AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER SHIRLEY N. WEBER, PH.D., CHAIR

MONDAY, APRIL 21, 2014

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

ITEMS TO BE HEARD

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4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

ISSUE 1: DEPARTMENT OVERVIEW

The Office of Statewide Health Planning and Development (OSHPD) develops policies, plans and programs to meet current and future health needs of the people of California. Its programs provide health care quality and cost information, ensure safe health care facility construction, improve financing opportunities for health care facilities, and promote access to a culturally competent health care workforce.

Seismic Safety

One of OSHPD's responsibilities is to implement the state's hospital seismic safety requirements. The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 established a seismic safety building standards program under OSHPD's jurisdiction for hospitals built on or after March 7, 1973. Numerous pieces of legislation since then have amended the Alquist Act, increasing OSHPD responsibilities and modifying seismic safety requirements and deadlines for hospitals.

Most recently, SB 90 (Steinberg), Chapter 19, Statutes of 2011, sought to respond to the fiscal challenges facing many hospitals, the resulting difficulty for them to meet the seismic deadline of 2013, and the possibility of hospital closures. SB 90 authorized OSHPD to grant hospitals an extension of up to seven years beyond the 2013 deadline if specific milestones and public safety conditions were met. Hospitals that applied for an SB 90 extension were granted an automatic two-year administrative extension and OSHPD is still processing the extension applications.

OSHPD states that 411 acute care hospital buildings remain in "Structural Performance Category 1," (the highest risk category, at risk of collapsing in an earthquake), out of an original inventory of 1,300 buildings. Hence, there has been a 69 percent reduction in the number of buildings in this highest-risk category. Put another way, given that some of these buildings have been demolished or otherwise removed from service, and new buildings built, 85 percent of the current inventory of acute care hospital buildings meet Structural Performance Category 2 standards or higher, meaning that, at a minimum, they are not at risk of collapse, though services may not be available in these buildings.

2013 Investment in Mental Health Wellness Initiative

As approved in the 2013 budget package, as a component of President Pro Tem Steinberg's Investment in Mental Health Wellness Initiative, the 2013-14 OSHPD budget includes $2 million in MHSA funds to provide training in the areas of crisis management, suicide prevention, recovery planning, targeted case management and related functions, and to facilitate employment of Peer Support classifications. OSHPD has met with stakeholders and released a call for proposals in December 2013.

OSHPD Budget

The OSHPD's proposed 2014-15 budget is summarized in the table below. Overall expenditures are proposed to decrease by $30.5 million (17 percent), primarily reflecting changes to Work Education and Training (WET) program funds, discussed in more detail under issue 5 of this section of the agenda. This reduction also reflects various grant funding that decreases over time.

OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT
(Dollars In Thousands)

Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed	BY to CY Change	% Change
General Fund	**$0**	**$74**	**$74**	**$0**	**0%**
Hospital Building Fund	45,766	57,897	57,822	(75)	(.13)
Health Data & Planning Fund	25,405	29,057	32,044	2,987	10.3
Federal Trust Fund	1,434	1,504	1,444	(60)	(3.9)
Reimbursements	363	8,153	7,860	(293)	(3.6)
Special Funds	(2,127)	27,202	20,200	(7,002)	(25.7)
Mental Health Services Fund	20,957	52,350	26,291	(26,059)	(49.7)
Total Expenditures	**$91,798**	**$176,237**	**$145,735**	**($30,502)**	**(17.3%)**
Positions	445.1	476.6	479.6	3	0.6

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to provide an overview of the department, its proposed budget, and significant department changes that occurred as a result of the state's recent fiscal crisis.

Staff Recommendation: This is an informational item and no action is necessary.

ISSUE 2: HEALTHCARE REFORM HEALTHCARE WORKFORCE DEVELOPMENT BCP

OSHPD requests an increase in expenditure authority of $355,000 in 2014-15 and ongoing (California Health Data and Planning Fund (CHDPF)) to make permanent 3.0 existing limited-term positions responsible for proactively seeking designations of Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA) and Medically Underserved Population (MUP). These positions proactively seek to make these designations to improve access to care in underserved communities. OSHPD also requests to make permanent one position responsible for continuing the implementation of the Health Care Reform work plan.

BACKGROUND

OSHPD traditionally processed HPSA, MUA, and MUP applications in a reactive fashion; community clinics or stakeholders submit their application to OSHPD and staff validates the information in the HPSA, MUA, and MUP applications and makes a recommendation to the federal government.

The 2011-12 budget authorized three positions to perform these designations on a proactive basis. The proactive process allows OSHPD to prepare the aforementioned applications by identifying which areas of the state meet the federal criteria for designation and preparing designation applications on behalf of communities. The 2013-14 budget reauthorized these positions through June 2014 on a one-year extension.

According to OSHPD, permanency for these positions is necessitated by the complexity of implementing Affordable Care Act (ACA) healthcare workforce provisions such as upcoming rule changes to the method of shortage designations, increasing demand to designate underserved areas, maximizing federal program and funding opportunities, developing policy recommendations on health workforce issues that promote employer health workforce diversity programs and invest in pipeline efforts, and developing workforce education and training programs that increase the health care workforce in underserved areas.

Furthermore, the ACA includes provisions and resources on health workforce. OSHPD has assumed the role of leading the state's efforts to ensure maximum funding for California on healthcare workforce development, including applying for grants that expand OSHPD programs, developing new programs, increasing awareness and providing technical assistance to grant applicants. OSHPD has been involved in guiding the implementation of health workforce provisions of the ACA, including development of a health care reform implementation work plan. One of the limited-term positions requested to be extended is responsible for continuing the implementation of the healthcare reform work plan.

In the 2012 calendar year, California received almost $1.7 billion in federal, state, local, and private funding for programs in which one of the pre-requisites for participation is a HPSA, MUA, or MUP designation. Given the myriad of programs whose funding status relies on its designation status, this number is expected to increase considerably. The $1.7 billion represented an increase of nearly $200 million in funds leveraged from the 2011 calendar year. Of the 2013 total, $1.6 billion was awarded to Federally Qualified Health Centers (FQHC), FQHC Look-Alikes, and Rural Health Clinics (RHC). Both FQHC and RHC funds require the sites to be located in either a Primary Care HPSA/MUA/MUP or serve in a MUA/MUP designation.

During 2012-13, the federal government approved 21 new communities as Primary Care HPSAs through the efforts of these three positions, which resulted in an additional 1.7 million Californians benefiting from these designations.

STAFF COMMENTS/QUESTIONS

These positions have resulted in substantial federal funding coming to several of California's neediest communities. No concerns have been raised with regard to this proposal.

The Subcommittee requests OSHPD to present this proposal.

Staff Recommendation: Staff recommends approving of this BCP, as proposed, for an increase in CHDPF expenditure authority of $355,00 and authority to make four limited-term positions permanent.

ISSUE 3: HOSPITAL INPATIENT DISCHARGE DATA AUDIT BCP

OSHPD requests 2.0 permanent positions and expenditure authority of $652,000 in 2014-15, and $636,000 ongoing (California Health Data and Planning Fund (CHDPF)) to conduct periodic audits of hospital discharge data related to any report that OSHPD publishes.

BACKGROUND

OSHPD began collecting hospital inpatient data in 1982, in response to a statutory mandate to do so. In 1991, subsequent legislation mandated OSHPD to use this data to analyze and publicly report hospital outcomes for medical, surgical, and obstetric conditions. Specifically, the law required OSHPD to produce "report cards" for hospitals. Ten years later, SB 680 (Figueroa), Chapter 898, Statutes of 2001, mandated periodic auditing of the data that is used to produce the report cards.

OSHPD states that funding was not initially requested to fulfill the mandate to audit the outcome reports data because the number of outcome measures OSHPD produced at that time was small, but since then, it has increased significantly. Specifically, between 2008 and 2010, the number of reports grew 500 percent (from 3 to 15), making additional resources for data auditing necessary. Furthermore, OSHPD is currently evaluating additional measures and anticipates that the number may grow to 23 by the end of 2014.

