

# AGENDA

## ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

MONDAY, APRIL 22, 2013

4:00 P.M. - STATE CAPITOL ROOM 127

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## ITEMS TO BE HEARD

### 4150 DEPARTMENT OF MANAGED HEALTH CARE

### 4260 DEPARTMENT OF HEALTH CARE SERVICES

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<b>ISSUE 1: OVERSIGHT OF NETWORK ADEQUACY RELATED TO THE TRANSITIONS OF HEALTHY FAMILIES, SENIORS &amp; PERSONS WITH DISABILITIES, RURAL MANAGED CARE EXPANSION, &amp; PEDIATRIC DENTAL MANAGED CARE</b>
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Department of Health Care Services (DHCS) has embarked on an ambitious expansion of the Medi-Cal Managed Care (MCMC) program. These program changes include all age groups and all geographic regions. The purpose of this oversight section of today's hearing is to examine the challenges inherent in the transition of millions of people into managed care in an effort to ensure high quality care, and continuity of care, during and after these transitions. The following is a summary of the vast managed care expansion underway in the Medi-Cal program, followed by more detailed information under "Background."

In 2011, DHCS transferred Medi-Cal only seniors and people with disabilities (SPDs) from voluntary to mandatory enrollment in MCMC as part of the Section 1115(b) Medicaid Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS) entitled "A Bridge to Reform Waiver." Enrollment was phased in over a one-year period, beginning on June 1, 2011 in the 16 two-plan and Geographic Managed Care (GMC) counties.

DHCS is also participating in a demonstration project authorized by the 2010 federal Affordable Care Act (ACA) to improve coordination of services for persons who are dually eligible for state Medicaid programs (Medi-Cal in California) and Medicare. Approximately 456,000 potential enrollees will be eligible for enrollment in managed care plans in this Coordinated Care Initiative (CCI) in a three-year, eight county demonstration project. (The eight counties are Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara). On March 27, 2013, DHCS signed a Memorandum of Understanding with the federal government. Phased-in enrollment is currently scheduled to begin no earlier than October 1, 2013.

DHCS is currently in the process of transitioning about 863,000 children, up to age 19, in families with incomes above the thresholds needed to qualify for Medi-Cal but below 250 percent of the federal poverty level into the Medi-Cal program from the Healthy Families Program (HFP). This transition involves children in Sacramento and Los Angeles moving into Medi-Cal dental managed care.

AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the expansion of MCMC to 28 mostly rural counties which could add approximately 365,000 additional enrollees to MCMC program. In February 2013, DHCS announced that Anthem Blue Cross and California Health and Wellness Plan, received Notices of Intent to Award for the expansion to the counties of Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. DHCS is also planning an exclusive MCMC contract with Partnership HealthPlan of

California for expansion in Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties. In addition, Lake and San Benito counties will become County Operated Health System (COHS) managed care counties served by Partnership HealthPlan of California and Central California Alliance for Health, respectively. DHCS is currently working with Imperial County on its managed care plan selection process.

**PANELISTS**

- Lynn Kersey, Executive Director, Maternal and Child Health Access
- Kelly Hardy, Director of Health Policy, Children Now
- Kristin Jacobson, President, Autism Deserves Equal Coverage
- Rachel Harris, Healthy Families Parent

**PANELISTS**

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

**BACKGROUND*****Healthy Families Transition to Medi-Cal***

The federal Children's Health Insurance Program (CHIP) provides health coverage to children in families that are low-income, but with incomes too high to qualify for Medicaid. Until January 1, 2013, California's CHIP was the HFP administered by the Managed Risk Medical Insurance Board (MRMIB) and provided health insurance for about 863,000 children, up to age 19, in families with incomes above the thresholds needed to qualify for Medi-Cal but below 250 percent FPL. (The FPL for 2013 is \$23,550 in annual income for a family of four). Under the CHIP program, states had the option to create a stand-alone program, such as HFP, or expand its Medicaid program to include these children in families with higher income. In both options, states receive a two-dollar federal match for every state dollar. As originally implemented in California, Medi-Cal was expanded to covered infants under age one in families with income under 200 percent of FPL, children aged one to five in families with income up to 133 percent of FPL, and children age six to 18 in families with income up to 100 percent of FPL. Children in families with income over the threshold, but up to 250 percent FPL, were covered by HFP.

MRMIB provided coverage by contracting with plans that provide health, dental, and vision benefits to HFP enrollees. Under state law, the benefits that HFP provided to enrollees were required to be equivalent to benefits provided to state employees through the California Public Employees' Retirement System, with certain exceptions for mental health benefits.

Affordable Care Act. The federal Patient Protection and Affordable Care Act (ACA), effective calendar year 2014, includes Medicaid eligibility simplification requirements, and specifically replaces many of the complex categorical groupings and limitations in the Medicaid program (Medi-Cal in California). The ACA requires, by January 1, 2014, the state's Medicaid program to cover all children in families with income up to 133 percent FPL, thereby eliminating discontinuity based on the age of the child. In effect, this requires California to transition children in families with income between 100 percent FPL and 133 percent FPL between age six and 19 to Medi-Cal from HFP by 2014. The ACA also gives the states authority to integrate CHIP programs into the exchanges or retain as stand-alone programs. The maintenance of effort (MOE) provision requires states to maintain eligibility standards, methods, and procedures that are not more restrictive than those in effect at the time of the enactment of the ACA.

Governor's 2012 Budget Proposal. In the 2012 Budget, the Brown Administration proposed to begin the transfer of children in families up to 133 percent FPL in 2012 and to shift the remainder of the children (with incomes up to 250 percent FPL) to Medi-Cal, rather than integrate CHIP into the Exchange or retain it as a stand-alone program. The Governor proposed to shift children in the HFP to Medi-Cal over a nine-month period beginning in October 2012.

AB 1494 (Committee on Budget), Chapter 28, Statutes of 2012. The Legislature adopted a modified version of this proposed transition. AB 1494 provides for the transition of approximately 860,000 HFP subscribers to the Medi-Cal Program beginning January 1, 2013, in four Phases throughout 2013. Children in HFP will transition into Medi-Cal's new optional Targeted Low Income Children's Program (TLICP) covering children with income up to and including 250 percent FPL. At the time AB 1494 was enacted, it was projected that this transition would result in \$13.1 million General Fund savings in 2012-13, \$58.4 million General Fund savings in 2013-14, and \$72.9 million General Fund savings annually thereafter.

The transition, as modified by the Legislature in AB 1494, breaks up the transfer to Medi-Cal into four phases. Phase 1 was to begin no earlier than January 1, 2013 and included about 415,000 children who are in an HFP plan that is also a Medi-Cal Managed Care (MCMC) plan. Phase 2 is to begin no earlier than April 1, 2013 and includes about 249,000 children enrolled in an HFP plan that subcontracts with a MCMC plan and requires, to the extent possible, the child to be enrolled in the MCMC plan that sub-contracts with the same plan. Phase 3 is to begin no earlier than August 1, 2013 and consists of about 173,000 children enrolled in an HFP plan that is not a Medi-Cal plan and does not contract with a Medi-Cal plan in that county. Plan enrollment for these children is to include consideration of whether the child's primary care provider is available through the new plan. Phase 4 is to begin no earlier than September 1, 2013 and transitions about 43,000 children in HFP residing in counties with no MCMC into Medi-Cal fee-for-service (FFS). However, once Phase 1 was approved, all newly eligible children, regardless of county are being enrolled into Medi-Cal.

HFP also provided a choice of dental care plans and a stand -alone vision plan. Dental services in HFP were provided through two different models—Open Network and Primary Care plans. In Primary Care plans, each enrollee has a primary care dentist who authorizes dental care provided by specialists. In Open Network plans, enrollees are not assigned a primary care dentist. In both models, MRMIB paid a per-member, per-month negotiated rate to the dental plan.

