AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

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

MONDAY, APRIL 7, 2014

3:00 P.M. - STATE CAPITOL ROOM 4202

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ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: RESTORATION OF MEDI-CAL OPTIONAL BENEFITS

Through the 2009 Budget Act and health trailer bill, the state eliminated several Medicaid optional benefits from the Medi-Cal program. These benefits were eliminated for budgetary, not policy, reasons in response to the fiscal crisis. There is considerable support for restoring these benefits to the Medi-Cal program.

BACKGROUND

States establish and administer their own Medicaid programs (Medi-Cal in California) and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to provide other "optional benefits." The chart below shows the various optional benefits that were eliminated in 2009.

Adult Dental Services

Adult dental services, with the limited exception of “federally required adult dental services” (FRADS) and dental services to pregnant women and nursing home patients, were eliminated among other benefits. Generally, FRADS primarily involves the removal of teeth and treating the affected area. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013 restores partial adult optional dental benefits on May 1, 2014. The chart below shows the cost to fully restore all dental benefits.

The budget includes $10.8 million ($3.3 million General Fund and $7.6 million federal funds) in 2013-14 and $239.5 million ($72.9 million General Fund and $166.6 million federal funds) in 2014-15 to restore this benefit and assumes a six-month phase-in until full caseload is reached. DHCS expects that there is some pent up demand for these services.

Restoration Costs

The table on the following page provides the costs associated with restoring these benefits. As pointed out in the table footnotes, these services would be fully federally funded for the population covered under the ACA-related Medi-Cal expansion. For the balance of the Medi-Cal population, the services qualify for federal financial participation at the state's usual 50:50 matching rate.

	Annual Costs				
	FFS	Managed Care	TF	FF**	GF
Optional Benefits Restoration:	A	B	A+B		
Acupuncture	$1,193,000	$618,000	$1,811,000	$940,000	$871,000
Audiology	$1,379,000	$714,000	$2,093,000	$1,087,000	$1,006,000
Chiropractic	$172,000	$89,000	$261,000	$136,000	$126,000
Incontinence Cream and Washes	$2,538,000	$3,550,000	$6,088,000	$3,357,000	$2,730,000
Optician / Optical Lab	$3,554,000	$1,255,000	$4,809,000	$2,466,000	$2,343,000
Podiatry	$761,000	$394,000	$1,155,000	$600,000	$555,000
Speech Therapy	$88,000	$45,000	$133,000	$69,000	$64,000
Dental*	$228,490,000	$0	$228,490,000	$158,911,000	$69,579,000
Grand Total	**$238,175,000**	**$6,665,000**	**$244,840,000**	**$167,566,000**	**$77,274,000**

* Dental: Additional costs to restore all adult dental benefits. Costs for partial restoration were already budgeted in Nov. 2013 Estimate: Restoration of Select Adult Dental Benefits policy change.

** The Department receives 100% FFP for services provided to ACA Optional population.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests LAO to provide a brief presentation on the history of these optional benefits in the Medi-Cal program, including any knowledge they have on the impacts of their elimination five years ago.

The Subcommittee requests DHCS to provide feedback, considerations, and recommendations on this proposal to restore these optional benefits and to respond to the following:

1. Will the restored dental benefits, that begin May 1, 2014, be available to women in the pregnancy-only Medi-Cal program?

Staff Recommendation: Staff recommends holding this issue open.

ISSUE 2: MEANINGFUL USE INCENTIVE PROGRAM

The California Primary Care Association (CPCA) requests $37.5 million ($4.1 million General Fund, $33.4 million Federal Funds) to support technical assistance for the Medi-Cal Meaningful Use Incentive Program.

BACKGROUND

The American Recovery and Reinvestment Act of 2009 established the EHR Incentive Program for Medicaid and Medicare providers. Since 2011, eligible Medi-Cal professionals and hospitals have been receiving incentive payments to assist in purchasing, installing, and using electronic health records in their practices.

The Office of Health Information Technology (OHIT) has been established in DHCS to develop goals and metrics for the program, establish policies and procedures, and to implement systems to disburse, track, and report the incentive payments. OHIT works closely with the Office of the Deputy Secretary for Health Information Technology in the California Health and Human Services Agency to coordinate the Medi-Cal EHR Incentive Program with wider health information exchange efforts throughout California and the nation.

The federal government will provide a 90 percent match for activities related to health information technology (HIT), including efforts tied to electronic health record (EHR) adoption and support. Previously, these efforts were funded with federal grant funds. These grant funds have expired.

The state has the opportunity to draw down $37.5 million in federal funds (over multiple years) if it can provide a state match of $4.1 million. The Governor's budget does not include a proposal on this.