The need for timely, accurate, and actionable healthcare information has been well documented in legislative mandates, national healthcare reform efforts, and consumer initiatives as well as by business and healthcare industry representatives and the public health community. OSHPD states that the outcome reports promote improved hospital performance, healthcare transparency and increased provider accountability. Those who benefit from the information include: hospital staff, employers, health plans, insurance companies, healthcare purchasers and payers, and individual consumers (i.e., patients).

Increasingly, health provider outcomes data is being used in programs that link payers' reimbursement levels with performance, such as the Center for Medicare and Medicaid Service's hospital performance-based incentive programs. OSHPD states that this proposal will support those programs and ensure more accurate reporting of hospital performance in the areas of risk-adjusted mortality, hospital-acquired infections, surgical and medical complications, rates of hospital readmissions, treatment errors, and patient safety incidents.

OSHPD requests the following two positions:

1. Research Scientist III –This position would utilize statistical techniques to analyze hospital discharge records to identify the hospitals most likely to have serious coding issues and recommend hospitals to be audited. This position would create, maintain, and update the data mining and analysis system for targeted hospital audits.

2. Associate Governmental Program Analyst – This position would communicate with hospitals, provide training interventions with facilities that have performed poorly on the audits, and provide technical assistance.

As part of this proposal, $400,000 would be used to contract with a vendor to conduct audits of medical records to assess data quality issues onsite at hospitals across the state. This would allow for reabstraction of 4,000 charts annually at 10 hospitals.

STAFF COMMENTS/QUESTIONS

No issues have been raised with this proposal.

The Subcommittee requests OSHPD to present this proposal.

Staff Recommendation: Staff recommends approval of this BCP, as budgeted, for 2.0 positions and CHDPF expenditure authority of $652,000 in 2014-15.

ISSUE 4: SONG-BROWN HEALTH CARE WORKFORCE TRAINING PROGRAM BCP & ADVOCATES' PROPOSAL

OSHPD requests the following:

1. $2.84 million per year for three years (California Health Data Planning Fund (CHDPF)) to expand its Song-Brown Health Care Workforce Training Program to fund primary care residency programs via the Song-Brown Program. This expansion will increase the number of primary care residents specializing in internal medicine, pediatrics as well as obstetrics and gynecology (OB/GYN).

2. To expand eligibility for Song-Brown residency program funding to teaching health centers. Song-Brown's focus on areas of unmet need (AUN) results in residents' exposure to working with underserved communities, providing culturally competent care and learning to practice in an inter-disciplinary team.

3. One three-year limited-term Staff Services Analyst position and $106,000 (CHDPF) to develop and implement the program. This position would, for example, draft regulations; seek stakeholder feedback; develop key program components such as eligibility criteria; work with OSHPD's e-application vendors to modify the grants management system to include the additional primary care residency programs; develop and implement an outreach and marketing campaign; administer the contract process; collect and maintain program data to prepare progress, final reports, and summaries; and evaluate the outcomes of the expansion program.

The funding source for this proposal will be the CHDPF which will receive a $12 million repayment from a loan to the General Fund in 2014-15.

BACKGROUND

Song-Brown provides grants to support health professions training institutions that provide clinical training for Family Practice residents, Family Nurse Practitioners, Primary Care Physician Assistants, and Registered Nurse students. Residents and trainees are required to complete training in medically underserved areas, underserved communities, lower socio-economic neighborhoods, and/or rural communities (Health Professional Shortage Areas, Medically Underserved Areas, Medically Underserved Populations, Primary Care Shortage Areas, and Registered Nurse Shortage Areas).

According to OSHPD, Song-Brown funded programs have led practitioners to be at the forefront of curricula development and clinical care for many contemporary challenges facing California's healthcare system such as homeless, refugee, and immigrant health. Various studies indicate that residents exposed to underserved areas during clinical training are more likely to remain in those areas after completing their training.

Funding is provided to family practice residency programs via capitation funding. Each training program funded by Song-Brown must meet the accreditation standards set forth by their specific discipline. Song-Brown funds do not replace existing resources but are used to support and augment primary care training. Family practice residency programs are funded in increments of $51,615 per capitation cycle ($17,205 per year for three years). The funding level per capitation cycle has remained the same since the program's inception in 1974 and only covers a portion of a resident's training cost which has been estimated to exceed $150,000 per year.

There are 110 primary care residencies in the state and of these, 44 are family practice programs that currently apply for Song-Brown funds. The remaining 66 residencies include 31 internal medicine, 18 OB/GYN, and 17 pediatric programs. Based on the number of primary care residency programs in California, the $2.84 million would be allocated into an annual 50/25/25 split at a capitation rate of $51,615 per resident for a maximum request of two residents per applicant. See below for tables on how these funds are proposed to be used.

Internal Medicine -- Projected Outcomes			
	2014-15	**2015-16**	**2016-17**
Requests received	31	31	31
Grants awarded	13	13	13
Residents/students supported	27	27	27
Funds awarded	**$1,420,000**	**$1,420,000**	**$1,420,000**

Obstetrics/Gynecology -- Projected Outcomes			
	2014-15	**2015-16**	**2016-17**
Estimate of possible applications	18	18	18
Estimate of possible awards	6	6	6
Possible # of residents/students supported	13	13	13
Funds to be awarded	**$710,000**	**$710,000**	**$710,000**

Pediatrics -- Projected Outcomes			
	2014-15	**2015-16**	**2016-17**
Estimate of possible applications	17	17	17
Estimate of possible awards	6	6	6
Possible # of residents/students supported	13	13	13
Funds to be awarded	**$710,000**	**$710,000**	**$710,000**

Total New Primary Care -- Projected Outcomes			
	2014-15	**2015-16**	**2016-17**
Estimate of possible applications	66	66	66
Estimate of possible awards	25	25	25
Possible # of residents/students supported	53	53	53
Funds to be awarded	**$2,840,000**	**$2,840,000**	**$2,840,000**

In the third year, OSHPD proposes that Song-Brown staff will engage in an extensive review of the expansion program to evaluate outcomes and impact. This will include documenting the number of primary care resident slots funded, exposure to primary care curricula and didactic clinical training in underserved areas, and retention of residents in those areas. Based on the evaluation of the program, permanent funding for the expansion program may be considered.

This proposal will be funded by the CHDPF. The CHDPF is supported by annual assessments on California's hospitals and skilled nursing facilities. Health and Safety Code Section 127280(h) provides for a maximum assessment rate of .035 percent of a hospital or skilled nursing facilities annual gross operating expenses. The current assessment rate for hospitals and skilled nursing facilities is .027 percent and .025 percent, respectively. In 2008, the CHDPF made a $12 million loan to the General Fund. This loan is scheduled to be repaid in 2014-15. The loan repayment will provide for the initial 3-year funding for this expansion program. If after evaluation of the first three years, on-going funding is supported, the assessment fee could be raised within the existing statutory limit to provide on-going support for this expansion program.

Trailer Bill

Statutory changes are needed to implement this proposal. For example, statutory language is necessary to expand the Song-Brown program criteria to include residencies in Teaching Health Centers, as the Song-Brown program is currently limited to medical school-based residency programs. Teaching health centers are community-based ambulatory patient care settings (e.g., clinics) that operate a primary care medical residency program. The administration provided proposed trailer bill language on April 17, 2014.

Advocates' Proposal

Advocates for physician groups propose $25 million (General Fund) to create a Graduate Medical Education Fund that would be used to fund new residency slots at hospitals or teaching health centers that are located in underserved areas and treat underserved populations. Advocates state that the Governor's proposal is unnecessarily restrictive to certain specialties, and should be restricted to new, rather than existing, residency slots.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to present this BCP and to respond to the following:

1. How will this proposal increase the number of medical professionals in underserved areas if these funds may be used for existing residency slots?

The Subcommittee requests the LAO to present the advocates' proposal described in this item.

Staff Recommendation: Staff recommends holding this item open to allow for sufficient time to review the proposed trailer bill language, as well as for additional discussions with advocates.

ISSUE 5: MENTAL HEALTH WORKFORCE EDUCATION & TRAINING BCP

OSHPD requests that $102,000 in unexpended Mental Health Services Act (MHSA) Workforce, Education, and Training (WET) funds be appropriated through 2017-18 for mental health WET Programs.