AB 1494 also required:

- The California Health and Human Services Agency (CHHSA), working with MRMIB, DHCS, and the Department of Managed Health Care (DMHC) to develop a strategic plan for this transition of children from HFP to Medi-Cal no later than October 1, 2012.
- DHCS to submit an implementation plan for each phase prior to transitioning children to Medi-Cal to ensure continuity of care with the goal of ensuring there is no interruption in services and there is continued access to coverage for transitioning individuals.
- At least 60 days prior to the transition of children, findings from a managed care health plan network adequacy determination must be submitted to the Legislature.
- Monthly status reports on the transition submitted to the Legislature. These reports must include information on health plan grievances related to access to care, continuity of care, requests and outcomes, and changes to provider networks (including provider enrollment and disenrollment).
- Managed care plan performance measures be integrated and coordinated with the HFP performance standards, including, but not limited to, child-only Healthcare Effectiveness Data and Information Set (HEDIS) measures, and measures indicative of performance in serving children and adolescents. This must occur prior to the implementation of Phase 1.
- Individuals must be informed of the change at least 60 days prior to the transition. This notification must include, at a minimum, information on how an individual's systems of care may change, when the change may occur, and whom to contact for assistance.

Behavioral Health Services. Prior to the transition, the HFP plans provided "basic" mental health services through the child's primary care provider or another mental health specialist that was part of the provider network. Children who are thought to be seriously emotionally disturbed (SED) are referred to the county mental health plan. Under Medi-Cal, children who are SED continue to be served by the county mental health plan. However, Medi-Cal managed care plans cover only the mental health services that can be provided by the child's PCP within the PCP's scope of practice. If the child's need exceeds this level the plan is supposed to refer them to a Medi-Cal fee for service (FFS) provider outside of the plan's network or to the county mental health plan if the health plan believes the child meets the medical necessity criteria to obtain specialty mental health services. During recent

Behavioral Health Workgroup and Stakeholder meetings, participants representing plans and enrollees have suggested that obtaining mental health services for the children that are supposed to be referred to a FFS mental health provider has been a problem. The plans do not have a list of these providers in the county and DHCS has not provided any assistance. There have also been reports of significant shortages and wait times for appointments in some counties.

Children With Autism. A similar issue has been raised with regard to children with autism spectrum disorder (ASD). HFP plans were required to provide Applied Behavioral Analysis (ABA) services to children with ASD. In the transition to Medi-Cal, some children qualify for, and are referred to, Regional Centers, which provide ABA services. If a child is not eligible for Regional Center services, the child no longer has access to ABA.

Advocates report that over 200 children with autism spectrum disorder (ASD) transitioning from Healthy Families to Medi-Cal were recently informed that they will no longer be able to access ABA once transferred to a Medi-Cal health plan and have had their services abruptly discontinued despite families being notified by the state in writing that, "Your child will continue to have all of the same services during this move. Your child's coverage will not be interrupted." Families were specifically told: "The Medi-Cal program covers mental health services. Your county mental health plan will provide the services, and your Medi-Cal health plan will help coordinate them." They further report that families who called the state's help lines did not receive adequate assistance leading to access to the services.

The National Institutes of Mental Health, Surgeon General, and American Academy of Pediatrics have endorsed ABA therapy as the clinical standard-of-care treatment for ASD. The medical community considers ABA to be the most effective treatment for ASD in that it can produce significant improvements in communication, social relationships, play, self-care, and school success as well as dramatically reduce problem behaviors such as self-injury and aggression.

For private coverage, state statute, created by SB 946 (Steinberg and Evans), Chapter 650, Statutes of 2011 mandates health plans to provide ABA services. Healthy Families Program plans also are required to provide ABA services under the state's mental health parity law, implemented via emergency regulations from DMHC in September 2012. Children enrolled in Medi-Cal, however, are not guaranteed access to these services, but should be under federal Medicaid law, according to advocates.

Medi-Cal "carves out" mental and behavioral health services from contracts with health plans. These services are provided by County Mental Health Departments for those with Asperger's and Pervasive Developmental Disorder–Not Otherwise Specified or PDD-NOS (about 2/3 of individuals with ASD). County Mental Health Departments do not provide ABA therapy. Twenty-one Regional Centers provide services for some of those with ASD. A majority of beneficiaries with ASD are unable to access ABA in Medi-Cal.

Network Adequacy. AB 1494 envisioned that Phase I would include approximately 400,000 children enrolled in 18 HFP plans that were also Medi-Cal managed care plans and who would be assigned to the same plan for Medi-Cal as they were in HFP. As required by AB 1494, DMHC and DHCS collaborated in assessing the adequacy of the Medi-Cal managed care plans networks for Phase 1. The first Network Adequacy Assessment Report was submitted on November 1, 2012. Generally, a high degree of overlap between providers contracted in the HFP and Medi-Cal networks in each county in which the health plans operate these lines of business was found. The report found that, although the departments had minor or moderate concerns with some health plan networks in Phase 1, the only health plans that the departments believed were not ready to transition on January 1, 2013 were Health Net of California, CalViva, and Anthem Blue Cross in Tulare County. Based on these findings the departments requested additional network information from these plans and submitted a First Addendum on January 1, 2013 summarizing the results of these inquiries.

Based on the findings of this report, stakeholder input and to ensure an orderly transition, DHCS sub-divided Phase 1 into in three sub-phases. The factors considered in placing counties in Parts A, B or C were:

1. A desire to have representation of each Medi-Cal managed care plan model—Two-Plan, County Organized Health System, and Geographic Managed Care—in each phase;
2. Findings from the network adequacy assessment demonstrating the degree of overlap in providers for health plans; and,
3. The desire to work with a smaller group of counties in each sub-phase to be able to appropriately identify and address any unanticipated issues that may arise to further ensure a smooth transition for children who are in Part B and C .

The Phase 1 Parts A, B, and C were as follows:

- Phase 1 Part A, January 1, 2013. Children in the following counties: Alameda, Riverside, San Bernardino, San Francisco, Santa Clara, Orange, San Mateo, and San Diego (except for Health Net managed care health plan).
- Phase 1 Part B. March 1, 2013. Children in Medi-Cal managed care health plans except for Health Net in the following counties: Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Tulare, Sacramento, Napa, Solano, Sonoma, Yolo, Monterey, Santa Cruz, Santa Barbara, and San Luis Obispo.
- Phase 1 Part C. April 1, 2013. Children in the Health Net managed care health plan in the following counties: Kern, Los Angeles, Tulare, Sacramento, San Diego, San Joaquin, and Stanislaus will transition.

The two most significant changes from the original Phase 1 plan resulted from the findings of the network adequacy assessments related to Health Net and CalViva. In the case of CalViva, the local initiative health plan that serves Fresno, Kings and Madera counties, CalViva did not have an HFP line of business and contracted with Health Net. CalViva was unable to secure assurances that the HFP-only providers would continue to treat the children in Medi-Cal post-transition. The departments expressed significant concerns about the adequacy of the CalViva network and found that key pieces of data were unavailable. Consequently, DHCS decided to move the transition of HFP members in CalViva to Phase 2.

With regard to Health Net, the original assessment raised enough concerns to warrant requests for additional information and required a reassessment before the departments could make a determination of adequacy for transition. For instance, the overlap between HFP providers and Medi-Cal providers was very low and at that time, the plan was unable to secure assurances that the HFP-only providers would continue to see the children after transition. Conversely, the plan was unable to secure assurances that its Medi-Cal providers who also treated HFP enrollees would continue to treat the children after transition. As a result, Health Net was moved to Phase 1 Part C.

On March 27, 2013, a second addendum was submitted. According to this report, DHCS and CMS felt it was important to provide Health Net with more time in which to contact and assist HFP enrollees in Los Angeles and San Diego counties in selecting a new primary care provider and ensuring continuity of care of existing services and changed the implementation date from April 1 to May 1, 2013.

Generally, with regard to Health Net, the report found that the Plan was providing continual updates to the departments regarding its progress in obtaining new Medi-Cal providers and confirming that existing Medi-Cal providers will treat HFP enrollees post-transition. The Plan has indicated that its entire Medi-Cal network is available for all transitioning HFP enrollees in Kern, Stanislaus, and Tulare counties. The Plan has indicated that for Los Angeles, Sacramento, San Diego, and San Joaquin counties, a network consisting of a combination of Medi-Cal and former HFP-only physicians will be available to treat HFP enrollees after they transition into Medi-Cal. In most cases, this has resulted in a larger network available to former HFP enrollees than would otherwise be available in the Medi-Cal network. In some cases, the new providers who have agreed to treat former HFP enrollees will also be available in the Medi-Cal network to treat existing Medi-Cal enrollees. For all counties, each assessment is based on the network that will be available to former HFP enrollees post-transition.