The Medi-Cal EHR incentive payments are 100 percent funded by the federal government. California's providers have received over $1 billion in these incentive payments. The operating costs of the Medi-Cal EHR Incentive Payment Program require a 10 percent match by the state in order to draw down an additional 90 percent funding from the federal CMS. Currently, $190,000 General Fund is used as the match for the state's operations.

A federal grant was used to provide the technical assistance support to implement EHR and achieve meaningful use. This technical assistance was provided at Regional Extension Centers and other entities. This grant has expired.

The CPCA estimates that there are 15,000 providers eligible for the MU program who are not participating. They believe that participation will increase with increased access to technical assistance. The cost of technical assistance is $5,000 per provider, which has been provided by Local Extension Centers and Service Providers under the Regional Extension Program that is now concluding.

STAFF COMMENTS/QUESTIONS

Given both the substantial policy and health care benefits associated with effective use of health information technology, as well as the availability of 90 percent federal funding for this program, it appears to be a critical lost opportunity to not attempt to secure state funding for this purpose.

Staff Recommendation: Staff recommends holding this issue open.

ISSUE 3: AFFORDABLE CARE ACT PREGNANCY SERVICES BCP (TBL)

DHCS is proposing trailer bill language to improve access to health care coverage for low-income pregnant women. The language proposes to:

1. **Provide Full Scope Medi-Cal for Pregnant Women Below 109 percent FPL.** DHCS proposes to provide full-scope coverage—rather than pregnancy-only coverage—to all pregnant women below 109 percent of the federal poverty level (FPL) who receive coverage from Medi-Cal (who are not otherwise eligible for full-scope). DHCS estimates no additional costs associated with providing full-scope coverage instead of pregnancy-only coverage, based on the assumption that there are no significant differences in coverage.

2. **Provide Medi-Cal Cost-Sharing and Benefit Wrap for Pregnant Women between 109 percent and 208 percent FPL.** DHCS also proposes to shift pregnant women between 109 percent and 208 percent of FPL who qualify for Medi-Cal pregnancy-only coverage to plans offered through Covered California. The budget assumes General Fund savings of $17 million in 2014-15 related to this component of the proposal since the federal government (through Covered California) would cover the costs of comprehensive health coverage for these women. DHCS would implement this provision beginning January 1, 2015 and estimates that 8,100 Medi-Cal enrollees currently receiving pregnancy-only coverage would shift into Covered California.

BACKGROUND

Beginning January 1, 2014, under the federal Patient Protection and Affordable Care Act (ACA), adults with incomes at or below 138 percent of the FPL who are under 65 years of age, not pregnant, and who meet other eligibility criteria can enroll into Medi-Cal and receive full-scope services as a newly-eligible adult.

If the newly-eligible adult is a childless woman and she subsequently becomes pregnant while enrolled in Medi-Cal under this coverage group, she has the ability to remain in this coverage group and can continue with her full scope coverage of Medi-Cal services. However, if the same individual applies for coverage and is pregnant at the time of enrollment, based on her income, she will be ineligible for the new adult group and may only be eligible for the limited scope pregnancy-related services.

Furthermore, individuals with income above applicable Medi-Cal limits but below 208 percent of the FPL can enroll into coverage via the California Health Benefit Exchange, also known as Covered California, and receive applicable premium tax credits and cost sharing reductions, under certain conditions, and are provided with comprehensive health care coverage including pregnancy related care. To the extent individuals enrolled in coverage through Covered California subsequently become pregnant, and become income eligible for Medi-Cal for pregnancy-related services; they will have the option to either remain in coverage through Covered California or can move to Medi-Cal for coverage under the pregnancy-only program.

For purposes of minimum essential coverage (MEC), as required by the ACA, individuals enrolled in limited-benefit programs, such as the pregnancy-only program under Medi-Cal, would not meet the MEC standard and they would need to seek coverage via Covered California where they may receive premium tax credits to purchase insurance and cost-sharing reductions to meet MEC.

Comprehensive Perinatal Services Program

The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal program that provides women with prenatal care, health education, nutrition services, and psychosocial support for up to 60 days after the delivery of their infants. Over 1,500 Medi-Cal providers are certified as CPSP providers, in both fee-for-service and managed care systems. Providers include physicians, clinics, certified nurse midwives, and family nurse practitioners.