BACKGROUND

The 2012-13 budget eliminated the Department of Mental Health (DMH) by creating a new Department of State Hospitals to oversee the state's mental hospitals, and by shifting all remaining DMH programs to other state departments. As a part of this reorganization, the WET program (a component of the Mental Health Services Act/Proposition 63) was transferred to OSHPD. The WET provides funding to increase the capacity of the mental health workforce. Even prior to this program transfer, OSHPD administered the Mental Health Loan Assumption Program (MHLAP). The MHLAP awards grants to mental health practitioners working in the public mental health system in hard to fill or retain positions.

AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, requires OSHPD to develop a Five-Year WET Plan. The Five-Year Plan must be informed by an evaluation of the relative efficacy of current state-level WET strategies and must include objectives to establish, expand, and/or promote the following: high school, university and post-secondary education pathways; scholarships, loan forgiveness and stipends for current and prospective public mental health system employees; regional partnerships; psychiatric residency programs; staff training curriculum; and the employment of consumers and family members in the public mental health system. The Five-Year Plan must be developed pursuant to a stakeholder process, be approved by the California Mental Health Planning Council, and is due April 1, 2014.

The 2013-14 budget includes the reappropriation of $7.8 million in unexpended WET funds through 2017-18 for WET programs. The $7.8 million included $1.6 million in unexpended WET contract funds from 2010-11 and 2011-12. Since this unspent balance was not from OSHPD appropriations (as it was originally appropriated when the program was at the DMH), OSHPD could not request a reappropriation of funds through 2017-18 as it did with all other WET appropriations in SB 68, amending the Budget Act of 2012 (Chapter 21, Statutes of 2012). Thus, OSHPD requested a new appropriation in 2013-14 via a May Revision budget request.

During year-end closing exercises, after the May Revision budget request was submitted to the Legislature, OSHPD received new information regarding unexpended balances for two vendors. As such, those unexpended balances could not be included in the 2013 May Revision proposal. This budget proposal captures those unexpended balances and requests reappropriation of them.

WET Funding History

The 2014-15 Governor's Budget reflects a $26,059,000 decrease from 2013-14 as a result of one-time appropriations and carryovers that were included in 2013-14. The following shows the reconciliation from the 2013-14 to the 2014-15 budget which includes adjustments for a budget change proposal and pro-rata increase. Furthermore, through this BCP, OSHPD is requesting authority to extend the appropriation of $102,000 in unexpended WET funds through 2017-18 for WET programs.

Description of WET funding	**Amount** ***(Dollars In Thousands)***
FY 2013-14 Budget	$52,350
FY 2014/15 One-Time Budget Change Proposal #001	102
FY 2014/15 Pro-Rata Increase Adjustment	254
Less FY 2013/14 WET and MHLAP BCP Adjustments [1/]	-26,219
Less FY 2013/14 WET Consultant BCP Adjustment	-196
FY 2014/15 Budget [2/]	$26,291

[1/]Includes FY 2013-14 Budget Change Proposal 001 and May Finance Letter 002 adjustments approved during the FY 2013/14 budget cycle.
[2/]Unspent or unencumbered WET funds will be available until FY 2017-18.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD present this proposal and respond to the following:

1. What is the status of the WET Five-Year Plan?

Staff Recommendation: Staff recommends approval of this BCP to authorize reappropriation of $102,000 in unexpended WET funds through 2017-18.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 1: DEPARTMENT OVERVIEW

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 and rankings of health plans and medical groups, and educates consumers about patient rights and responsibilities.

Network Capacity & Plan Oversight

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 and the Affordable Care Act (ACA). Specifically, in 2011, the state transitioned approximately 350,000 seniors and persons with disabilities from fee-for-service Medi-Cal into Medi-Cal managed care. In 2012, budget trailer bill established the Coordinated Care Initiative (CCI), 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, budget trailer bill gave the DHCS authority to seek managed care contracts for California's 28 remaining fee-for-service counties. In 2013, under the auspices of the ACA, the Legislature adopted and the Governor signed legislation expanding the Medi-Cal program, beginning January 1, 2014. This expansion can be expected to result in the enrollment of another 1.4 million Californians. Finally, the ACA, through California's health benefits exchange (Covered California), will result in millions more Californians gaining managed care coverage in the private market.

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.

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 31st of each year. The Knox-Keene Act requires each licensed plan to reimburse the department for all its costs and expenses.

As summarized in the table below, the Governor's 2014-15 Budget proposes a modest increase of $1.9 million (3.4%) in the Department's overall budget.

DEPARTMENT OF MANAGED HEALTH CARE
(Dollars In Thousands)

Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed	BY to CY Change	% Change
General Fund	**$0**	**$0**	**$0**	**$0**	**0%**
Federal Trust Fund	4,329	1,749	75	(1,674)	(95.7)
Managed Care Fund	40,671	51,432	55,485	4,053	7.8
Reimbursements	1,066	3,832	3,412	(420)	(10.9)
Total Expenditures	**$46,066**	**$57,013**	**$58,972**	**$1,959**	**3.4%**
Positions	288.6	370.5	397.3	26.8	7.3

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to provide an overview of the department, its proposed budget, and any significant changes at the department that occurred as a result of the state's recent fiscal crisis.

Staff Recommendation: This is an informational item and no action is necessary.

ISSUE 2: INFORMATION TECHNOLOGY CONTRACT STAFF CONVERSION BCP

The DMHC requests 2.0 positions and a reduction of $50,000 for 2014-15 and ongoing to provide information technology (IT) programming services for the Customer Relationship Management (CRM) system that is currently performed by contracted vendors. This request includes the redirection of existing contract resources to fund the two positions.

BACKGROUND

The DMHC's Office of Technology and Innovation (OTI) provides programming support for all departmental databases, applications, public and internal websites, and secured web portals that deliver mission-critical services to DMHC staff and stakeholders. As part of the DMHC's components of consumer assistance, all interaction between the DMHC's Help Center and consumers is tracked in a CRM database system. This system is the data warehouse for all consumer complaint contact information and provides essential case tracking, workflow, automated correspondence, email notifications, reminders, workload tracking, and customized reporting.

Since 2000, the DMHC has used a CRM system known as "Clarify." This system was procured in order to meet legislatively mandated requirements. At that time, the availability of the CRM technology that was needed to meet these requirements was very limited and the tailored programming necessary for the business and functional requirements was not available through the civil service system. Over the years, the Clarify system has been extensively customized to meet the continuously changing and increasing needs of the DMHC, including the ability to track all forms of consumer contacts, such as telephone, email, web forms, US mail and faxed complaints. The CRM system also has been modified to include similar tracking of health care provider complaints. Since the Clarify system requires expert programmer knowledge not available in the civil service system, the DMHC has used contracted consultants to perform all work necessary on Clarify, including ongoing maintenance, database and report customization, and customer support.

The company which owns the Clarify CRM software recently announced it would no longer provide support and maintenance of the Clarify software used by DMHC. The Clarify CRM software utilized by DMHC uses an esoteric programming language (Clear Basic) that requires specialized programming expertise not currently available in the civil service system.

According to the DMHC, following a comprehensive review of business and functional requirements, a review and demonstrations of available CRMs, and a comparison of CRM software systems, the DMHC selected an off-the-shelf CRM product, OnContact, as the recommended replacement for Clarify. The OnContact CRM system is compatible with the DMHC's technical environment and programming standards.

The DMHC proposes that OnContact be maintained and supported by Senior Programmer Analysts, a civil service classification. Redirection of consultant services to establish two in-house programmers will also comply with Government Code Section 19130(b)(3), which states that contracting is allowed only when the services contracted are not available within civil service.

The DMHC is currently working with the OnContact CRM vendor to complete the migration of data and reports from Clarify to OnContact. This migration is scheduled to be completed by June 30, 2014. Once the migration is complete, the DMHC will no longer need to contract with a vendor for support of the outdated Clarify system and will fully utilize the OnContact CRM software system.

STAFF COMMENTS/QUESTIONS

No issues or concerns have been raised regarding this item.

Staff Recommendation: Staff recommends approval of this BCP for 2.0 new positions at DMHC and savings of $50,000.