With the exception of moving Los Angeles and San Diego one month out, the report stated no concerns about the plan's networks. The report for Phase 2 with regard to CalViva in Kings and Madera was similar. However there are network issues identified that could cause concern:

- Specialists - Most of the counties were reported to have fewer individual provider specialists in the Medi-Cal network in some cases half as many specialists, the overlap ranged from a high in the 90<sup>th</sup> percentile to lows around the 50<sup>th</sup> percentile. In

some of the counties with fewer specialists and low overlap, the report found that there was adequate network in the areas of high utilization or that the plan would be required to provide out of network access.

- Geographic – In a few counties, such as Kern, Los Angeles and San Diego there were cities identified with no Medi-Cal PCPs. However, there were PCPs within the required 10 miles of 30 minutes.

Phase 2. In Phase 2, children will be transitioned from HFP Health Net, which also serves as a Medi-Cal subcontractor to CalOptima in Orange County and as a subcontractor to Molina Healthcare of California in Riverside and San Bernardino counties. Because Health Net is a subcontractor to CalOptima and Molina, also known as the “primary” Medi-Cal plans, the HFP enrollees will be assigned to CalOptima and Molina health plans when they transition to Medi-Cal. Those primary plans will subsequently assign the enrollees to Health Net in order to maintain continuity of providers for these enrollees. Because the HFP enrollees will belong to CalOptima and Molina health plans as their primary plans, patients who cannot maintain continuity of their provider with Health Net will be assigned a provider by the primary plan that does maintain continuity of provider, to the extent possible. Medi-Cal beneficiaries have the option to choose to be enrollees of the primary plan rather than be assigned to Health Net so that they may have access to the primary plans’ networks.

There are some network adequacy issues identified in the March 27<sup>th</sup> addendum to the Phase 2 assessment. For example, the Health Net Medi-Cal network in Orange County does not contain neonatologists, physical medicine and rehabilitation specialists, and plastic surgeons, all of which were included in the HFP network. In Riverside County, there are no pathologists and infectious disease specialists, which were utilized by a significant number of Medi-Cal enrollees over the past year. Access to these specialists is required to be provided by the plan out-of-network and is available through the primary plans (CalOptima and Molina). However, ensuring access may require close follow-up monitoring and will be more complex than the earlier transitions.

### ***Seniors & Persons With Disabilities***

In November of 2010, California obtained federal approval for a Section 1115(b) Medicaid Demonstration Waiver from CMS entitled “A Bridge to Reform Waiver.” Among the provisions, this waiver authorized mandatory enrollment into MCMC plans of over 600,000 low-income seniors and persons with disabilities (SPDs) who are eligible for Medi-Cal only (not Medicare) in 16 counties. Enrollment was phased in over a one-year period in the affected counties. This new mandatory enrollment began on June 1, 2011 and approximately 20,000 people per month were enrolled. Prior to this, enrollment was mandatory for children and families in 30 counties and for SPDs in 14 counties served by County Organized Health Plans (COHS), one of three models of MCMC in California. SB 208 (Steinberg), Chapter 714, Statutes of 2010, contained the provisions implementing this and other waiver requirements.

SB 208 included continuity of care protections for some enrollees that allowed them to maintain existing relationships with providers who they were utilizing on a fee for service basis prior to the transition but were not part of the plan's network. Many of these enrollees have complex medical conditions and had been in course of treatment for these conditions or diseases. The continuity was for a maximum of 12 months. For many of these patients this continuity period will be coming to an end and they will be required to obtain all medical services through the plan.

### ***Managed Care Expansion to Rural Counties***

There are three models of Medi-Cal MCPs. As of October 2012, MCMC in California served about 4.8 million enrollees in 30 counties, or about 65 percent of the total Medi-Cal population. As a result of the new initiatives that have been implemented, primarily the mandatory enrollment of SPDs, this has increased by 5 percent in the past year. The oldest model is the COHS. COHS plans serve about one million enrollees through six health plans in 14 counties: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Mateo, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Ventura, and Yolo. In the COHS model, DHCS contracts with a health plan created by the County Board of Supervisors and all Medi-Cal enrollees are in the same health plan. The second model is the Two-Plan model in which there is a "Local Initiative" and a "commercial plan" (CP). DHCS contracts with both plans. The Two-Plan model serves about 3.6 million beneficiaries in Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Two counties employ the GMC model: Sacramento and San Diego. DHCS contracts with several commercial plans in those counties and there are about 600,000 enrollees.

Fourteen counties are part of the two-plan model. In most Two-Plan model counties, there is a "Local Initiative" (LI) and a "commercial plan" (CP). DHCS contracts with both plans. Local government, community groups, and health care providers were able to give input when the LI was created. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. The Two-Plan model serves about 3.3 million beneficiaries in Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Two-counties employ the Geographic Managed Care (GMC) model: Sacramento and San Diego. DHCS contracts with several commercial plans in those counties and there are about 500,000 enrollees.

AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the expansion of MCMC to 28 mostly rural counties. The stated purpose is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in these counties that currently receive Medi-Cal services on a FFS basis: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Nevada, Mono, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba. Currently, approximately 365,000 enrollees would qualify for managed care.

In February 2013, DHCS announced that Anthem Blue Cross and California Health and Wellness Plan, received Notices of Intent to Award for the expansion to the counties of Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. DHCS is also planning an exclusive MCMC contract with Partnership HealthPlan of California for expansion in Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties. In addition, Lake and San Benito counties will become County Operated Health System (COHS) managed care counties served by Partnership HealthPlan of California and Central California Alliance for Health, respectively. DHCS is currently working with Imperial County on its managed care plan selection process.

Implementation of the rural expansion was set for June 1, 2013, however DHCS recently announced a delay until September 1, 2013. DHCS stated that the delay is necessary to allow for all readiness activities to be completed, including each health plans' development of a sufficient provider network

### ***Pediatric Dental Managed Care***

Medi-Cal provides dental care only to children, as the 2009 Budget Act eliminated dental benefits for adults. For children in Medi-Cal, dental care is provided on a fee-for-service basis in all counties except one: Sacramento, which only has managed care for dental care. With a few exceptions, Medi-Cal recipients in Sacramento are mandatorily enrolled in one of the Dental Plans. It is the only county in the state that has mandatory managed care for dental services. Los Angeles County utilizes both fee-for-service and managed care for the provision of dental services; however, enrollment in managed care is done on a voluntary basis, and about 15 percent of Medi-Cal recipients in Los Angeles enroll in a dental managed care plan.

Covered dental services under managed care are the same dental services provided under the Fee-For-Service Denti-Cal Program. These services include 24-hour emergency care for severe dental problems, urgent care (within 72-hours), non-urgent appointments (offered within 36-days), and preventive dental care appointments (offered within 40-days).

The HFP shift included a change in dental and vision benefits. For Sacramento County, if their plan is not a Medi-Cal dental managed care plan, the individual will be assigned to a plan, with preference to a plan with which their current provider is a contracted provider. For Los Angeles County, if their plan is not a Medi-Cal dental managed care plan, the individual may select a Medi-Cal dental managed care plan or choose to move into Medi-Cal FFS for dental coverage. For all other counties, dental coverage for these children transitions to Medi-Cal FFS dental coverage.

State Oversight of Dental Managed Care. The Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) share oversight of managed care plans in the state. Both departments have the statutory authority to conduct quality reviews. DHCS conducts annual reviews on the quality of services provided to Medi-Cal beneficiaries by medical managed care plans. These studies include the collection and annual public reporting of data measuring their performance according to the nationally recognized Health Plan Employer Data and Information Set (HEDIS) indicators. For medical plans, DHCS establishes minimum performance levels for HEDIS indicators. Both departments conduct periodic medical audits of health plans that evaluate the overall performance of the health plan in providing care to enrollees.

Historically, both departments have utilized these monitoring tools only on medical plans, by and large ignoring the operations of dental plans, despite dental plans also being licensed under Knox-Keene. Dental plans were not required to submit annual reports on timely access as required of medical plans. DMHC indicated in the past that their primary tool for becoming aware of problems with any managed care plan, of any type, was through their consumer complaint data.

