DHCS requests three permanent full-time Health Program Auditor IV positions, effective July 1, 2013, to conduct audits of local health departments' use of federal public health emergency funds.

The total cost for these positions is $379,000 and would be funded with reimbursements from the Department of Public Health ((DPH, which receives federal Centers for Disease Control and Prevention (CDC) grants for these activities)).

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

DPH does not have audit staff to perform financial and compliance audits of local health departments' (LHD) use of federal grant funds on a three year cycle, as required by Health and Safety Code Section 10137(g)(3). Consequently, it has entered into an interagency agreement with the Audits and Investigations (A&I) branch of DHCS to conduct these audits. The CDC has approved the use of California's public health emergency preparedness funds to finance the LHD audits.

At the March 4, 2013 Subcommittee hearing, this Subcommittee approved related positions at the Department of Public Health.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DHCS to present this proposal.

Staff Recommendation: Hold open**.**

ISSUE 7: CALIFORNIA MEDICAID MANAGEMENT INFORMATION SYSTEM (CA-MMIS) REPLACEMENT PROJECT BCP

DHCS requests a three-year extension of 26 of the previously authorized 34 limited-term positions, to provide continued oversight of the California Medicaid Management Information System (CA-MMIS) Replacement Project through its completion in 2015-16.

The cost to extend 26 positions would be $3.52 million ($839,000 General Fund and $2.69 million federal funds). These positions are funded at a 90 percent enhanced federal funding rate as they support the CA-MMIS system replacement efforts (per federal approval).

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

CA-MMIS is used to process over 210 million claims annually for payment of medical services provided to Medi-Cal beneficiaries. DHCS contracts with a fiscal intermediary (FI) to maintain and operate CA-MMIS.

The CA-MMIS system replacement project was originally scheduled to begin in 2010 and end in 2015. However, due to delays in the execution of the FI contract and the assumption of operations by the new FI (Xerox State Healthcare, LLC), the system replacement project was delayed. Project planning began in October 2011 and the project is scheduled to be completed by June 30, 2016. A Special Project Report (SPR) was completed and approved by the California Technology Agency on July 26, 2012, to extend the project timeframe and expenditure plan.

According to DHCS, this information technology project is very important because the existing legacy CA-MMIS is aged, inflexible, and costly to modify. By extending these positions, it will allow for the project to move forward to help reduce waste, improve fraud detection, cost recovery, and support quality assurance activities.

CA-MMIS System Replacement Phases. The system replacement project is divided into four phases:

- Phase I – Replaces pharmacy claims processing drug rebates functionality.
- Phase II – Focuses on pharmacy authorizations.
- Phase III – Encompasses medical authorizations.
- Phase IV – Implements full Health Enterprise system.

Business rule validation is underway for Phase I and just beginning for Phase II. Work on Phases III and IV are expected to begin in 2014.

STAFF COMMENTS/QUESTIONS

The Subcommittee has requested DHCS to present this proposal and to provide a brief description of the CA-MMIS system replacement project and timeline.

Staff Recommendation: Hold open**.**

ISSUE 8: MEDI-CAL MANAGED CARE CONTINUATION OF 1115 WAIVER ACTIVITIES BCP

DHCS requests to extend 18 limited-term positions through the end of the 1115 Waiver, which expires on October 31, 2015. DHCS also requests $1 million per year, for three years, in contract funds for actuary services and $10,000 for actuarial and auditing training. These positions expire in 2013 (15 in June and 3 in December).

The 2013-14 cost for this proposal is $3.165 million ($1.3 million General Fund, $1.7 million federal funds, and $107,000 reimbursement from counties).

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

Effective November 1, 2010, CMS approved California's five-year, $10 billion "Bridge to Reform" Section 1115 Waiver proposal. Generally, the waiver expands health care coverage to uninsured adults; provides support for uncompensated care; improves care coordination for vulnerable populations; and promotes public hospital delivery system transformation. Provisions of the waiver and waiver amendments that relate to this budget proposal include:

- The transition of seniors and persons with disabilities (SPDs) from voluntary to mandatory enrollment in Medi-Cal managed care in a phased-in manner over a twelve-month period commencing June 1, 2011.

- The development and implementation of intergovernmental transfers to allow the transfer of public funds between governmental entities.

- The transition of Adult Day Health Care (ADHC) to Community-Based Adult Services (CBAS).

- The transition of Healthy Families into the Medi-Cal managed care program.

- The expansion of Medi-Cal managed care into rural counties.

These 18 limited-term positions work on activities related to the above-specified provisions of the waiver and waiver amendments. Key activities performed by these positions include:

- **Administration Division (1 position) -** Prepares and analyzes managed care reconciliations; analyzes and interprets financial data for federal reporting (the adopted waiver requires the accounting federal reporting unit to produce 1,700 additional federal reports annually to report and draw federal funding); responds to requests from program management and CMS auditors; processes invoices for payment; issues and processes difference checks; and prepares quarterly summary information.

- **Medi-Cal Managed Care Division (9 positions) -** Update managed care contracts with requirements specific to the Special Terms and Conditions of the 1115 Waiver, monitor the additional contract requirements specific to the 1115 waiver (e.g., SPD specific network and medical reviews), and complete the 1115 waiver reporting required by the federal government.