ISSUE 3: INDIVIDUAL MARKET REFORMS BCP

The DMHC requests 13.5 positions and $1,518,000 for 2014-15 and 19.0 positions and $2,010,000 for 2015-16 and ongoing to address the increased workload resulting from the implementation of SB 2 X1 (Hernandez), Chapter 2, Statutes of 2013-14 of the First Extraordinary Session related to health care reforms in the individual market. These positions will be responsible for providing consumer assistance and resolving consumer complaints.

BACKGROUND

The DMHC is a health care consumer protection organization that helps California consumers resolve problems with their health plans and works to provide a stable and financially solvent managed care system. The DMHC regulates health care service plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended.

The Affordable Care Act (ACA), enacts major health care coverage market reforms that took effect January 1, 2014. With the passage of SB 2 X1, California law now conforms to the ACA requirement that health plans that offer health coverage in the individual market accept every individual that applies for that coverage. As a result, DMHC is now responsible for providing consumer assistance and regulatory oversight to potentially millions of new enrollees and new health plans and products offered in Covered California.

Based on a November 7, 2012 Covered California report, it is estimated that by the end of 2015-16 approximately 1,701,000 previously uninsured new enrollees will enter the individual market and be enrolled in health plans that are regulated by the DMHC. It is likely that many of these individuals will not have had health care coverage and will be unfamiliar with how to use a health care coverage delivery system. The DMHC's Help Center uses a conservative standard increase of three percent in consumer assistance, complaint resolution and Independent Medical Review (IMR) workload as new consumers enroll in health plans that are regulated by the DMHC. The three percent factor is based on historical experience of serving new populations.

SB 2 X1 Help Center Data

The Help Center has been able to identify 1,149 calls (out of 7,288 total calls) related to SB 2 X1 for the period January 1, 2014 to March 10, 2014. The DMHC has opened 743 formal complaints from information gained through these 1,149 phone calls. The table below breaks down the categories/issues raised by enrollee's related to SB 2 X1. Enrollees may have raised more than one issue when contacting DMHC. Because of this, the total number of issues noted in the table (1,166) is greater than the total number of calls (1,149) received.

SB 2 X1-Related Help Center Calls January 1, 2014 – March 10, 2014	
Categories/Issues	**Number of Issues Identified**
Enrollee (EE) did not receive ID cards/enrollment packet	209
EE could not confirm premium payment was received by the Plan	66
Incorrect premium amount on statement	64
EE cannot obtain medication due to lack of enrollment confirmation	112
EE cannot access care due to lack of enrollment confirmation	140
EE cannot confirm enrollment with the Plan/Covered CA	183
EE could not reach the Plan	78
EE could not reach Covered CA	25
EE unsure where to send premium payment	48
EE states their effective date is incorrect	65
EE is requesting premium reimbursement	28
EE states the Plan has incorrect personal data	22
EE states Provider is not accepting Covered CA Plans	51
EE wants to cancel current Covered CA Plan	19
EE states Covered CA Plan was cancelled due to lack of premium payment or personal data confirmation received by the Plan	55
EE states their medications are not on the Plan formulary	1
Total Issues	**1,166**

Projected Workload

For 2014-15, the DMHC estimates a total of 37,271 additional contacts. This is based on 1,242,000 new enrollees for 2013-14 and 2014-15, as follows:

- 29,808 calls
- 4,471 pieces of correspondence
- 1,129 Quick Resolution cases
- 745 Standard Complaints
- 373 Independent Medical Review (IMR)
- 745 Urgent Nurse cases

For 2015-16, the DMHC estimates 51,031 additional contacts. This is based on 1,701,000 new enrollees through 2015-16, as follows:

- 40,824 calls
- 6,124 pieces of correspondence
- 1,531 Quick Resolution cases
- 1,021 Standard Complaints
- 510 IMRs
- 1,021 Urgent Nurse cases

Requested Positions

The requested permanent positions are as follows:

Help Center	2014-15	2015-16
Attorney	2.0	3.0
Nurse Evaluator II	1.5	1.5
Associate Governmental Program Analyst	5.0	7.0
Consumer Assistance Technician	5.0	7.5
Total Positions	**13.5**	**19.0**

The DMHC proposes the following responsibilities for the requested positions:

- **Attorneys** would review 21 percent of Standard Complaints and five percent of general correspondence (including calls and correspondence) from consumers enrolled in the individual market. These positions require direct enrollee and health plan contact for case clarification, and to request additional information. Once the requested documentation has been received, the attorneys review this information and apply case facts to the KKA and relevant regulations. Once a finding is complete, the attorneys draft correspondence advising of compliance, and discuss complaint findings with the enrollee, health plan, and/or provider. These positions require documenting progress in the case management database and drafting closing letters to the health plans and enrollees.

- **Nurse Evaluators** would review and respond to individual market enrollee Urgent Nurse cases within the mandated timeframes. The Nurse Evaluator receives requests from the Help Center's Call Center staff to review cases where the pre-determined Urgent Nurse case trigger has been noted. Once the Urgent Nurse case has been initiated, the nurse reviews the submitted complaint documentation, medical records and other relevant clinical information; confers with Help Center management and legal staff; contacts the consumer, health plan and provider to gather information and documents this research in the case management database. The Nurse Evaluator is responsible for researching Current Procedural Terminology (CPT) codes, emerging medical treatments, standards of care, and health plan contracts. These positions require the information exchange between parties and negotiating resolution with health plan representatives. Once the case has been resolved, the Nurse Evaluator is responsible for composing closing letters to the health plans and enrollees.

- **Associate Governmental Program Analysts (AGPAs)** would perform the initial review of incoming Individual Market Standard Complaints and IMR requests, which includes direct contact with enrollees to clarify complaint issues and providing enrollees with additional direction and a review and application of the KKA to determine plan compliance and potential violations.

- **Consumer Assistance Technicians (CATs)** would answer incoming enrollee calls, research and reference policies and procedures, and document pertinent enrollee information in the case management database.

Legislative Analyst Comment and Recommendation

LAO finds that the estimated workload for this proposal is partially based on a set of assumptions about the increase in the number of additional enrollees in DMHC-regulated individual market products under the ACA. The proposal assumes that additional enrollment will be 90 percent of projected Covered California enrollment. The open enrollment period for Covered California ended on March 31 and the LAO expects that there will be more reliable estimates of 2014 enrollment in DMHC-regulated individual market health insurance products available within the next couple of months. Consequently, the LAO recommends that the Legislature: 1) hold this proposal open; 2) direct the Administration to report on estimates of enrollment in DMHC-regulated products at the time of the May Revision; and 3) direct the Administration to report on how the updated enrollment information affects the estimated workload associated with this proposal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the DMHC to present this proposal and provide a highlight of the types of calls the Help Center has been receiving related to SB 2 X1.

Staff Recommendation: Staff recommends holding this item open pending receipt of updated data at May Revise.

ISSUE 4: MEDI-CAL EXPANSION BCP

The DMHC requests 18.0 positions and $2,404,000 for 2014-15 and $2,356,000 for 2015-16 and ongoing, to address increased workload resulting from implementation of AB 1 X1 (Pérez), Chapter 3, Statutes of 2013-14 of the First Extraordinary Session. This request includes $312,000 for 2014-15 and $416,000 for 2015-16 and ongoing for expert witness and deposition costs for enforcement trials.

BACKGROUND

AB 1 X1 implements a key provision of the Affordable Care Act (ACA) by expanding the state's Medi-Cal program, effective January 1, 2014, to a new group of adults aged 19 - 64 with incomes up to 138 percent of the federal poverty level and who are not eligible for Medi-Cal today. AB 1 X1 also implements the Medi-Cal expansion by implementing federal rules to simplify and streamline Medi-Cal eligibility determination, enrollment, and renewal.

In addition, SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session implements the Medi-Cal expansion by establishing the Medi-Cal benefit package for the expansion population which includes the same benefits all full-scope Medi-Cal enrollees receive. SB 1 X1 also expands the benefit package for the existing Medi-Cal population to include mental health and substance use disorder benefits that mirror those provided under the Essential Health Benefits (EHB) for the individual and small group markets. SB 1 X1 requires Medi-Cal managed care (MCMC) plans that are regulated by the DMHC to provide mental health benefits that are not covered by county mental health plans under the Specialty Mental Health Services Waiver. AB 1 X1 and SB 1 X1 together implement the Medicaid expansion in California.