First 5 Report on Sacramento's Geographic Managed Care. In 2010, First 5 of Sacramento commissioned the "Sacramento Deserves Better" report, produced by Barbara Aved Associates, which analyzed access, utilization, and quality of dental care under Sacramento's Geographic Managed Care (GMC) Dental Services model. Key findings from this report include the following:

- Only 20 percent of children in GMC Dental Services used a dental service in 2008 as compared to over 40 percent of children in Medi-Cal statewide who are predominately in Fee-For-Service;
- Only 30 percent of children in GMC Dental Services received a dental service in 2010;
- Sacramento GMC Dental Services is consistently one of the lowest-ranking counties for Medi-Cal dental access in the entire state;
- Dental plans have not complied with a "first tooth/first birthday" recommendation for the initial dental visit;
- Inadequate prevention services were provided; and,
- The state provided minimal oversight of GMC Dental Services contracts.

Early in 2012, through a series of articles and editorials, the *Sacramento Bee* brought attention to the dire conditions of Sacramento County's pediatric dental managed care program that is a component of the State's Medi-Cal program. The *Bee* coverage focused on the findings of the report commissioned by First 5 of Sacramento, which revealed shockingly low utilization rates and highlighted a series of examples of specific children who had been in desperate need of dental care, yet unable to access the care they needed without significant delays, worsening conditions, prolonged pain, and a significant amount of fear, frustration, and relentless advocacy on the part of their parents.

DHCS Response and Action. In response, the DHCS has undertaken a substantial corrective action plan for dental managed care, with a focus on Sacramento's GMC. The DHCS actions in 2012 included:

- Met with the five Dental Plans serving Sacramento to discuss how to implement immediate actions to improve access to dental care for children;
- Provided a letter to Dental Plans articulating immediate expectations and necessary improvements;
- Convened a stakeholder work group to obtain recommendations for improvement, including suggestions for improving the DHCS draft Request for Application (RFA), which is used as the basis for contracting with Dental Plans;
- Communicated with beneficiaries by: 1) letter on the importance of dental care as well as on how to access care; and, 2) by phone with beneficiaries who have not accessed care in the past 12 months;
- Began collecting utilization data from plans which the department shares with the stakeholder group;
- Increased monitoring of plans and providers based on data that indicates low utilization rates;
- Implemented a beneficiary dental exception process, per 2012 budget trailer bill (summarized below); and,
- Implemented changes to all dental plan contracts, including adoption of all Healthy Families Program HEDIS measures.

2012 Budget Trailer Bill. Also in response to the First 5 report, subsequent press coverage, legislative hearings and stakeholder input, provisions to address the shortcomings of dental managed care were included in AB 1467 (Chapter 23, statutes of 2012, budget trailer bill). This bill includes the following key provisions:

- *Sacramento Stakeholder Advisory Committee*. The bill allows Sacramento County to establish a stakeholder advisory committee to provide input on the delivery of oral health and dental care. It authorizes the advisory committee to provide input to the DHCS and to the Sacramento County Board of Supervisors. Requires DHCS and the Sacramento County Department of Health and Human Services advisory committee to meet with this advisory committee.
- *Beneficiary Dental Exception*. The bill authorizes the Director of DHCS to establish a beneficiary dental exception (BDE) process in which Medi-Cal beneficiaries who are mandatorily enrolled in dental health plans in Sacramento County can move to fee-for-service Denti-Cal. The BDE is to be available to beneficiaries in Sacramento who are unable to secure access to services through their managed care plan, within time-frames established within state contracts and state law.
- *Dental Plan Performance Measures*. The bill requires DHCS to establish a list of performance measures to ensure that dental health plans meet quality criteria. The bill requires DHCS to post on its website on a quarterly basis, beginning January 1, 2013, the list of performance measures and each plan's performance. The bill requires the performance measures to include: provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers. The bill also requires DHCS to designate an external quality review organization to conduct external quality reviews for all dental health plan contracting.
- *Dental Plan Marketing and Information*. The bill requires each dental plan to submit its marketing plan; member services procedures, beneficiary informational materials, and provider compensation agreements to DHCS for review and approval.
- *Annual Reports*. The bill requires DHCS to submit annual reports to the Legislature, beginning March 15, 2013, on dental managed care in Sacramento and Los Angeles, including changes and improvements implemented to increase Medi-Cal beneficiary access to dental care. The bill also requires the DMHC to provide the Legislature, by January 1, 2013, its final report on surveys conducted and contractual requirements for the dental plans participating in Sacramento.
- *Amendments to Contracts*. Requires DHCS to amend contracts, upon enactment of the statute, with dental health plans to reflect and meet the requirements of this new statute.

Study on Fee-for-Service. In 2012, dental health plans contracted with Barbara Aved Associates to conduct research on Medi-Cal's fee-for-service dental care. The study found, in part, that: 1) 97 percent of non-participating dentists cited low reimbursement rates as the reason for not participating; 2) 90 percent of general dentists said it was somewhat or very difficult to find a pediatric dentists accepting Medi-Cal referrals; and, 3) 38 percent of general dentists and 69 percent of pediatric dentists who take Medi-Cal have 15 percent or less of their patient population in Medi-Cal. The author concludes that children in Medi-Cal are getting inadequate dental care, largely due to insufficient provider participation, reflecting low reimbursement rates. The author recommends: 1) streamlining the provider enrollment process; 2) increasing rates; 3) adopting more quality measures; 4) increasing monitoring of utilization data; and, 5) increasing public oral health education to families.

HFP had been providing comprehensive dental coverage and evaluating dental plan performance since 1998. MRMIB monitors the quality of services provided to children in the program by annually collecting and reporting data on dental performance measures from the dental plans. HFP is one of the few programs in the country that measures dental quality and MRMIB has been at the forefront of developing quality measures. MRMIB revised its HFP dental measures in 2007. Reports are made annually at the Board meetings. In addition to collecting data on the quality of dental services, MRMIB has also administered the Dental-CAHPS survey to assess members' satisfaction with the dental care that they received. Families receive the results in enrollment materials, including the program handbook, and can use the information to compare dental plans. Reports are also available to the public on the MRMIB website. DHCS has committed to continuing to monitor these metrics. According to DHCS, both the Dental Managed Care (DMC) plans and Dental FFS (Denti-Cal) program will be required to report on 11 performance measures. The DMC plans will provide encounter data and Denti-Cal will provide claims data. The data will be monitored on a monthly basis and publicly reported quarterly, but there are no current plans for public comment. An annual report will be produced to represent the findings, similar to the current Healthy Families Quality Report.

DHCS March 2013 Report. On April 5, 2013, DHCS submitted a follow-up report to the Legislature on their efforts to improve the Dental Managed Care program. The report cites a substantial increase in dental care utilization rates in the program, from 2011 to 2012. Specifically, DHCS finds an "Increase of plans' utilization rates in Sacramento County from 32.3 percent in 2011, to 43.7 percent in 2012, and in Los Angeles County from 24.6 percent in 2011, to 36.8 percent in 2012."

The report lists the following actions that DHCS has taken over the past approximately two years to improve dental managed care:

- DHCS implemented the Immediate Action Expectations (IAE), which has resulted in the submission of monthly reporting to DHCS to compile and publish reports to the public.
- Implementation of the Beneficiary Dental Exemption (BDE) process, has allowed the staff to assist and manage these special needs cases until the rendering provider completes the necessary services.