- **Capitated Rates Development Division (5 positions) –** Review capitation rate development, provide fiscal analysis and health care plan analysis of the 1115 Waiver, provide oversight for risk adjustment and rate setting, and review the intergovernmental transfer process for public hospitals.

- **Information Technology Services Division (3 positions) –** Support the 1115 Waiver activities in regard to system modifications and enhancements, assist with technical documentation and testing of system changes related to the Waiver.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DHCS to present this proposal.

Staff Recommendation: Hold open**.**

ISSUE 9: 1115 WAIVER LOW INCOME HEALTH PROGRAM AND DELIVERY SYSTEM REFORM INCENTIVE POOL COMPONENTS BCP

DHCS requests the extension of 26 limited-term positions and contract funds to continue the workload associated with the Low Income Health Program (LIHP) and Delivery System Reform Incentive Pool (DSRIP), components of the 1115 Bridge to Reform Demonstration Medicaid Waiver.

The cost for this request is $2.7 million ($260,000 General Fund, $1.4 million federal funds, and $1.1 million in reimbursements from counties). The positions requested to be extended include:

- **Low Income Health Program (18 positions) -** Complete workload associated with the implementation, close-out, and transition of the LIHP to the Medi-Cal program and the Exchange.

- **Delivery System Reform Incentive Pool (3 positions and contract services) -** Complete workload associated with the DSRIP.

- **Hospital Financing Activities (5 positions) -** Complete workload associated with ongoing hospital financing activities, the final reimbursement activities for the Health Care Coverage Initiative, and the transition of the LIHP to the Medi-Cal program and the Exchange.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

Low Income Health Program

The Low Income Health Program (LIHP) is a voluntary, county-run program to provide a Medicaid-like coverage to low-income individuals who are uninsured. There are 17 LIHPs in operation, covering 52 counties, and each LIHP can have different income eligibility requirements. The County Medical Services Program (CMSP) LIHP includes 35 counties.

The LIHP is authorized under the state's 1115 waiver. The 1115 waiver provides a bridge to implement the ACA and an opportunity for county health departments to improve coverage, increase access to care, pay for uncompensated services, identify persons eligible for care under the ACA, and build the right delivery systems for a uninsured population with a 50:50 match of existing county health spending for the newly-eligible and federal funds.

The terms of this waiver limit operations of LIHP to December 31, 2013, as LIHP enrollees would be eligible for Medi-Cal or coverage offered through the Exchange starting January 1, 2014 (under provisions of the ACA).

The LIHP consists of two programs: Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). MCE will provide coverage for very low-income adults with incomes under 138 percent of the FPL, and its federal funding through the waiver is uncapped. HCCI is coverage for low-to-moderate income adults with incomes between 138 percent and 200 percent of FPL, and its expenditures are capped.

Transition of LIHP Enrollees to Medi-Cal. On January 1, 2014, LIHP enrollees will automatically transition to Medi-Cal (unless the state has not yet expanded its Medi-Cal program) or to the Exchange. Welfare and Institutions Code Section 15910(c) requires that LIHPs be designed and implemented with the system and program elements that are necessary to facilitate the transition of LIHP enrollees to Medi-Cal coverage. Additionally, the Special Terms and Conditions of the Waiver requires implementation of a simplified, streamlined process for transitioning eligible enrollees from LIHP to Medi-Cal or the Exchange in 2014 without need for additional determinations of enrollees' eligibility.

Delivery System Reform Incentive Pool

The Delivery System Reform Incentive Pool (DSRIP) Program was created to support the efforts of California's Designated Public Hospitals (DPHs) to transform their health care delivery systems in order to enhance the quality of care and the health of the patients they serve. The program involves the development of hospital plans that include specific work efforts to encourage and create systems to prepare for implementation of federal health care reform.

The funding for DSRIP is $3.3 billion in federal funds ($6.6 billion total as counties use intergovernmental transfers to finance DSRIP projects) over a five-year period (November 1, 2010 – October 31, 2015) and is allocated among the 17 DPH systems. The focus in years one and two of the program is on building infrastructure and systems and the focus in years three through five of the program is on outcomes. DSRIP projects fall within five distinct categories:

- **Category 1 - Infrastructure Development.** Lays the foundation for delivery system transformation through investments in people, places, processes, and technology. Projects include implementing disease management registries, expanding primary care capacity, and increasing training of the primary care workforce.

- **Category 2 - Innovation & Redesign.** Includes the piloting, testing, and replicating of innovative care models. Many plans include projects to expand medical homes, integrate physical and behavioral health care, expand chronic care management models, redesign primary care, and improve patient experience.

- **Category 3 - Population-Focused Improvement.** Requires all public hospital systems to report on the same 21 measures across four domains: (1) the patient's experience, (2) the effectiveness of care coordination (e.g., measured by hospitalization rates for heart failure patients), (3) prevention (e.g., mammogram rates and childhood obesity), and, (4) health outcomes of at-risk populations (e.g., blood sugar and cholesterol levels in patients with diabetes).