The Medi-Cal program is administered by the Department of Health Care Services (DHCS). The DMHC regulates health care service plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended. The KKA provisions apply to Medi-Cal managed care plans, except as specifically exempted. Health plans that arrange for services provided to Medi-Cal beneficiaries through the Medi-Cal managed care program are required to be licensed by the DMHC. Accordingly, Medi-Cal managed care beneficiaries can avail themselves of all the consumer assistance and complaint resolution processes offered by the DMHC, except those in exempted County Organized Health Systems.

DHCS estimates approximately 1,390,000 new beneficiaries will enroll in the Medi-Cal managed care program over the next three years as a result of the expansion of Medi-Cal eligibility. As reported by DHCS, the annual breakdown is as follows:

Fiscal Year	Optional Total Enrollees	Mandatory Total Enrollees	Total New Enrollees (Cumulative)
2013-14	326,592	333,372	**659,964**
2014-15	769,069	551,912	**1,320,981**
2015-16	821,634	568,469	**1,390,103**

AB 1 X1 Medi-Cal Expansion Call Data

The Help Center has been able to identify 551 Medi-Cal calls for the period January 1, 2014 to March 10, 2014; see table below for details. The Help Center is unable to confirm the number of Medi-Cal calls that were specifically related to AB 1 X1; however, the Help Center is currently discussing methods to specifically identify these consumers.

Medi-Cal-Related Help Center Calls January 1, 2014 – March 10, 2014		
Category	**Medi-Cal Managed Care**	**Medi-Cal Fee For Service Seniors and Persons with Disabilities**
Access	27	3
Appeal of Denial	8	0
Claims/Financial	10	1
Coordination of Care	14	1
Coverage/Benefits	41	4
Covered California	7	6
Enrollment Disputes	35	13
General Inquiry	227	141
Plan Service	9	1
Provider Service	3	0
Total	**381**	**170**

Help Center

Based on the DMHC's historical experience, Medi-Cal populations typically contact the DMHC at a higher rate than the existing commercial managed care population. The DMHC anticipates an increase in consumer assistance, complaint resolution, and Independent Medical Review (IMR) workload as approximately 1,390,000 new enrollees enter the Medi-Cal managed care arena. In turn, the DMHC anticipates an increase in enforcement referrals from the Help Center regarding violations of the new law.

The Help Center uses a conservative standard of three percent in increased contact rate when projecting consumer assistance workload for new populations it serves. Based on this percentage and the estimated number of new enrollees provided by the DHCS, the Help Center estimates 39,629 additional contacts resulting from the Medi-Cal expansion.

For 2014-15, these contacts are in the form of:

- 31,703 calls
- 4,755 pieces of correspondence
- 1,189 Quick Resolution cases
- 793 Standard Complaints
- 396 Independent Medical Reviews (IMRs)
- 793 Urgent Nurse cases

For 2015-16, and ongoing, the Help Center estimates 41,703 additional contacts. This is based on the total new enrollment for 2013-14 through 2015-16 as reported by the DHCS. These contacts will generate:

- 33,362 calls
- 5,004 pieces of correspondence
- 1,251 Quick Resolution cases
- 834 Standard Complaints
- 417 IMRs
- 834 Urgent Nurse cases

Office of Enforcement

The Office of Enforcement handles the litigation needs of the DMHC, representing the department in actions to enforce the managed health care laws including the quality, accessibility, and continuity of care and the denial of treatment and claims in enforcing the managed health care laws. Cases are referred to this office from the Help Center, as well as other DMHC divisions that review the activities of health care service plans for compliance with the managed health care laws. Based on the projected increased enrollment of 1,390,000, the DMHC estimates that the Office of Enforcement will experience a 20 percent annual increase in referrals based on the rate of referrals currently made to Enforcement by the Help Center.

Of the anticipated annual referrals to the Office of Enforcement, the DMHC estimates that approximately 10 percent of the enforcement referrals involving this new law will result in a trial. This equates to three trials in 2014-15 and four trials in 2015-16 and ongoing as a result of AB 1 X1 and is based on the current actual percentage of enforcement referrals that typically go to trial.

Requested Positions

The requested permanent positions are as follows:

Help Center	
Attorney	2.0
Nurse Evaluator II	2.0
Associate Governmental Program Analyst	5.0
Consumer Assistance Technician	6.0
Office of Enforcement	
Attorney	1.5
Associate Corporations Investigator	1.5
TOTAL POSITIONS	**18**

The DMHC states that these positions are necessary to address the increased workload associated with newly-enrolled consumers in Medi-Cal managed care plans licensed by the DMHC. This new workload includes answering consumer calls, reviewing and resolving consumer complaints, IMR applications, and urgent nurse cases, and enforcing the managed health care laws that protect this new population. The DMHC proposes the same responsibilities for the requested positions as in the prior BCP.

Legislative Analyst Comment and Recommendation

LAO finds that the estimated workload for this proposal is partially based on a set of assumptions about the increase in the number of additional enrollees in Medi-Cal managed care. LAO finds that there will be more reliable estimates of 2014 Medi-Cal managed care enrollment available within the next couple of months. Consequently, the LAO recommends that the Legislature: 1) hold this proposal open; 2) direct the Administration to report on estimates of enrollment in Medi-Cal managed care at the time of the May Revision; and 3) direct the Administration to report on how the updated enrollment information affects the estimated workload associated with this proposal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the DMHC to present this proposal and describe what data are likely to change and be updated at May Revision.

Staff Recommendation: Staff recommend holding this item open pending receipt of updated data at May Revision.

ISSUE 5: FEDERAL MENTAL HEALTH PARITY

The federal Mental Health Parity and Addiction Equity Act of 2008 requires that group health plans and health insurance coverage, offered in connection with group health plans that offer mental health and substance use disorder (MH/SUD) benefits, do so in a manner comparable to medical and surgical (med/surg) benefits. The Governor's budget does not include a proposal to implement the new federal rules.

BACKGROUND

The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), expands federal mental health parity protections beyond the limited requirements of the previously enacted federal Mental Health Parity Act of 1996 (MHPA). The MHPAEA requires that group health plans and health insurance coverage offered in connection with group health plans that offer mental health and substance use disorder (MH/SUD) benefits do so in a manner comparable to med/surg benefits. For most plans, the MHPAEA became applicable to plan years beginning on or after October 3, 2009.

Final Rules

Because the MHPAEA itself does not explain how health plans are to analyze or achieve parity, the Centers for Medicare and Medicaid Services (CMS), the Department of Labor's Employee Benefits Security Administration, and the Internal Revenue Service (collectively, the Departments) issued the Interim Final Rules on the MHPAEA on February 2, 2010, and the Final Rules on November 13, 2013. These regulations provide an in-depth explanation of what the MHPAEA entails.

The Final Rules provide a framework for application and enforcement of the MHPAEA. The Final Rules explain how health plans must classify benefits, and how they must assess financial requirements and treatment limitations (both quantitative and non-quantitative) for parity purposes. The Final Rules also address the applicability, enforcement, and effective dates of the MHPAEA and regulations.

Under the Final Rules (and Interim Final Rules), parity is not determined under a static "matching" approach that compares similar or analogous treatments. Instead, the Final Rules require that all covered benefits must be sorted into specific classifications, and then the broader classifications are compared and analyzed for parity. The Final Rule provides that if the health plan covers any MH/SUD benefit, it must then provide benefits in any classification for which it provides med/surge coverage.

Final Rules Benefit Classifications:

- Inpatient, In-Network
- Inpatient, Out-of-Network
- Outpatient, In-Network
- Outpatient, Out-of-Network
- Emergency Care
- Prescription Drugs

Financial Requirements and Quantitative Treatment Limitations

Under the Final Rules, health plans must perform a detailed financial and mathematical analysis to determine "parity" for financial requirements and quantitative treatment limitations. The MHPAEA defines "financial requirements" to include deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes aggregate lifetime and annual limits. "Treatment limitations" are defined to include limits on the scope and duration of treatment; "quantitative treatment limitations" (QTLs) are numerical limits, such as limits on the number of visits, episodes, or days of treatment covered under the plan.