- Conducting stakeholder and all plan meetings, to collaborate on dental issues, have become a component in improving the program.
- Assembly Bill 1467 (Committee on Budget), Chapter 23, Statutes of 2012 was enacted July 1, 2012, to improve requirements of DMC and amend Welfare and Institutions (W&I) Codes.
- Since IAE were implemented in March and April of 2012, the dental plans have realized higher utilization increases in the second half of the year. Utilization is expected to continue to increase in 2013.
- The DMC Contract procurement process was changed from a Request for Application to a Request for Proposal, which allowed DHCS to award contracts to plans demonstrating an ability to meet DHCS' goals and objectives, resulting in improved delivery of services in DMC.
- DMHC in conjunction with DHCS conducted non-routine surveys on most of the Sacramento County dental plans, and noted Knox-Keene deficiencies and contract findings

The report lists the following Immediate Action Expectations that have been requested (though not required) of the plans:

- Distribution of beneficiary letters by DHCS and dental plans. The letter from DHCS assured beneficiaries improvements to DMC would be made and provided each dental plan's member services phone number. Each dental plan also developed and distributed a letter to their members, providing information on available dental benefits, the importance of dental care for children, information regarding assigned primary care provider, and his/her phone number and office location.
- Conduct a phone call campaign to all beneficiaries, who had not seen a primary care dentist within the previous 12 months. The goal was to schedule an appointment for the beneficiary with a primary care dentist.
- Develop an informational flyer providing consistent dental information to all beneficiaries and stakeholders. The flyer contained the plans' contact and grievance information as well as DHCS, Health Care Options (HCO), and Medi-Cal Managed Care Ombudsman contact information.
- Conduct outreach educational seminars for providers and the provider community. The seminars were to cover information on the beneficiary benefits, submitting encounter data, and any incentive programs available. All materials presented at the seminars and the schedules were submitted to DHCS for approval. This allowed the opportunity for providers to voice any issues or concerns they were experiencing related to DMC.

- Develop provider incentive programs for children ages 0-21. The incentive program included applying provider performance measures to members, who actually received services. The performance measures were to include preventive services.
- Submit annual timely access reports to DHCS, including information on the average number of days it takes to schedule a routine, preventive, and/or emergency appointment; the number of members, whose primary care dentist is more than 30 minutes or more than 10 miles away from their residence; the number and percentage of routine authorizations received and approved; and the number of specialist referrals received, approved, denied, and completed.
- Implement utilization control by identifying providers not meeting thresholds of utilization and halting all new enrollments to those providers. For providers exceeding the plans' performance measures, including for preventative services, an incentive program was developed for members, ages 0-21.
- Develop enrollment outreach campaigns to expand provider, specialists, and Federally Qualified Health Center (FQHC) enrollment in the plans' network. Plans were to work with DHCS to develop credentialing criteria in order to increase enrollment and expedite the enrollment process.

Finally, the report also outlines the following new Dental Managed Care 2013 contract improvements:

- Quality Improvement Projects (QIP) – The plans are required to participate and/or conduct two QIPs. One QIP must be either an internal QIP or a small group collaborative. The second will be a project established by DHCS.
- External Quality Review Organization (EQRO) – The plans must have an EQRO to audit performance measures and conduct annual surveys.
- Provider Monitoring – The plans are to conduct provider monitoring based on quality improvement thresholds, e.g., access and availability standards, encounter data submission, and dental record accuracy.
- Performance Measures and Benchmarks – DHCS will monitor 11 performance measures and benchmarks tied to ten percent monthly withholds of capitation payment. DHCS may halt new enrollment into a plan if the contractor fails to achieve benchmarks for the performance measures. The utilization performance measures will be posted online.
- Review Provider Contracts – DHCS will review provider contracts and compensation arrangements, and may deny any inappropriate payment schedules. The plans are encouraged to provide incentive programs for providers and are required to conduct provider outreach to expand the provider network to include FQHC, Rural Health Centers, and Indian Health Service Facilities.

- Access and Availability – DHCS added standard appointment timeframes for preventive dental appointments and emergency appointments; a timely access survey that must be conducted annually, and monthly phone call campaigns to members, who have not been to the dentist in the previous 12 months.
- Payment to Plans – DHCS increased withhold amounts for performance measures and for deliverables. Withhold payments will be paid annually and a bonus incentive was added for plans, who show outstanding accomplishments in performance.
- CAP and Sanctions – DHCS can implement CAPs for plans with repeated deficiencies and require them to correct them in a timely manner. Sanctions were modified to include stricter provisions, such as the ability to halt new enrollment of Medi-Cal beneficiaries as a consequence of non-compliance.

<b>STAFF COMMENTS/QUESTIONS</b>
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*Healthy Families Transition*

1. Please describe the directions DHCS has given to Health Net, Molina, Inland Empire, and other plans in Phase 2 with regard to ensuring that families are fully informed regarding the need to find a new PCP and/or the unavailability of certain specialists.
2. In Phase 1, CalOptima made multiple attempts to contact the families that had to be reassigned to a new PCP. Are similar plans being made by the other plans?
3. Are plans informing enrollees of the right to go out of network for specialty care?
4. Are plans identifying potential out of network providers and establishing relationships with them?

*Autism*

1. Please explain why Applied Behavioral Analysis, which is considered the standard of care, was a guaranteed benefit for children in HFP, yet it is only available to some in Medi-Cal.
2. What is DHCS doing to ensure continuity of care for children who had been receiving ABA services in HFP?
3. Please explain why these families were not notified in advance of this anticipated change in services?
4. Please provide a list of all other benefits that are provided through HFP and not by Medi-Cal.

*SPD Transition*

1. What efforts is DHCS making to ensure that enrollees continue to receive necessary medical care after the continuity of care period has expired?
2. Has DHCS monitored the plans to ensure compliance with continuity of care requirements?
3. What is the status of the process by which a denied Medical Exemption is treated as an automatic continuity request and are plans complying with this?

*Rural Expansion*

1. Please describe the process that will be utilized to determine network adequacy.
2. Will there be transparency to the determination of network adequacy, similar to the HFP transition?
3. Please describe the plans for mandatory enrollment?

*Pediatric Dental*

1. How was the 2012 data collected for the Medi-Cal Dental Managed Care report? The report indicates a significant increase in utilization for children ages 0-20; is this broken down by age range (0-3, etc.) and if yes, is this comparable to data from 2011?
2. In the April 15 monitoring report, the total number of active service office locations accepting Denti-Cal referrals appears to have decreased by 136 locations from the first monitoring report in January. Please verify if this decrease over the past three months is correct and if so, what actions will Denti-Cal take to increase the number of offices?
3. The April report says that 51 percent of enrolled dental service locations are accepting new referrals. Which counties comprise the remaining 49 percent of providers who are **not** accepting referrals?
4. Does the Administration anticipate expanding the Dental Managed Care program?
5. Will DHCS adopt the monitoring activities that MRMIB carries out with regard to dental care?

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**Staff Recommendation:** Oversight issue; no action recommended

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**4280 MANAGED RISK MEDICAL INSURANCE BOARD****ISSUE 1: OVERVIEW OF DEPARTMENT AND PROPOSED BUDGET**

The Governor's proposed budget for this department includes total funds of \$611,284,000, a \$143.9 million General Fund decrease over the current year budget, primarily reflecting the discontinuation of the Healthy Families Program, as approved through the 2012 budget and described above.

**PANELISTS**

- Managed Risk Medical Insurance Board
- Department of Finance
- Legislative Analyst's Office

**BACKGROUND**

The Managed Risk Medical Insurance Board (MRMIB) administers five programs, which provide health care coverage through private health plans to certain populations without health insurance, as follows:

- 1. Healthy Families Program (HFP).** The HFP, California's version of the federal Children's Health Insurance Program (CHIP), provides subsidized health, dental and vision coverage through managed care arrangements to children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are not eligible for Medi-Cal but meet citizenship or immigration requirements. Eligibility is conducted on an annual basis. A 65 percent federal match is obtained through a federal allotment (Title XXI funds). As discussed in more detail above, the 2012 budget package approved of the Governor's proposal to discontinue this program by transitioning all children in the program to Medi-Cal.
- 2. The Major Risk Medical Insurance Program (MRMIP).** MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. Proposition 99 (tobacco tax) funds are used to supplement premiums paid by participants to cover the cost of care in MRMIP. MRMIP was the state's pre-existing conditions program (PCIP) prior to the passage of the federal Affordable Care Act (ACA) and creation of the federal PCIP (described below).