- **Category 4 - Urgent Improvement in Care.** Requires public hospital systems to achieve significant improvement in targeted quality and patient safety measures that are particularly meaningful to safety net populations and have a strong base of evidence.

- **Category 5 – HIV Transition Projects.** Enables public hospital systems to implement infrastructure, program design, and clinical and outcome projects related to health care practices that support continuity of care for those LIHP enrollees who have been diagnosed with HIV, and who received their care formerly through Ryan White programs.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DHCS to present this proposal and provide an update on the planning for the transition of LIHP enrollees to Medi-Cal or the Exchange.

Staff Recommendation: Hold open**.**

ISSUE 10: SPECIAL TRANSITION PROJECTS – ASSISTED LIVING WAIVER PROGRAM BCP

DHCS requests to extend two limited-term positions for three years to work on the Assisted Living Waiver (ALW) program. These positions are set to expire on June 30, 2013. The total cost of these positions is $235,000 ($117,000 General Fund and $118,000 federal funds). The two positions requested are:

- **Health Program Manager I (HPM I)** – This position would direct the expansion and administration of the waiver. This position would be responsible for executing the requirements of the waiver, conducting outreach and providing technical assistance to external partners, resolving all internal policy and system issues, overseeing financial audits, and monitoring the quality and effectiveness of the waiver.

- **Research Analyst II (RA II)** – This position would ensure that the fiscal oversight process is in compliance with the fiscal intermediary, which is required for this waiver by CMS and contingent upon renewal of this waiver.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The ALW offers assisted living services in two settings: Residential Care Facilities for the Elderly and publically subsidized housing. Qualified participants have full-scope Medi-Cal benefits with zero share of cost and are determined to meet the Skilled Nursing Facility Level of Care, A or B.

The ALW expires February 28, 2014. The waiver extension application is currently in development (the application would extend the project through February 2019). The ALW was preceded by the Assisted Living Waiver Pilot Project (ALWPP), which was created by AB 499 (Statues of 2000). It tasked DHCS to test the efficacy of assisted living as a Medi-Cal benefit and as an alternative to long-term nursing home placement. The ALWPP was tested in three counties: Sacramento (representing urban, northern California-350 beneficiaries); San Joaquin (representing rural, central California-50 beneficiaries); and Los Angeles (representing urban, southern California-600 beneficiaries).

On March 1, 2009, CMS approved a statewide ALW, and granted it a five-year waiver cycle. As of October 2012, approximately 1,840 individuals have enrolled in this program. Medi-Cal enrollees interested in applying to the ALW do so through a Care Coordinator Agency (CCA), which initially ascertains eligibility through the Medi-Cal provider website and through a nursing assessment conducted by a CCA nurse. Final eligibility for the ALW is determined by DHCS's Long-Term Care Division. The allocation of waiver slots is limited to 60 waiver slots per county, per year, and is dependent upon CMS approval and state appropriations.

DHCS finds that these two positions would permit DHCS to significantly increase nursing facility transitions and develop the necessary community resources to enable thousands of additional Medi-Cal beneficiaries in several different counties to participate in these projects. The ALW results in potential savings for both Medicare and Medi-Cal as individuals are placed in a more cost effective placement.

LAO Findings and Recommendation. The LAO finds that there has been insufficient workload justification to support continuing the Health Program Manager (HPM) position. Specifically, the LAO finds that the workload data provided by DHCS related to the HPM position appears overstated. Therefore, the LAO recommends rejecting the request for the HPM position, resulting in $124,000 in savings ($62,000 General Fund).

STAFF COMMENTS/QUESTIONS

The Subcommittee has requested DHCS respond to the following question:

1. Please provide a brief summary of this proposal and how DHCS proposes to expand the ALW.

2. What is DHCS's estimate as to the potential savings that could be realized if the ALW were expanded as proposed?

Staff Recommendation: Hold open**.**

ISSUE 11: PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM INTERSTATE PROGRAM BCP

DHCS requests one full-time permanent Associate Governmental Program Analyst (AGPA) to operate the Public Assistance Reporting Information System (PARIS) Interstate program on a statewide basis.

This proposal does not seek new General Fund resources as funding for the new staff will come from redirection of program savings of $102,000 ($51,000 General Fund and $51,000 federal funds) resulting from the implementation of PARIS Interstate.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

On July 1, 2009, DHCS began participation in the PARIS data match process with three pilot programs to improve program integrity. PARIS is an information-sharing system, operated by the U.S. Department of Health and Human Services Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances affecting Medicaid program eligibility. PARIS includes three different data matches, as follows:

PARIS Data Match Type	Where Implemented?	2013-14 General Fund Savings
PARIS-Veterans allows states to compare their beneficiary information with the U.S. Department of Veterans Affairs.	Implemented in 10 counties	$519,350
PARIS-Federal allows states to compare their beneficiary information with the U.S. Department of Defense and the U.S. Office of Personnel Management.	Implemented in 30 counties. DHCS plans to expand to 40 counties in 2013-14	$332,400
PARIS-Interstate allows states to compare their beneficiary information with other states.	Implemented in 30 counties. DHCS plans to expand to 40 counties in 2013-14	$1,474,000

DHCS' PARIS-Interstate program began with three counties, and currently has 30 participating counties. Los Angeles County is not yet included. Under PARIS- Interstate, DHCS sends residency verification letters to a limited number of Medi-Cal beneficiaries identified by PARIS-Interstate as receiving public assistance in another state. The residency verification letter requires a response from the beneficiary within ten days. If no response is received, or if the beneficiary responds confirming they are not residents of California, DHCS considers the individual an ineligible, nonresident beneficiary and their benefits are discontinued. DHCS sends the list of discontinued, ineligible, nonresident beneficiaries to the county offices and the county workers update case files.