Under the MHPAEA and the Final Rules, the financial requirements and treatment limitations applied to MH/SUD benefits in a classification cannot be more restrictive than the *predominant* (more than one half) requirements or limitations applied to *substantially all* (at least two-thirds) med/surg benefits in the same classification.

Implementation Dates

The MHPAEA has always applied to the large group market, and the Final Rules for the large group market apply as of July 1, 2014. For the small group market, the MHPAEA applies as of January 1, 2015, and the Final Rules apply as of July 1, 2014. For the individual market, the MHPAEA applies as of January 1, 2015. Although, the Final Rules apply as of July 1, 2014, because the individual market in California is now based on the calendar year, the Final Rules will be effective for individual plan contracts as of January 1, 2015.

DMHC's Implementation of the State's Mental Health Parity Laws

The DMHC currently enforces the Knox-Keene Act's mental health parity statute, Health and Safety Code section 1374.72, which requires health care service plans to cover nine enumerated severe mental illnesses, as well as serious emotional disturbances of a child, under the same terms and conditions plans apply to medical conditions. The DMHC plan reviews Evidences of Coverage for compliance with Section 1374.72, focusing generally on whether services to treat the limited enumerated conditions are covered the same as medical conditions. The DMHC's implementation of California's mental health parity statute has primarily focused on ensuring the mandated benefits are covered and parity for the cost-sharing provisions of the plan benefit designs.

DMHC's Implementation of the New Federal Final Rules

In contrast, the MHPAEA and its associated regulations require a detailed parity analysis whereby plans must: 1) classify all benefits into six federally-mandated classifications; 2) mathematically analyze all benefits to ensure that the financial requirements (such as copayments or coinsurance) and quantitative treatment limitations (such as visit limits or days of treatment) for MH/SUD use disorder benefits are not more restrictive than the predominant requirements or limitations applied to substantially all med/surg benefits in the same classification; and 3) analyze all benefits to ensure that any non-quantitative treatment limitations (such as medical management standards regarding medical necessity) apply comparable processes, strategies, and evidentiary standards for both mental health/substance use disorder and med/surg benefits.

This detailed analysis, required by the federal rules, requires both clinical and actuarial expertise whereas the implementation of California's mental health parity law was a more straightforward legal analysis. The DMHC indicates it has never applied such a clinical/actuarial analysis of health plan benefit designs and, consequently, it is taking additional time to evaluate how to conduct such an analysis. Moreover, the DMHC also must expand its existing parity compliance review, not only to evaluate the plans' implementation of the complex mathematical and analytical processes the MHPAEA requires, but also to oversee plans' treatment of the mental health/substance use disorder conditions covered by the MHPAEA, including all conditions in the Diagnostic and Statistical Manual IV (DSM-IV) (for small group and individual plans, per California's Essential Health Benefit statute) and any conditions large group plans cover beyond those required by Section 1374.72.

STAFF COMMENTS/QUESTIONS

The DMHC indicates that it is currently assessing how it will enforce the new federal rules and the workload associated with this new federal requirement. The new federal requirement includes processes and assessments that are different from what DMHC currently performs. For example, the new rules include a "non-quantitative" component to assess parity.

Given that these rules are effective July 1, 2014 and January 1, 2015 (depending on the rule type and plan type), it would be expected that, prior to the start of the next fiscal year, the DMHC complete its analysis of: 1) the implementation of these rules; and 2) the resources that may be needed.

Subcommittee staff recommends keeping this item open as discussions continue on implementation and the resources that may be necessary to ensure that millions of Californians, who are suffering from mental health and substance abuse disorders, get the help they need.

The Subcommittee requests the DMHC to provide an overview of the new federal requirements, how these requirements differ from state law, and how the department is implementing them.

Staff Recommendation: Staff recommends holding this item open at this time.

4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: DEPARTMENT OVERVIEW

The Managed Risk Medical Insurance Board (MRMIB) was created in 1989 to administer programs that would provide health care coverage through private health plans to certain populations that lacked health insurance and for whom insurance was not readily available. Since 1997, MRMIB's primary focus and workload has been the operation of the Healthy Families Program, which ceased serving children at the end of 2013. The MRMIB still operates the following three programs:

1. ***Major Risk Medical Insurance Program (MRMIP).*** MRMIP provides health insurance to Californians unable to obtain coverage in the individual health insurance market, historically 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), which included creation of the federal PCIP.

2. ***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.

3. ***County Children's Health Initiative Matching Fund Program (CHIM).*** 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.

Healthy Families Program

The HFP was California's version of the federal Children's Health Insurance Program (CHIP). It provided 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 were not eligible for Medi-Cal but met citizenship or immigration requirements. A 65 percent federal match was (and still is) obtained through a federal allotment (Title XXI funds). The program consistently served approximately 860,000 children. The 2012 budget package approved of the Governor's proposal to discontinue this program by transitioning all children in the program to Medi-Cal. This transition occurred in 2013 and all HFP children have been transitioned to Medi-Cal.

MRMIB Budget

The Governor proposes to eliminate MRMIB, as reflected in the proposed 2014-15 budget which is summarized in the table below. The substantial reductions that can be seen that occurred between 2012-13 and 2013-14 reflect the transition of all Healthy Families Program children to Medi-Cal, as well as the subsuming of the state's Pre-Existing Conditions Insurance Program (PCIP) by the federal government into the national program.

MANAGED RISK MEDICAL INSURANCE BOARD
(Dollars In Thousands)

Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed	BY to CY Change	% Change
General Fund	**$177,873**	**$23,214**	**$0**	**($23,214)**	**(100%)**
Federal Trust Fund	580,156	110,728	0	(110,728)	(100)
Special Funds & Reimbursements	173,968	97,019	0	(97,019)	(100)
Federal Temporary High Risk Health Insurance Fund	519,002	119,243	0	(119,243)	(100)
Total Expenditures	**$1,451,999**	**$350,204**	**$0**	**($350,204)**	**(100%)**
Positions	81.1	56.9	0	(56.9)	(100)

STAFF COMMENTS/QUESTIONS

MRMIB estimates that only about 3,200 individuals (on a monthly basis) would be enrolled in MRMIP, yet the budget includes funding for a caseload of about 7,500. While funding to close-out reconciliation from prior year MRMIP claims may be necessary, it is too soon to estimate for post ACA caseload.

The Subcommittee requests MRMIB to provide an overview of the department and its current programs, and to explain how the budget reflects the anticipated caseload impacts of the ACA.

Staff Recommendation: This is an informational item and no action is necessary.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: ELIMINATION OF MRMIB

The Governor's budget proposes to eliminate MRMIB and transfer its programs to the Department of Health Care Services (DHCS). The proposed trailer bill language would:

- Transfer the Major Risk Medical Insurance Program (MRMIP), the Access for Infants and Mothers (AIM) program, and the County Children's Health Initiative Matching Fund Program (CHIM) to DHCS. The Administration proposes no changes to these programs and states that individuals currently in these programs would experience no disruption in care or changes in coverage, benefits, or eligibility.

- Rename the AIM-linked infants program to the "Medi-Cal Access Program" in order to simplify messaging of subsidized coverage options to solely Medi-Cal and Covered California.

- Transition the responsibility for the close-out activities, related to the Healthy Families Program transition to Medi-Cal and the Pre-Existing Conditions Insurance Program (PCIP) transition to the federal government, to DHCS.

- Delete reference to adults from the CHIM Program provisions as the program was never expanded to cover parents.

- Transition 27 positions at MRMIB to DHCS and Covered California.