3. **Pre-Existing Conditions Insurance Program (PCIP).** Created by the ACA, the PCIP offers health coverage to medically uninsurable individuals 18 years or older who live in California. It is available for people who have not had health coverage in the six months prior to applying. PCIP uses a preferred provider network that has contracted health providers in all 58 counties statewide. Monthly premium costs are based on the applicant’s age and the region where the applicant lives.
4. **Access for Infants and Mothers (AIM).** AIM provides low cost insurance coverage to uninsured, low-income pregnant women. The subscriber cost is 1.5 percent of their adjusted annual household income. AIM is supported with Proposition 99 funds, as well as federal funds to supplement the participant’s contribution to cover the cost.
5. **County Children’s Health Initiative Matching Fund Program (CHIM).** The CHIM offers counties the opportunity to use local funds to obtain federal matching funds for their Healthy Children’s Initiatives, which provide health coverage to uninsured children. Currently, San Francisco, San Mateo, and Santa Clara Counties participate in CHIM.

<b>MRMIB Program Caseloads</b>			
<b>MRMIB PROGRAM</b>	<b>2011-12 Actual</b>	<b>2012-13 Estimated</b>	<b>2013-14 Projected</b>
Healthy Families	873,442	200,464	4,002
Access for Infants and Mothers (AIM)	7,572	7,603	7,603
County Children's Health Insurance Matching (CHIM)	1,652	1,736	1,736
Managed Risk Medical Insurance (MRMIP)	5,957	5,713	7,000/0*
Pre-Existing Conditions Insurance (PCIP)	11,746	15,833	18,304/0**

*\*Due to budgetary constraints and a maintenance-of-effort requirement for MRMIP, MRMIB establishes enrollment caps in lieu of caseload estimates to manage the program within its budget allocation of \$31.8 million. The enrollment cap for calendar year 2013 is 7,000, a decrease from 8,000. The reduction is due to the implementation of AB 1526 (Monning), Chapter 855, Statutes of 2012, which subsidizes subscriber premiums. It is anticipated that with implementation of the ACA, all subscribers will transition to the individual market or to the Health Benefit Exchange where, if eligible, they can receive premium subsidies.*

*\*\*PCIP is 100 percent federally funded and the coverage of health care services ends on December 31, 2013, due to the implementation of the ACA on January 1, 2014. PCIP is enrolling an average of 1,000 new subscribers each month. The projected caseload assumes the enrollment growth of 1,000 new subscribers each month and federal funding throughout 2013.*

**MRMIB Budget**

The chart below summarizes the proposed budget and reflects the transition of HFP children to Medi-Cal as well as the assumed “phasing out” of the MRMIP and PCIP programs due to the implementation of the ACA, discussed in more detail in the next item in this agenda.

<b>MANAGED RISK MEDICAL INSURANCE BOARD</b>					
<b>Fund Source</b>	<b>2011-12 Actual</b>	<b>2012-13 Projected</b>	<b>2013-14 Proposed</b>	<b>BY to CY Change</b>	<b>% Change</b>
<b>General Fund</b>	\$272,738,000	\$165,508,000	\$21,651,000	(\$143,857,000)	(87%)
<b>Federal Trust Fund</b>	811,594,000	643,286,000	126,394,000	(516,892,000)	(80%)
<b>Special Funds &amp; Reimbursements</b>	206,264,000	252,374,000	114,557,000	(137,817,000)	(55%)
<b>Federal Temporary High Risk Health Insurance Fund</b>	214,766,000	350,982,000	348,682,000	(2,300,000)	(.6%)
<b>Total Expenditures</b>	<b>\$1,505,362,000</b>	<b>\$1,412,150,000</b>	<b>\$611,284,000</b>	<b>(\$800,866,000)</b>	<b>(57%)</b>
<b>Positions</b>	90.0	104.9	104.90	-	-

**STAFF COMMENTS/QUESTIONS**

Subcommittee staff has asked MRMIB to provide an overview of the department and its proposed budget, including major changes underway at the department, and to briefly describe the impacts that the state's recent fiscal crisis had on the department and its programs.

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

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**ISSUE 2: PHASE-OUT OF MANAGED RISK MEDICAL INSURANCE PROGRAM & PRE-EXISTING CONDITION INSURANCE PLAN**

The Governor's January Budget Summary indicates the Managed Risk Medical Insurance Program (MRMIP) and the Pre-Existing Condition Insurance Program (PCIP), health coverage programs for individuals with pre-existing conditions, will phase-out with the implementation of the federal Affordable Care Act (ACA).

The budget includes full year funding for MRMIP related to the fact that MRMIB must complete reconciliations for MRMIP. Under current statute, health plans have until December 31, 2014 to submit claim information. MRMIB anticipates that it would take an additional six months (until June 2015) to complete the reconciliations.

**PANELISTS**

- Managed Risk Medical Insurance Board
- Department of Finance
- Legislative Analyst's Office
- Public Comment

**BACKGROUND**

MRMIB has indicated that it is working with Covered California regarding the transition of MRMIP and PCIP subscribers to the Exchange. However, details regarding this transition, such as the transfer of protected health information between the programs, are still being worked out.

**MRMIP.** MRMIP provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions. Californians qualifying for the program participate in the cost of their coverage by paying premiums. Cigarette and Tobacco Product Surtax Funds are deposited into a special fund and are used to supplement premiums paid by participants to cover the cost of care in MRMIP.

**PCIP.** As a result of the ACA, California has a contract with the federal Department of Health and Human Services to operate this federally-funded high-risk pool program to provide health coverage for eligible individuals. The program will last until December 31, 2013, when the national health reform is set to begin. The PCIP offers health coverage to medically-uninsurable individuals who live in California and is available to individuals who have not had health coverage in the last six months.

**Federal Government Requires Closure to New Enrollment for PCIPs Nationwide.** The federal government notified all state administered PCIPs to close to new enrollments after March 2, 2013. As the contractor that operates PCIP in California, MRMIB has closed PCIP enrollment except for persons coming into California with PCIP from another state and for persons who applied prior to March, but whose application was missing information.

California's PCIP has incurred costs of \$529 million of its \$761 million allocation.

<b>STAFF COMMENTS/QUESTIONS</b>
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The Subcommittee has requested MRMIB to provide an overview of this budget proposal.

1. What would facilitate a successful transition of MRMIP and PCIP subscribers to the Exchange?
2. What recommendations does MRMIB have with regard to the future of MRMIP?

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**Staff Recommendation:** Hold open pending a more detailed proposal and updated information later this year.

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## 4150 DEPARTMENT OF MANAGED HEALTH CARE

### ISSUE 1: OVERVIEW OF DEPARTMENT AND PROPOSED BUDGET

The Governor's 2013-14 Budget proposes total funding of \$52,107,000, a decrease of \$4,185,000 reflecting a \$4.7 million decrease in federal funds.

#### PANELISTS

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

#### BACKGROUND

The mission of the Department of Managed Health Care (DMHC) is to help California consumers resolve problems with their Health Maintenance Organizations (HMOs) and to ensure a better, more solvent and stable managed health care system through: 1) administration and enforcement of California's HMO patient rights laws; 2) operation of a 24-hour-a-day Help Center; and, 3) licensing and oversight of all HMOs in the state.

Formerly within the Business, Transportation, and Housing Agency, AB 922 (Monning), Chapter 552, Statutes of 2011, transferred the DMHC to the Health and Human Services (HHS) Agency effective January 1, 2012. Chapter 552 also removed the Office of Patient Advocate (OPA) from DMHC and established it as an independent entity under the HHS Agency effective July 1, 2012. The OPA offers information to consumers on choosing health plans, rankings of health plans and medical groups, and educates consumers about patient rights and responsibilities.

**Premium Rate Review.** The ACA directs states to establish a formal process for the annual review of health insurance premiums to protect consumers from unreasonable rate increases. In response, SB 1163 (Leno), Chapter 661, Statutes of 2010, was signed into law. As a result of the ACA and SB 1163, Knox-Keene licensed full-service health plans are now required to file premium rate data for their individual, small employer and large employer products with the DMHC, which is required to review these for unreasonable premium rate increases.