During quarterly PARIS-Interstate matches, DHCS identified approximately 1,300 ineligible nonresident beneficiaries on Medi-Cal in 2009-10, 2,700 in 2010-11, and 4,000 in 2011-12. The May 2012 Medi-Cal Estimate includes savings for PARIS-Interstate and PARIS-Federal of $8.5 million ($4.2 million General Fund) for 2011-12, and $17.7 million ($8.9 million General Fund) for 2012-13. These cost savings were achieved by avoiding actual managed care capitation payments through the identification of nonresident ineligible beneficiaries. DHCS notes that if given the resources to expand PARIS-Interstate, DHCS will likely achieve double the savings as it is estimated that there are 957,334 Medi-Cal beneficiaries in Los Angeles County, who would be included in the PARIS file.

STAFF COMMENTS/QUESTIONS

No issues have been raised in regards to this proposal for additional resources related to PARIS – Interstate. However, as noted in the chart above, PARIS-Veterans is only in 10 counties. According to a DHCS PARIS report submitted to the Legislature in April 2012, other states have more aggressively maximized the PARIS-Veterans data match and have shown substantial cost avoidance/savings results. For example, Pennsylvania estimated annualized cost avoidance/savings of approximately $27.8 million from a period covering nine quarters. Pennsylvania worked 40,769 cases resulting in reducing 4,448 cases from Medicaid.

The Subcommittee has requested DHCS to provide an overview of this proposal and to describe what resources and planning would need to occur in order to expand the use of the veterans matches.

Staff Recommendation: Hold open**.**

ISSUE 12: MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS) RESOURCES BCP

DHCS requests the authority to establish five permanent, and two limited-term, full-time positions for $822,000 ($371,000 General Fund and $451,000 federal funds) to provide Medi-Cal Eligibility Data System (MEDS) program and systems management oversight authority, of county California Department of Social Services (CDSS) program administrators, as well as quality control to ensure compliance with federal requirements.

The request is for seven new positions, four Associate Governmental Program Analysts (AGPA), one Staff Information Systems Analyst (SISA), one Systems Software Specialist, and one Staff Programmer Analyst.

These positions will perform authorization, maintenance, and tracking of approximately 10,000 CDSS MEDS accounts; enter into county security agreements with CDSS' business partners; and to perform periodic assessments in the counties to ensure that counties are in compliance with Social Security Administration (SSA) requirements regarding the safeguarding of information.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

CDSS has access to MEDS, a database maintained by DHCS. Some of the data in this database comes from the federal Social Security Administration (SSA). The SSA imposes strict requirements on any entity that has access to SSA data, and it required CDSS to submit a Corrective Action Plan (CAP) specifying its steps in maintaining the acceptable and sufficient level of security oversight.

Effective January 1, 2010, SSA executed an Information Exchange Agreement (IEA) with CDSS. The IEA requires CDSS to perform a range of security and privacy activities. The IEA focused on limiting access to SSA data to only authorized employees who need it to perform their official duties and the security procedures relating to protecting the privacy of SSA personally identifiable information.

SSA required CDSS recertify compliance with the IEA on June 30, 2012. The IEA recertification process revealed a number of deficiencies in the areas of management and oversight, computer security safeguards and physical security. CDSS was required to submit a CAP to the SSA because it was found that CDSS was inappropriately allowing county Adult Protective Services (APS) workers access to the SSA data within MEDS.

In order to satisfy the CAP and to strengthen the State's management oversight capabilities, DHCS will assist CDSS with authorizing access for county employees, reviewing and signing county security agreements, conducting periodic security assessments, responding to breach notifications, quality control, and ensuring compliance with federal requirements. DHCS currently works with county welfare agencies to provide this type of access assistance and oversight for the Medi-Cal program.

DHCS is requesting the position authority to establish the positions necessary to carry out the new workload that is required to ensure that CDSS programs are in compliance with SSA requirements, and for all the activities stated above.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DHCS to present this proposal.

Staff Recommendation: Hold open**.**

ISSUE 13: WOMEN, INFANTS, AND CHILDREN APPEAL HEARINGS BCP

DHCS requests one new permanent full-time Health Program Auditor IV position and to convert one existing limited-term Administrative Law Judge position into a permanent full-time position. These positions would conduct the increasing number of Women, Infants and Children's (WIC) appeal hearings as a result of WIC's increased efforts to disqualify vendors that have failed to adhere to program policies and procedures.

These positions are funded through reimbursement funding from the Department of Public Health (DPH) at a total cost of $293,000 (federal funds).