BACKGROUND

AB 60, Chapter 1168, Statutes of 1989, established the Major Risk Medical Insurance Board, which was renamed in 1993 to the Managed Risk Medical Insurance Board (MRMIB or Board). MRMIB has administered the following programs:

Healthy Families Program (HFP). Established in 1998, the HFP was California's version of the national Children's Health Insurance Program (CHIP) and provided comprehensive health, dental, and vision benefits through participating health plans to children ineligible for Medi-Cal. Pursuant to AB 1494 (Committee on Budget) Chapter 28, Statutes of 2012, as amended by AB 1468 (Committee on Budget), Chapter 438, Statutes of 2012, and in accordance with federal approvals, the HFP transition to Medi-Cal was implemented in four major phases and was completed on November 1, 2013. It is proposed that any remaining close out activities will transfer to DHCS.

Access to Infants and Mothers (AIM). The AIM program, established in 1992, provides medically necessary services to pregnant women with incomes above 200 percent and up to and including 300 percent of the federal poverty level (FPL) through participating health plans. Eligibility for the AIM program requires the pregnant woman to have no maternity insurance or have health insurance with a high (over $500) maternity-only deductible, and have a family income too high to qualify for no-cost Medi-Cal, up to 300 percent of the FPL. The total cost to eligible women enrolled in AIM is 1.5 percent of the family's adjusted annual household income after applying applicable deductions.

The AIM Program has a monthly statewide enrollment of approximately 6,000 women. The program provides covered services throughout the pregnancy, hospital delivery and through the month of which their 60th day of postpartum care falls. Under the prior HFP statute, infants born to AIM program subscribers, referred to as AIM-linked infants, were automatically enrolled into the HFP for one year without review of the family's income. Pursuant to AB 82 (Committee on Budget) Chapter 23, Statutes of 2013, AIM-linked infants with incomes above 250 percent and up to and including 300 percent of the FPL, transitioned to DHCS beginning on November 1, 2013.

Major Risk Medical Insurance Program (MRMIP). Since 1991, MRMIP has provided health insurance to Californians unable to obtain coverage in the individual health insurance market due to pre-existing conditions. Californians qualifying for the program contribute to the cost of their coverage by paying premiums. The premiums are subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99). Prior to the ACA, because of funding limitations, MRMIP sometimes developed a waiting list.

MRMIP provides comprehensive benefits to subscribers and their dependents. Health plan participation in the program is voluntary. One Preferred Provider Organization and three Health Maintenance Organizations participate in the program. The program has statewide coverage and subscribers have a choice of two or more health plans in most urban areas of the State. DHCS will assume responsibility for the program July 1, 2014.

County Health Initiative Matching (CHIM) Program. AB 495 (Diaz), Chapter 648, Statutes of 2001, created the CHIM program. MRMIB administers this program, which is funded through the use of intergovernmental transfers of local funds. Originally, there were four proposed pilot counties – Alameda, Santa Clara, San Francisco and San Mateo, however, prior to federal approval Alameda withdrew its application for program participation. Under this program, local county funds are used as the non-federal share to draw down unused federal State CHIP/Title XXI funds for CHIP-eligible children. Eligible children are uninsured with family incomes above 250 percent and up to 300 percent of the FPL and are otherwise ineligible for Medi-Cal and AIM-linked infants program. Counties have the option of going up to 400 percent. CHIM serves approximately 2,100 children in the three counties and total county expenditures are estimated to be $629,000 in 2013-14 and $509,000 in 2014-15.

In order to ensure compliance with ACA maintenance-of-effort requirements, the state budget includes approximately $212,000 General Fund for 2013-14 and $424,000 General Fund for 2014-15 for the local match.

Pre-Existing Conditions Insurance Program (PCIP). SB 227 (Alquist), Chapter 31, Statutes of 2010 and AB 1887 (Villines), Chapter 32, Statutes of 2010, authorized MRMIB to establish and administer a new federal high risk pool program, contingent on a contract with the U.S. Department of Health and Human Services and receipt of adequate federal funding for the program.

California's program, known as PCIP, offered health coverage to medically uninsurable individuals who live in California. As of July 1, 2013, the federal government took over operations of the PCIP program from MRMIB. MRMIB is required to complete closeout activities of the state-run PCIP program through 2013-14. Any residual closeout activities beyond 2013-14 will transition to DHCS effective July 1, 2014.

Justification for Proposal

With the transition of the HFP to DHCS, the Administration argues that MRMIB has been relieved of most of its workload. The Administration further contends that transitioning the remaining MRMIB duties to DHCS makes operational sense and further streamlines California's publicly-financed health care programs. In addition, the Administration finds that the reorganization would simplify the enrollment process for consumers applying through Covered California to two options: Medi-Cal or Covered California. This would reduce confusion and the need for branding of a separate program that provides similar benefits and delivery system to Medi-Cal.

Future of MRMIP

MRMIP was designed for a time when individuals could be denied coverage because of a pre-existing health condition. Given the ACA, prohibition against the denial of coverage for pre-existing health conditions, the purpose of MRMIP has evolved. Most individuals with pre-existing conditions can now seek coverage through Covered California. However, there will still be situations in which individuals may not be eligible for coverage through Covered California, such as when the Covered California open enrollment period is closed.

MRMIB estimates that between 3,000 and 3,200 individuals will remain enrolled in MRMIP in 2014-15. Prior year monthly enrollment was generally around 6,000. The Governor's budget includes $41.7 million for MRMIP. This assumes a full caseload of about 7,500 (the MRMIP cap). The annual cost per MRMIP subscriber is about $5,500.)

AIM and Covered California

CalHEERS, the online enrollment system for Covered California, did not originally include the ability to perform a Modified Adjusted Gross Income (MAGI) determination for AIM, as required by the ACA. Maximus, the AIM administrative vendor, and CalHEERs have developed a workaround to apply the MAGI rules and then transmit the eligibility determination to Maximus. It is anticipated that this functionality will be incorporated into CalHEERs in June.

Advocates' Concerns

Advocates have raised concerns and recommended changes to the proposed trailer bill specific to the transition of AIM from MRMIB to DHCS. Specifically, they recommend: 1) against changing the name of the program in order to avoid unnecessary confusion; 2) to implement a substantial outreach effort; 3) keep in effect the current program regulations, until they expire, unless amended or repealed by DHCS; and 4) add proposed language specific to ensuring that funding, eligibility, and benefits continue to be successfully governed by federal CHIP law.

Legislative Analyst Comments and Recommendations

The LAO states: "…there is some basis to go forward with the transition, but the administration has not made a compelling case that there would be an immediate improvement in the efficiency or effectiveness of the programs that would transition from MRMIB to DHCS." The LAO also argues that there likely would be a loss of financial transparency with this reorganization. The LAO therefore recommends that the Legislature weigh whether the administration's policy rationale is compelling and whether it aligns with legislative priorities in deciding whether or not to approve of this proposal.

STAFF COMMENTS/QUESTIONS

The Administration indicates that it working on a detailed transition plan outlining administrative and operational issues (e.g., the process for transitioning contracts). This plan is not yet ready. It is critical that administrative and operational issues are outlined and worked out prior to any such transition. Although the caseload for these programs is small in comparison to other DHCS-run programs and Covered California, it is important that individuals who may be eligible for these programs are told of the programs and that enrollment into these programs is seamless through CalHEERs and at counties.

The Subcommittee requests DHCS and MRMIB to present this proposal and to respond to the following:

1. When will a detailed transition plan be completed and provided to the Legislature?

2. What is the justification for elimination of this department?

3. Will there be savings associated with this elimination?

Staff Recommendation: Staff recommend holding this item open pending receipt of a detailed transition plan.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEDI-CAL EXPANSION COUNTY SAVINGS (AB 85) OVERSIGHT, BCP, & ADVOCATES' PROPOSAL

Under the Affordable Care Act (ACA), county costs and responsibilities for indigent health care are expected to decrease as more individuals gain access to health care coverage. The state-based Medi-Cal expansion will result in indigent care costs previously paid by counties shifting to the state. AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, modifies 1991 Realignment Local Revenue Fund (LRF) distributions to capture and redirect savings counties will experience from the implementation of federal health care reform effective January 1, 2014.