**Network Capacity & Plan Oversight.** As discussed in detail in issue 1 of this agenda, the significance of the role, and workload, of this department can be expected to increase substantially over the next few years as a result of thousands of Californians enrolling in managed care plans for the first time. This increase in managed care is a result of several state initiatives as well as the federal ACA. In 2011, the state chose to transition 350,000 seniors and persons with disabilities from fee-for-service Medi-Cal into managed care. In 2012, budget trailer bill included the Coordinated Care initiative, which will result in the transition of hundreds of thousands of "dual eligibles" from fee-for-service Medi-Cal into

managed care. The CCI also transitions a range of Medi-Cal long-term care benefits into managed care for the first time. 2012 also brought the approval of the transition of nearly a million children in the Healthy Families Program into Medi-Cal, thereby requiring network assessment work by DMHC in preparation for the transition, as well as increased oversight of Medi-Cal’s dental managed care plans in Los Angeles and Sacramento. Finally, in 2012, the budget trailer bill gave the DHCS authority to seek managed care contracts for California’s 28 remaining fee-for-service counties. Looking forward to 2014, the Governor has proposed to implement the ACA by increasing eligibility for Medi-Cal, which can be expected to bring another 1.4 million into Medi-Cal managed care coverage. Finally, the ACA, through California’s health benefits exchange (Covered California), will result in millions more Californians gaining coverage in the private market.

**DMHC BUDGET**

The DMHC receives no General Fund and is supported primarily by an annual assessment on each HMO. The annual assessment is based on the department’s budget expenditure authority plus a reserve rate of 5 percent. The assessment amount is prorated at 65 percent and 35 percent to full-service and specialized plans respectively. The amount per plan is based on its reported enrollment as of March 31<sup>st</sup> each year. The Knox-Keene Act requires each licensed plan to reimburse the department for all its costs and expenses. The table below summarizes the proposed budget for DMHC.

DEPARTMENT OF MANAGED HEALTH CARE					
Fund Source	2011-12 Actual	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
General Fund	\$0	\$0	\$0	\$0	0%
Federal Trust Fund	4,307,000	5,391,000	691,000	(4,700,000)	(87%)
Managed Care Fund	40,199,000	49,715,000	48,677,000	(1,038,000)	(2%)
Reimbursements	975,000	1,186,000	2,739,000	1,553,000	131%
Total Expenditures	\$45,481,000	\$56,292,000	\$52,107,000	(\$4,185,000)	(7%)
Positions	286.4	352.8	346.0	(6.8)	(2%)

**STAFF COMMENTS/QUESTIONS**

Subcommittee staff has asked DMHC to provide an overview of the department and its proposed budget, including major changes underway at the department, and to briefly describe the impacts that the state's recent fiscal crisis had on the department and its programs.

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

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**ISSUE 2: MEDI-CAL DENTAL MANAGED CARE PROGRAM BCP**

DMHC is requesting authority to convert 2.0 limited term positions into permanent positions, and for \$378,000 in 2013-14 funding authority, to support this increased workload. The funding is to be split evenly between DMHC special funds and reimbursements from DHCS (i.e., federal funds). DMHC also requests \$130,000 for consultant services to provide specialized dental expertise for the dental plan surveys. The requested positions would conduct triennial dental surveys and financial audits of Medi-Cal Dental Managed Care (DMC) plans commencing July 2013. The requested permanent positions are as follows:

- 0.5 Health Program Specialist (HPS) II
- 0.5 Associate Health Care Service Plan Analyst (AHCSPA)
- 1.0 Corporation Examiner

**PANELISTS**

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

**BACKGROUND**

Medi-Cal DMC plans are licensed and regulated by the DMHC pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The DMHC is mandated by the Knox-Keene Act to conduct dental surveys and financial audits of dental managed care plans on three-year survey and five-year audit schedules.

The DHCS Medi-Cal Program contracts with Liberty Dental Plan, Access Dental, and Health Net Dental Plan in Sacramento County, effective January 1, 2013, and Los Angeles County, effective July 1, 2013, for a total of six DMC plans. Each dental plan receives a negotiated monthly per capita rate from the state for each Medi-Cal beneficiary enrolled in the plan. Medi-Cal DMC beneficiaries enrolled in contracted plans receive dental benefits from providers within the plan's provider network.

In Sacramento County, the dental Geographic Managed Care (GMC) is a mandatory program where certain populations of Medi-Cal recipients who are eligible to receive dental services must select one of the three available GMC plans for their dental care. In Los Angeles County, the dental managed care program is voluntary.

***Increased DMHC Oversight of Dental Managed Care***

In February 2012, a Sacramento Bee article describing significant access and quality of care problems in the dental GMC program in Sacramento County generated an influx of consumer complaints to the Help Center and concern about the lack of access to dental care for children in that county. As a result, the subcommittee took action to adopt legislatively proposed trailer bill language and approve a May Revise proposal to require DMHC to conduct non-routine surveys of DMC contracts operating in Sacramento County and conduct additional onsite dental surveys of the dental plans participating in the DMC program.

Prior to the implementation of non-routine audits described above, DMHC did not directly survey Medi-Cal DMC products. Additionally, DMHC did not review, assess, or evaluate the plan's performance of their Medi-Cal DMC contractual deliverables; nor did they request, review, or evaluate DMC's enrollment data, quality issues, network adequacy, language assistance, or any other potential barriers to care.

DMHC requests to convert two limited-term positions to permanent to address the increased workload attributable to the expanded oversight of the Medi-Cal Dental Managed Care (DMC) plans and the transition of the Healthy Families Program (HFP) children to the Medi-Cal DMC program.

DMHC also requests \$130,000 for consultant services to provide specialized dental expertise for the dental plan surveys. DMHC indicates that consultants provide specialized dental expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to dental care.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee has requested DMHC provide an overview of this budget proposal and a brief review of the findings from non-routine DMC surveys and the resulting corrective actions.

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**Staff Recommendation:** Approve as budgeted.

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**ISSUE 3: 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.

**PANELISTS**

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

**BACKGROUND**

SB 1163 (Statutes of 2010) requires health plans to submit premium rate information and gives DMHC the authority to review premium rate filings effective January 1, 2011. Under SB 1163, health plans are required to submit premium rate information to DMHC at least 60 days in advance of implementing a rate increase. Upon receipt of a premium rate filing, DMHC documents and publicly posts receipt of the rate filing, reviews the rate filing, and makes a determination as to whether or not the proposed rate increase is justified, and then publicly posts the DMHC determination.

SB 1163 provides the rate review authority for all individual and small group market products, but limits review authority in the large employer market to only those rate increases deemed "unreasonable" through actuarial review.

SB 1163 requires DMHC to make premium rate filing information available on its website and to accept and post public comments regarding the rate filings on the website. In addition, SB 1163 imposes a reporting requirement on DMHC to submit quarterly reports to the Legislature with regard to any unjustified or "unreasonable" rate increases received. States are also required to monitor premium rate trends both inside and outside of Exchanges established under federal health care reform.

Prior to January 1, 2011, DMHC had limited authority to review health plan rate filings. The only rates that were required to be filed, with very limited scope review, were for the small group market Health Insurance Portability and Accountability Act (HIPAA)-guaranteed issue and conversion products. Health plans were not required to file individual and small group commercial products for premium rate changes. At the time, DMHC did not have a rate review program or employ actuaries.

In response to the enactment of SB 1163, DMHC submitted a 2011-12 budget request to address the new anticipated workload associated with the receipt, review and reporting of health premium rate data. DMHC was granted two Associate Life Actuary positions for a two-year limited-term. Additionally, \$600,000 was approved to obtain external actuarial consultant services.

DMHC states that when the positions were originally requested as limited-term positions, DMHC did not yet know whether or not the workload would be limited or on-going. Nevertheless, DMHC found that it was very difficult to hire people for limited-term positions, and therefore reclassified certain vacant permanent positions in order to fill these limited-term positions. Now, DMHC asserts that the positions need to be made permanent, as the workload is on-going.

<b>Workload History and Projections</b>					
	2010-11	2011-12	2012-13	2013-14	2014-15
Premium Rate Review Filings	34	90	110	120	120

**Federal Grant for Rate Review Program**

In addition to the above resources, DMHC applied for and received federal Cycle I and Cycle II grants to develop an approved premium rate review program. The use of the federal funds is limited to carrying out the requirements set forth in the federal grant. The federal grant’s funding focus is policy oriented on the development of a good rate review program, while the focus of SB 1163 is on the actual collection and analysis of the premium rate data to determine if rate increases are justified, and the reporting of unreasonable rate increases to the Legislature.