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

DPH administers the WIC Program, which provides nutritious supplemental foods, nutrition education, and referrals to health and social services for low-income women, infants and children who are at nutritional risk. DPH contracts with DHCS's Office of Administrative Hearings and Appeals (OAHA) for the appeal functions related to WIC.

Over the last several years, the United States Department of Agriculture (USDA) has enhanced federal regulations governing the WIC Program to increase accountability. Specifically, federal WIC regulations require states to: 1) conduct compliance activities on authorized grocers; 2) ensure grocers do not sell their stores to circumvent a State sanction for program violations; and, 3) deny authorization to grocers lacking business integrity. The federal regulations provide for stricter sanctions for grocers who violate program rules. In addition, federal regulations contain new requirements for more extensive monitoring of grocers.

In 2011-12, WIC denied 239 out of 534 new vendor applications due to stringent stocking requirements and a moratorium on new vendors. The WIC program has contracted with the State Controller's Office to conduct 200 audits of the vendors and agencies. In addition to the audits, the program routinely monitors over 250 vendors through undercover investigations and compliance buys. All these actions create appeal workload for DHCS when the actions are taken against the vendors and agencies.

The appeals workload has increased by over 50 percent from 2010-11 and over 400 percent from 2008-09. The increase in the number of WIC appeals has created a significant backlog and OAHA cannot meet the 120 day time frame for completing the first level appeal process. The staff requested in this proposal will be used to meet the appeal requirements mandated by the federal government.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DHCS to present this proposal.

Staff Recommendation: Hold open**.**

ISSUE 14: HIPAA BASELINE STAFFING & ELECTRONIC HEALTH RECORDS INCENTIVES BCP

DHCS requests the establishment of three permanent and two limited-term positions (three-year) in the Office of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance (OHC). The total cost for these positions is $682,000 ($235,000 General Fund and $447,000 federal funds). The following positions are requested:

- **Two Staff Information Systems Analyst (Limited-Term)** - Support the HIPAA ICD-9 conversion to HIPAA ICD-10. These two positions will work specifically on ICD-10 project management tasks, processes, documentation, and the development of best practices. The effective implementation date of this rule is October 1, 2014.

- **One Systems Software Specialist II (Permanent) and One Senior Information Systems Analyst (Permanent)** – Support and implement future HIPAA initiatives and enhancements related to the Short-Doyle Medi-Cal system for the behavioral health and substance abuse claims adjudication system that processes claims for all Mental Health Counties and Drug Program Direct Providers.

- **One Staff Information Systems Analyst (Permanent)** – Maintain and implement HIPAA compliant security solutions and perform mandated activities that will further protect the protected health information of millions of beneficiaries in DHCS programs.

These positions would address the anticipated workload attributed to health care reform, new federal HIPAA regulations, and the integration and expansion of technological systems.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

In 1996, the federal government enacted HIPAA to help beneficiaries maintain group health insurance coverage when they change jobs. The law also outlined a process to achieve uniform national health data standards and health information privacy in the United States. These provisions require all covered organizations to standardize the way they transmit and code health information for billing and record keeping purposes, and to protect the privacy and security of that information.

The Affordable Care Act (ACA) includes HIPAA-related changes, such as:

- More frequent HIPAA updates: New standards and operating rules can change every two years while the previous process resulted in only one significant update in ten years.

- New transaction standards: New HIPAA standards and compliance dates for:
  - National Health Plan Identifier (NHPI) by October 1, 2012
  - Electronic Funds Transfer by January 1, 2014
  - Claims attachment standards and operating rules by January 1, 2016

- New health plan certification requirements: Health plans will need to certify (i.e., document and test) their compliance with every HIPAA transaction and standard operating rule.

- Privacy and Security Requirements: HIPAA privacy and security requirements are exponentially increased for electronic health records and health information exchange, creating more exposure of protected health information with each exchange of information.

- Higher penalties for non-compliance: Penalties of $1 per covered life per day not certified compliant, up to a maximum of 20 days (approximately $200 million annually for Medi-Cal). Penalties are doubled if false statements are submitted with certification documents; penalty amounts are based on the number of beneficiaries.

According to DHCS, failure to maintain or achieve HIPAA compliance by established federal deadlines has several implications for DHCS, including additional administrative burdens for Medi-Cal providers, increased risk of federal penalties (monetary, and the withholding of federal funds), loss of support to HIPAA-implemented solutions, and additional breach reporting costs.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DHCS to present this proposal.

Staff Recommendation: Hold open**.**

ISSUE 15: OFFICE OF HEALTH INFORMATION TECHNOLOGY STAFF AUGMENTATION FOR ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM BCP

DHCS' Office of Health Information Technology (OHIT) requests the extension of 11 limited-term positions for the administration of the Medi-Cal Electronic Health Record (EHR) Incentive Program.

Total cost for these positions is $1.3 million ($1.2 million federal funds and $93,000 reimbursement from outside entities, and [$38,000 General Fund]). DHCS is not requesting any additional General Fund in this proposal, as the $38,000 General Fund cost associated with these positions is covered by the General Fund support specified in AB 1467 (a 2012 budget trailer bill) for support costs associated with this program.