According to the Administration, county savings are estimated to be $300 million in 2013-14 and $900 million in 2014-15, and those savings will be redirected to counties for CalWORKs expenditures. This redirection mechanism frees up General Fund resources to pay for rising Medi-Cal costs. Counties can either choose a reduction of 60 percent of their health realignment funds, including their maintenance-of-effort, or choose a formula that accounts for the revenues and costs of indigent care programs in their county. Counties have the following options:

- **Option 1** uses a formula that measures actual county health care costs and revenues. The state receives 80 percent of any calculated savings, with the county retaining 20 percent of savings to invest in the local health care delivery system or spend on public health activities.

- **Option 2** transfers 60 percent of a county's health realignment allocation plus the county maintenance-of-effort (MOE) to the state to be captured as savings; the county retains 40 percent of its realignment funding for public health, remaining uninsured, or other health care needs. (To receive health realignment funds, counties are required to meet a MOE. Under this option, a percentage of the MOE is considered in the calculation.)

Counties participating in the County Medical Services Program (CMSP) are subject to an alternative similar to Option 2. Total realignment funding for CMSP consists of a direct allocation that grows over time and $89 million that CMSP counties collectively contribute annually to the CMSP Governing Board. For CMSP counties, AB 85 redirects the $89 million as savings, and the Governing Board will be responsible for covering the remainder of the amount equal to 60 percent of the program's total realignment and MOE funding.

Future year savings for all counties will be estimated in January and May, prior to the start of the year, based on the most recently available data. Further, for counties that choose the formula, reconciliation will occur within two years of the close of each fiscal year. Counties had until January 22, 2014 to adopt a resolution to select Option 1 or Option 2 and inform DHCS of the final decision.

DHCS issued a final determination on the historical percentage spent on indigent health care to each county and it can be found at:

http://www.dhcs.ca.gov/provgovpart/Documents/AB%2085/DHCS_Historical_Determinations.pdf

Counties had until February 28, 2014 to appeal to the County Health Care Funding Resolution Committee (created by AB 85) DHCS' determination on the historical percentage, petition to change options, and petition for an alternative cost calculations. This committee is composed of representatives from the California State Association of Counties, DHCS, and the Department of Finance. Eight counties have submitted appeals to this committee, three of these have been withdrawn.

BUDGET CHANGE PROPOSAL

DHCS requests $3,446,000 ($1,723,000 General Fund and $1,723,000 federal funds) in 2014-15 and $3,410,000 ($1,705,000 General Fund and $1,705,000 federal funds) in 2015-16 and ongoing to fund 18 positions and contract funds to implement and maintain the provisions of AB 85 (Committee of Budget), Chapter 24, Statutes of 2013.

The 18 positions requested in this proposal are for the Safety Net Financing Division (SNFD), Audits and Investigations Division (A&I), Office of Legal Services (OLS), Office of Administrative Hearings and Appeals (OAHA), and the Capitated Rates Development Division (CRDD).

Effective July 1, 2013, DHCS administratively established 12.0 positions and will absorb the costs, in the current year. This proposal requests authorized position and expenditure authority, effective July 1, 2014. DHCS states that resources were redirected in the current year, but that this redirection is not sustainable.

DHCS also requests $1.2 million ($600,000 General Fund and $600,000 federal funds) for consultant contracts:

- $1.0 million for a contract with Mercer (actuarial services). The Mercer contract will fund critical aspects of the program such as rate development and financial reporting.

- $200,000 to contract for a subject matter expert on public hospital data.

Requested Positions
The proposed positions are:

Safety Net Financing Division – 7.0 Positions (5.0 permanent, 2.0 limited-term)
1.0 Staff Services Manager (AE)
2.0 Associate Government Program Analyst (AE)
2.0 Health Program Auditor IV
2.0 Associate Government Program Analyst (limited-term)

Audits and Investigations – 1.0 Position (permanent)
1.0 Health Program Auditor IV

In the current year, these positions developed and calculated the historical percentages of county indigent care spending, and developed interim calculations for 2013-14 and 2014-15. Staff will also need to develop estimates of redirected amounts to include in the May 2014 Estimate. Throughout the next year, these staff would work with counties to finalize data, develop the final calculation model, and complete final calculations. The final calculations for 2013-14 must be completed by December 31, 2015.

In the budget year and ongoing, these positions would perform interim and final calculations annually until the latter of 2023 or until amounts in the formula are fairly static. The formula looks at all health care costs and revenues and then determines the portion of those costs and revenues spent on Medi-Cal and the uninsured. Different county groups have different kinds of costs and revenues, and counties capture and record data differently. The calculations contain numerous steps, including comparisons of each year's actual data to the historical data for that county, adjustments to data depending on different variables, cost containment limits, weighted trend factors, a low income shortfall calculation, and other steps. This workload will be ongoing.

Office of Legal Services – 3.0 Positions (2.0 permanent, 1.0 limited-term)
1.0 Attorney IV (AE)
1.0 Attorney I (AE)
1.0 Legal Analyst (AE) (limited-term)

These positions would be responsible for developing regulations related to AB 85 and represent DHCS on any county appeals of the calculations.

Office of Administrative Hearings and Appeals – 3.0 Positions (permanent)
1.0 Administrative Law Judge II (AE)
1.0 Administrative Law Judge II
1.0 Legal Analyst (AE)

These positions would process appeals, conduct hearings, and produce proposed decisions related to AB 85.

Capitated Rates Development Division – 4.0 Positions (2.0 permanent, 2.0 limited-term)
2.0 Research Program Specialist II (AE)
2.0 Research Program Specialists I (AE) (limited-term)

These positions will: 1) plan, organize, and conduct studies and provide consultation regarding the impact on Medi-Cal managed care plans with the implementation of AB 85; 2) analyze Medi-Cal managed care data and extract data specific to the newly-eligible beneficiaries enrollment to be used by the actuaries in the development of capitation rates; 3) provide analyses to determine the accuracy and reasonableness of the data by specific service type; 4) develop critical evaluations of AB 85; and 5)

develop written narratives (briefing papers, issue memos and policy letters) advising on proposals and alternatives related to the newly-eligible population.

The requested $1.0 million for Mercer Health and Benefits LLC contract for actuarial services (Mercer) would fund two aspects of the program:

- Implementation of AB 85 requires specified percentages of newly-eligible Medi-Cal beneficiaries to be assigned to public hospital health systems in an eligible county until the county public hospital health system meets its enrollment target. Actuarially sound capitation rates need to be calculated to pay the managed care plans at least 75 percent of the rate range available so they can in turn pay county public hospitals at cost for services.

- Managed care plans are to pay the entire rate range as additional payments to county hospitals for providing and making available services to newly-eligible enrollees under the 133 percent Federal Poverty Level (FPL).

Advocates' Proposal on the Remaining Uninsured

Over a million Californians are estimated to remain uninsured after full implementation of the Affordable Care Act purely because of their immigration status. Therefore, a large group of consumer advocates propose the following in order to extend health coverage to this population:

1. California would provide full-scope Medi-Cal coverage to those Californians who would be eligible for Medi-Cal except for immigration status. California would build on the existing Medi-Cal program that offers restricted scope benefits to undocumented Californians by creating a "wrap" or blended payment arrangement that offers these Californians full-scope Medi-Cal while maintaining the federal match for the existing restricted scope benefits.

2. The state-county health realignment formula adopted last year would be amended to allow additional counties that voluntarily choose to do so to fund nonemergency care for the undocumented. Counties would be able to count nonemergency care for the undocumented as a cost if a county voluntarily chooses to begin offering such care or to reinstate access to care.

3. California would create a state-only Health Exchange for those Californians who are barred from participating in Covered California by reason of immigration status. These Californians barred from the Exchange by reason of immigration status would have the same subsidies and cost sharing as Californians enrolled in coverage through Covered California. The same board would govern both the state-only Health Exchange and Covered California.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an update on implementation of AB 85 and DHCS' work on calculating the 2014-15 county savings and respond to the following:

1. What county programs and services are funded with health realignment funds?

2. Is there any reporting to the state on how counties use this funding or how counties have changed or propose to change their services as a result of AB 85?

3. What is known about on-going public health and health care costs for counties, such as for the remaining uninsured?

The Subcommittee requests the Legislative analyst to present the advocates' proposal included in this item.

Staff Recommendation: Staff recommends holding this item open at this time, pending receipt of updated information at May Revise.