DMHC states that it has negotiated plan rate decreases of approximately \$46 million since this program began in 2011. In just a few cases, DMHC has been unable to negotiate a decrease, and the plan has gone forward with implementing a rate increase that DMHC deemed unreasonable or unjustified. DMHC does not have the authority to prohibit unreasonable rate increases.

**STAFF COMMENTS/QUESTIONS**

Subcommittee staff has asked DMHC to present this proposal and provide a brief overview of their premium rate review work.

- 1) Please describe some situations wherein DMHC has found a proposed rate increase unjustified, and DMHC's response.

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**Staff Recommendation:** Approve as budgeted.

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**ISSUE 4: LEGISLATIVE OFFICE BCP**

DMHC requests an internal transfer of the Legislative Unit from the Office of Legal Services to the Director's Office. This will include the transfer of four positions and \$530,000 for 2013-14 and ongoing from the Health Plan Program to Administration. This is an organizational change only. There is no increase in funding or positions.

**PANELISTS**

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

**BACKGROUND**

DMHC legislative activities currently operate within the department's Office of Legal Services. However, the department believes that the recent passage of complex health care and health care reform legislation, including the federal Affordable Care Act that the unit can operate more efficiently if it can work more closely with the DMHC Director and Chief Deputy Director. Furthermore, DMHC recently established a Legislative Director position to lead and direct the legislative office staff, and this position is located in the Director's Office. The Legislative Director was placed in the Department Director's Office in anticipation of this BCP to move the entire Legislative Unit as well.

**STAFF COMMENTS/QUESTIONS**

Subcommittee staff has asked DMHC to briefly present this proposal.

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**Staff Recommendation:** Approve as budgeted.

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**ISSUE 5: MEDI-CAL MANAGED CARE RURAL EXPANSION 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. 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 this managed care expansion.

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.

The Help Center positions requested are:

- 0.5 Nurse Evaluator II – Provide clinical review of cases and handle urgent nurse cases.
- 0.5 Associate Governmental Program Analyst – Resolve standard complaints involving a review of the complaint, contacting the patient, and reviewing the health plan response.
- 0.5 Associate Health Care Service Plan Analyst – Prepare, organize, conduct, and lead survey teams performing surveys on an annual basis.
- 2.0 Consumer Assistance Technicians – Respond to consumer phone calls and correspondence.

**PANELISTS**

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

**BACKGROUND**

AB 1467 (a 2012 budget trailer bill) authorizes the expansion of the Medi-Cal Managed Care program into 28 rural counties that currently offer only fee-for-service (FFS) Medi-Cal. AB 1468 (a 2012 budget trailer bill) authorized DHCS to enter into an interagency agreement with the DMHC to conduct financial audits, medical surveys, and a review of the provider networks in connection with the expansion of Medi-Cal managed care into rural counties.

On February 28, 2013, DHCS announced that the state has chosen four health plans to provide managed care services to more than 400,000 Medi-Cal members in 28 rural counties, expanding Medi-Cal managed care to all of California's 58 counties.

<b>STAFF COMMENTS/QUESTIONS</b>
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When this budget proposal was prepared, it was anticipated that only two health plans would be selected to serve the 28 rural counties. However, subsequent to the preparation of this proposal, DHCS announced that it has chosen four health plans to provide managed care services to 28 fee-for-service counties.

DMHC has indicated that it is working with the Department of Finance to assess the workload impact associated with four health plans (instead of two) being selected for the expansion of Medi-Cal managed care to rural counties.

The Subcommittee has requested DMHC to provide an overview of this budget proposal and respond to the following:

- 1) When will DMHC have an updated estimate regarding the workload impact from the rural Medi-Cal managed care expansion?

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**Staff Recommendation:** Hold open pending an updated workload estimate and proposal at May Revise.

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**ISSUE 6: NETWORK ADEQUACY FOR HEALTHY FAMILIES PROGRAM & RURAL TRANSITION TO MEDI-CAL BCP**

DMHC is requesting 4.0 limited-term positions, effective July 1, 2013 to December 31, 2014, and associated funding of \$546,000 for 2013-14 and \$262,000 for 2014-15 (1/3 DMHC special funds and 2/3 reimbursements of federal CHIP funding through DHCS), to address increased workload related to network adequacy assessments required for the Healthy Families Program transition to Medi-Cal and the Medi-Cal managed care expansion into rural counties.

The requested positions include:

**Division of Licensing**

1. 1.0 Attorney III
2. 1.0 Health Plan Specialist I
3. 1.0 Associated Government Program Analyst

**Office of Technology and Innovation**

1. 1.0 Staff Programmer Analyst

**PANELISTS**

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

**BACKGROUND**

As described earlier in this agenda, DMHC has a significant role to play in the many transitions and expansions to Medi-Cal managed care, in terms of assessing and monitoring network adequacy of health plans. Specifically for the HFP transition, DMHC will perform network adequacy assessments prior to each transition phase as well as ongoing monitoring for one year after the completion of each transition phase.

In 2012-13, DMHC received a one-time augmentation of \$400,000 for its work on the HFP transition. Specifically, \$250,000 was used for consultant services and \$150,000 supported 1.0 Attorney III position. This current year workload includes network adequacy assessments to determine health plans' readiness to include HFP enrollees in their Medi-Cal managed care networks. These resources, however, were not sufficient to cover the costs of on-going monitoring after each phase of the transition occurs.

DMHC will provide quarterly monitoring which will be specific to each phase of the transition, and will begin three months after the start of each phase. The monitoring will last for one year following the beginning of each phase, with Phase 4 scheduled to begin September 1, 2013, and therefore the monitoring being completed by December 2014.

Quarterly monitoring by DMHC will consist of performing a detailed analysis of each plan's provider network on a county-by-county basis. DMHC explains that this will entail 488 detailed analyses of various submitted data elements along with other tasks.

This request includes 1.0 limited-term Staff Programmer Analyst position for the Office of Technology and Innovation (OTI) to provide technical programming and required reporting associated with the HFP transition and the rural expansion. DMHC states that the workload of the Systems Development Division will increase due to the development, testing, implementation, and support necessary to develop an automated Plan Provider Network Analysis and Review system to conduct the required health plan/provider network adequacy reviews, to ensure the plan networks continue to meet mandated access and capacity standards. This position also will develop a secured web portal to facilitate the exchange of data between DMHC, DHCS, Covered California, and other stakeholders.

<b>STAFF COMMENTS/QUESTIONS</b>
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Subcommittee staff has asked DMHC to present this proposal.

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**Staff Recommendation:** Approve as budgeted.

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**ISSUE 7: CONSUMER ASSISTANCE PROGRAM FEDERAL GRANT REAPPROPRIATION BCP**

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 complete the work required of this federal grant.

**PANELISTS**

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

**BACKGROUND**

On August 24, 2012, DMHC was awarded a second federal consumer assistance grant of \$4.6 million in support of implementation of the Affordable Care Act. The focus of the grant is education and outreach to uninsured individuals and families and seniors and persons with disabilities. DMHC is working with the Department of Insurance, community-based organizations, and the Office of the Patient Advocate (within the Health and Human Services Agency), to assist the uninsured and seniors and persons with disabilities to enroll into health coverage, file grievances and appeals, navigate the health care system and educate consumers about their health care rights.

This was a one-year grant with an original ending date of August 23, 2013. However, subsequently DMHC was approved for a six-month extension to February 23, 2014. DMHC is seeking approval for a second extension and is confident of receiving such approval to extend to August 23, 2014. DMHC states that they need additional time, and the funded positions, in order to spend all of the federal funds provided through this grant. In addition to the 4.0 positions, \$100,000 of the amount requested is for software and consultant services to develop a knowledge management database. Finally, \$324,000 will be used to develop: 1) a new online system for accepting public comment on various DMHC projects, and initiatives; 2) creating a new email subscription system for users to receive automatic updates on a variety of health coverage-related topics; 3) refining, and updating the DMHC public website to ensure that all information is up-to-date and relevant; and, 4) exploring the development of a mobile website platform.

**STAFF COMMENTS/QUESTIONS**

From the beginning, DMHC had planned to implement this grant in two years rather than one. DMHC states that, from the outset, the grant program was established in a way that would allow for implementation time-frames longer than one year.

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**Staff Recommendation:** Approve as budgeted.

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