The positions requested to be extended are:

Two-Year Extension – July 1, 2013 to June 30, 2015 (8.0 positions)

- Two Staff Services Manager I
- Three Research Program Specialist II
- Three Associate Governmental Program Analyst

Three-Year Extension – July 1, 2013 to June 30, 2016 (3.0 positions)

- One Research Program Specialist II
- Two Health Program Auditor IV

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The Medi-Cal EHR Incentive Program is a multi-year program that began on October 3, 2011, and will operate through December 31, 2021. Since the implementation of the Medi-Cal EHR Incentive Program, DHCS has paid over 1,600 providers over $272 million in federal incentive payments.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorizes $45 billion for federal Medicare and Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade and use electronic health records (EHRs). The goal of HITECH is to improve the quality, safety, and efficiency of health care through "meaningful use" of EHRs. HITECH will result in a significant increase in provider adoption and use of EHR systems. The use of EHR technology in this manner includes the use of electronic prescribing (e-prescribing), submission of clinical quality measures, reporting to

immunization and disease registries, and exchanging health information between DHCS and its providers to improve the quality of patient care.

The HITECH Act authorizes state Medicaid programs to directly administer Medicaid EHR Incentive Programs. The programs will lead the efforts to advance patient safety and quality of care by incentivizing Medi-Cal providers to adopt, implement, or upgrade and use EHRs in a meaningful way.

On October 26, 2009, DHCS submitted a funding request to the federal Centers for Medicare and Medicaid Services (CMS) that was approved for $2.8 million to establish the OHIT and to provide funding for a consulting contract to begin the State Medicaid Health Information Technology Plan (SMHP) process. The department completed and received approval of the SMHP and Implementation Advance Planning Document on September 30, 2011.

The department indicates that it has not yet secured agreements for the $93,000 in reimbursements from outside entities. It indicates that it is currently exploring opportunities for this funding.

STAFF COMMENTS/QUESTIONS

The Subcommittee has requested the DHCS respond to the following:

1. Please provide a brief summary of this proposal.

2. What is the status of the department's efforts to secure outside funding for this proposal? When does the department anticipate agreements may be reached?

Staff Recommendation: Hold open**.**

ISSUE 16: MEDI-CAL COVERAGE OF ELIGIBLE COUNTY MEDICAL PAROLE AND COMPASSIONATE RELEASE (SB 1462) BCP

DHCS is requesting 1.0 full time permanent Associate Governmental Program Analyst position, effective July 1, 2013, and $103,000 ($51,000 county reimbursement and $52,000 federal funds), related to the implementation of SB 1462 (Leno), Chapter 837, Statutes of 2012, which requires the county board of supervisors to "adopt a process to fund the nonfederal share of Medi-Cal costs for the period of time that a prisoner would have otherwise been incarcerated or for the period of time that a probationer is on medical probation.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

SB 1462 authorizes a county sheriff or his or her designee to release certain prisoners from a county correctional facility on medical probation and to request that a court grant medical probation or resentence certain individuals in lieu of jail time. SB 1462 also requires a county that chooses to implement these provisions to pay the non-federal share of a prisoner's Medi-Cal costs. The bill requires DHCS to develop a process to allow counties who voluntarily participate in this program to receive federal financial participation for eligible Medi-Cal services, and to require counties to pay the non-federal share of the services provided. The requested position will develop the process for counties that choose to participate, thereby creating access for those counties for approximately half of these medical costs to be covered with federal Medicaid dollars.

STAFF COMMENTS/QUESTIONS

The Subcommittee has requested DHCS to present this proposal.

Staff Recommendation: Hold open**.**

ISSUE 17: MEDI-CAL ADULT QUALITY CARE IMPROVEMENT PROGRAM SFL

DHCS has been awarded a federal grant of $2 million by the Centers for Medicare and Medicaid Services (CMS), for the period of December 2012 to December 2014, with funding made available under the Affordable Care Act (ACA).

For the DHCS project, titled *Medi-Cal Adult Quality Care Improvement (MAQCI): Diabetes Management, Maternal Health and Birth Outcomes, and Mental Health Medication Management,* DHCS requests six two-year, limited-term positions over the life of the grant, $530,000 expenditure authority in 2012-13, $937,000 in 2013-14, and $533,000 in 2014-15 to increase DHCS capacity for reporting on quality measures and performing associated quality improvement activities.

A current year request for increased federal fund expenditures of $530,000, as a result of this grant, was submitted to the Joint Legislative Budget Committee in March.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

DHCS will undertake coordinated activities to improve capacity for standardized collection and reporting of data on the quality of health care provided to approximately four million adults covered by Medi-Cal. These activities will focus on collection, analyzing and reporting on 16 of the 26 Initial CMS Core Adult Quality Measures that describe the quality of care in three major areas: 1) Diabetes management; 2) Maternal health and birth outcomes; and, 3) Mental health medication management.

Each of these three areas is of critical importance to DHCS because they: 1) are linked to significant morbidity and mortality when care is suboptimal; 2) represent significant health care costs; and, 3) have available, evidence-based interventions to improve quality, outcomes, and population health.

The core MAQCI staff will be in the Office of the Medical Director (OMD), and include: 1) the Project Manager (Research Scientist Supervisor I), who will be responsible for the overall project including the deliverables, contracts, activities, and staff supervision; 2) the Project Assistant (Staff Services Analyst), who will assist the Project Manager and will have primary responsibilities to manage the contracts (Interagency Agreements), budget and compilation of reports due to CMS; and, 3) four Research Scientists (levels II and III), who will work with programs to analyze the data and develop the quality measures and reporting methods. In addition to coordinating quality measure development within DHCS, the OMD will manage interagency agreements and contracts with external organizations that will: 1) contribute to the preparation of the quality measures; 2) provide technical support for staff development in the area of clinical quality; and, 3) provide assistance with the implementation of the identified QI projects.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DHCS to present this proposal.

Staff Recommendation: Hold open**.**

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 1: COORDINATED CARE INITIATIVE, DUAL ELIGIBLE DEMONSTRATION PROJECT BCP

DMHC requests to extend 13.0 limited term positions, set to expire June 30, 2013, and add 3.5 new limited term positions to address the workload associated with the transition of dual eligible enrollees in eight counties into managed health care under the Coordinated Care Initiative (CCI). These positions would expire on June 30, 2016.

DMHC also requests $334,000 for consultant services to perform triennial medical plan surveys and financial audits. DMHC indicates that consultants provide specialized medical expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to the care for dual eligible beneficiaries.

This proposal would be funded by 50 percent Managed Care Fund and 50 percent reimbursement from DHCS seeking a federal Medicaid match.

The requested positions are:

Help Center – 11.5 Positions

- Attorney III (1.5)
- Health Program Specialist II
- Nurse Evaluator II
- Associate Health Care Service Plan Analyst
- Associate Governmental Program Analyst
- Consumer Assistance Technicians (5.0)
- Office Technician

Division of Financial Oversight – 2.0 positions

- Corporation Examiner IV Specialists

Provider Solvency Unit – 2.0 positions

- Corporation Examiners

Division of Licensing – 1.0 position

- Health Program Specialist I

PANELISTS

- Department of Managed Health Care
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The 2012 budget authorized the Coordinated Care Initiative (CCI), by which persons eligible for both Medicare and Medi-Cal (dual eligibles) would receive medical, behavioral, long-term supports and services, and home- and community-based services coordinated through a single health plan in eight demonstration counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).

AB 1468 (a 2012 budget trailer bill) requires DHCS to enter into an Interagency Agreement with DMHC to perform certain oversight and readiness review activities related to CCI, including:

- Provide consumer assistance to beneficiaries;
- Conduct medical plan surveys;
- Conduct financial audits;
- Conduct financial solvency audits, and,
- Conduct reviews of the adequacy of provider networks of participating health plans.

In 2012-13, DMHC received a one-time augmentation of $1,097,000 and 13.0 one-year limited-term positions to address new workload attributable to the evaluation of plan readiness and oversight of health plans providing managed health care services for CCI. DMHC explains that only 3 of these 13 positions were filled due to the very challenging nature of recruiting qualified individuals for limited-term positions. These positions were approved for either 6 months or one year. Last year, the positions were proposed and approved for just one year given the very short time-frame to plan for the CCI implementation. This proposal extends the positions for three years, as DMHC still does not know with certainty if the workload will be permanent.

In response to questions asked at a prior Subcommittee hearing regarding overall CCI resources, the Department of Finance provided the following chart:

CCI Resources

	2012-13	2013-14	Vacancy Rate
	Positions	BCP Requested positions	
DHCS [1/]	(31)	1	7.0%
DMHC [2/]	13	16.5	17.0%
DSS [3/]	(1)	7	12.7%
Total	13	24.5	

1/ DHCS notes the position requested for 2013-14 is related to the Dual Eligibles Demo, not CCI per se.
DHCS positions in 2012-13 are redirected internally.
DHCS vacancy rate is as of December 2012.

2/ DMHC positions in 2012-13 are one-year limited term.
DMHC vacancy rate is as of April 2013.
Without limited-term positions that are hard-to-fill, DMHC vacancy rate is 7%.

3/ DSS position in 2012-13 is redirected internally.
DSS vacancy rate is as of March 2013.
Requested positions in BY are limited term.

STAFF COMMENTS/QUESTIONS

The Subcommittee has requested DMHC respond to the following:

1. Please provide an overview of this budget proposal.

2. Please provide a brief description of the CCI-related activities in which DMHC currently is engaged.

Staff Recommendation: Approve as proposed**.**

ISSUE 2: AFFORDABLE CARE ACT SFL

DMHC requests to convert 13.0 limited-term positions, set to expire June 30, 2013, to permanent and to add 1.0 new permanent position. This request includes $1,841,000 for 2013-14 and $1,932,000 for 2014-15 and ongoing (100 percent Managed Care Fund). These resources are to support the workload associated with implementing the federal Affordable Care Act (ACA). The requested positions include:

Help Center – 2.0 positions
- Attorney (1.0)
- Research Program Specialist I (1.0)

Division of Licensing – 6.0 positions
- Attorney III (4.0)
- Attorneys (2.0)

Division of Financial Oversight – 5.0 positions
- Corporation Examiner IV Supervisor (1.0)
- Corporation Examiners (4.0)

Office of Technology and Innovation – 1.0 position
- Staff Programmer Analyst (1.0)

PANELISTS

- Department of Managed Health Care
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

President Obama signed into law the federal Patient Protection and affordable Care Act (ACA) on March 23, 2010. As described by DMHC, "The ACA fundamentally alters the availability and structure of health insurance, brings coverage for the first time to millions of Californians, and brings new coverage options for millions of enrollees who receive care through Knox-Keene Act-licensed health plans and contracted medical groups." Within the context of implementing the ACA in California, DMHC is charged with consumer assistance, oversight, and implementation of many private sector aspects of the ACA, and also serves as the regulatory expert and consultant to the Legislature and Governor on these reforms. DMHC estimates that approximately 6.16 million consumers will join health plans that fall under DMHC's jurisdiction over the next several years. Currently, there are approximately 20 million enrollees covered by health plans regulated by DMHC. The requested positions would address the following:

DMHC expects new enrollees to seek assistance from the DMHC Help Center on accessing care, information about health care options, dealing with non-compliance issues affecting their care, responding to denials and delays in receiving care, and reporting of health care complaints for resolution.

DMHC is requesting legal positions for the Division of Licensing to provide legal analysis of health plan license filings, which they expect to continue after 2014 and ongoing. This legal work is complex due to the interplay between federal and state law, as well as new licensees entering the market.

DMHC is requesting positions for the Division of Financial Oversight to address the Medical Loss Ratio (MLR) workload associated with the SB 51 rebate requirements of commercial plans. DMHC has the authority to impose and enforce an 85 percent MLR in the large group market and an 80 percent MLR in the small group and individual markets. If a health plan does not meet its MLR, DMHC is required to ensure the plan provides appropriate rebates to consumers.

The Systems Development Division, within the Office of Technology and Innovation, will have permanent workload reflecting new reporting requirements, expansion of information to be collected from health plan and ongoing support of programs created by the ACA. The requested position will work on the development, data mapping, compilation, and continued support of technical documentation, databases, and reporting tools required by the ACA.

STAFF COMMENTS/QUESTIONS

The LAO believes that the DMHC has justified the permanent workload for all of the positions requested, except for the 6.0 positions requested for the Division of Licensing, and therefore recommends that the Legislature approve these positions as limited-term for two years.

DMHC has experienced, and communicated to the Legislature, the extremely challenging nature of attracting and hiring qualified staff for limited-term positions. When the department cannot fill limited-term positions, the workload must be absorbed by existing staff. DMHC's workload is clearly increasing substantially, while many limited-term positions remain unfilled throughout the department.

The Subcommittee has asked DMHC to present this proposal and to respond to the LAO's recommendation.

Staff Recommendation: Approve as proposed**.**

ISSUE 3: HEALTH BENEFIT EXCHANGE REIMBURSEMENT AUTHORITY SFL

DMHC is requesting 3.0 limited-term positions for eighteen months (July 1, 2013 through December 31, 2014) for the Division of Licensing (DOL) and 5.0 limited-term positions for one year (January 1, 2014 through December 31, 2014) for the Help Center (HC) to address workload associated with enrolling consumers into managed care plans and health plan participation in the California Health Benefit Exchange (Covered California).

The request is for reimbursement (Covered California) authority for $622,000 in 2013-14 and $394,000 in 2014-15 for these positions. The positions include:

Help Center – 5.0 positions
Consumer Assistance Technicians (3.0)
Staff Services Analysts (2.0)

Division of Licensing – 3.0 positions
Attorneys (2.0)
Associate Health Program Advisor (1.0)

PANELISTS

- Department of Managed Health Care
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

President Obama signed the federal Affordable Care Act (ACA) on March 23, 2010, which requires states to establish a purchasing Exchange to facilitate subsidies to purchasers of health insurance. Covered California is California's Exchange and it is charged with creating a new insurance marketplace in which individuals and small businesses will be able to purchase health coverage using federal tax subsidies and credits beginning in 2014. DMHC anticipates that 600,000 Californians will enroll in managed care plans licensed by DMHC in 2014.

Covered California received a two-year federal grant in January of 2013 to assist with implementation of the Exchange. As a component of this grant, Covered California will enter into an interagency agreement with DMHC to reimburse DMH for its services related to Exchange activities. The terms of both the interagency agreement and the federal grant are January 1, 2013 through December 31, 2014.

Generally, DMHC anticipates a substantial expansion in the overall healthcare market as a result of ACA implementation, in the form of many more Californians in coverage as well as many new health plans entering the market. New entrants and expansion proposals will require DMHC to establish and maintain the legal framework for new types of plans and products, and to provide legal analysis relating to qualified health plan certification standards. DMHC also will be required to initiate and maintain tracking of health plan regulator filings, revisions to plan operations, and to assist plan in adhering to filing guidelines. DMHC will act as a liaison between the plans and Covered California.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DMHC to present this proposal.

Staff Recommendation: Approve as proposed**.**