Proposed Medi-Cal Cost-Sharing and Benefit Wrap

For pregnant women with incomes between 109 percent and 208 percent of FPL who qualify for Medi-Cal and who enroll in a qualified health plan offered through Covered California, DHCS would:

- Pay the woman's premium costs minus the woman's premium tax credit.
- Pay for any cost-sharing (e.g., copays) for benefits and services under the Covered California health plan.
- Provide any Medi-Cal benefits (e.g., dental and nonemergency transportation) that are not offered by the Covered California health plan.
- Provide access to Medi-Cal providers who do not contract with the Covered California health plan for services that are not available in the qualified health plan. This may include, but is not limited to perinatal specialists and services in Comprehensive Perinatal Services Program (CPSP).

DHCS indicates that it is currently analyzing how its current Medi-Cal managed care plans provide CPSP services and whether health plans offered in Covered California provide CPSP-like services. For example, according to one qualified health plan that offers products through Covered California, the only Medi-Cal and CPSP benefits that it does not provide are dental benefits and nonemergency medical transportation. This plan contracts with birth centers and utilizes midwives as part of its network.

Additionally, DHCS is in the process of assessing if there is a difference in the outcomes from services if they are provided by certified CPSP providers or non-CPSP certified providers.

Legislative Analyst Comments and Recommendations

The LAO finds that the Governor's proposal would: 1) likely reduce General Fund spending, while potentially providing more generous benefits; 2) full-scope coverage would eliminate coverage inconsistencies for pregnant women; and 3) that certain details of the proposal remain unclear, such as the differences in covered services and costs between full-scope and pregnancy-only coverage. The LAO recommends the Administration clarify: 1) the differences in covered services between full-scope Medi-Cal and pregnancy-only Medi-Cal; and 2) continuity of coverage and plan choice for individuals moving between Medi-Cal and Covered California.

Many consumer advocates highlight the inequity of the Administration's proposal in that adults, female and male with incomes under 138 percent of the FPL are eligible for full-scope Medi-Cal; however, pregnant women (with incomes under 138 percent of the FPL) who apply and are eligible for Medi-Cal could only receive pregnancy-only Medi-Cal or could choose comprehensive coverage through Covered California, with Medi-Cal providing a cost-sharing and benefit wrap. Additionally, consumer advocates urge the strengthening of the Medi-Cal benefit wrap provisions and consumer protections in the Administration's proposal. Many advocates find that CPSP services must be delivered comprehensively as a program and by CPSP-certified providers and do not think that the success of this program can be duplicated as a "wrap" service.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of this proposal and to respond to the following:

1. Please provide an update on DHCS' analysis of how Medi-Cal managed care plans provide CPSP services.
2. Please provide an update on DHCS' analysis of whether or not qualified health plans offer CPSP services, and whether they are of the same quality as the services in Medi-Cal.
3. What are the differences in benefits and costs between full-scope and pregnancy-only coverage?
4. If the wrap is enacted, pregnant women will have multiple coverage options – how does DHCS propose to inform women of the multiple options?
5. How does DHCS propose to inform Medi-Cal eligible pregnant women of their right to receive services that are not available in their qualified health plan?
6. How does DHCS propose to coordinate pregnancy-related wrap services that would be provided outside the Covered California qualified health plan?

Staff Recommendation: Staff recommends holding this issue open to allow for more discussion with the administration and stakeholders on the proposal.

ISSUE 4: ACA-IMPLEMENTATION ABX1 1 / 032 BCP

DHCS requests eight positions and expenditure authority of $1,062,000 ($295,000 General Fund and $767,000 federal funds) in 2014-15 and $1,046,000 ($290,000 General Fund and $756,000 federal funds) in 2015-16 needed to implement the various statutory requirements of AB 1 X1 (Pérez), Chapter 3, Statutes of 2013-14 of the First Extraordinary Session. Specifically, AB 1 X1 authorizes DHCS to implement various Medicaid provisions of the Affordable Care Act (ACA).

BACKGROUND

AB 1 X1 authorizes the DHCS to implement various Medicaid provisions of the ACA. Specifically, AB 1 X1 1 implements the new "adult group" in California; transitions Low Income Health Program (LIHP) beneficiaries to Medi-Cal beginning January 1, 2014; implements the use of the Modified Adjusted Gross Income (MAGI) methodology; simplifies the annual renewal and change in circumstances processes for Medi-Cal beneficiaries; requires DHCS to use electronic verifications of eligibility criteria both at initial application and redeterminations of eligibility; permits Covered California to make Medi-Cal eligibility determinations in limited situations; and establishes performance standards for DHCS, Covered California, and the Statewide Automated Welfare Systems (SAWS).

Positions Requested

Of the requested positions, the Medi-Cal Eligibility Division requests four two-year limited-term, full-time positions as follows:

- Two Health Program Specialists II
- Two Associate Governmental Program Analysts

The Medi-Cal Eligibility Division (MCED) is responsible for the planning, development, coordination, and implementation of Medi-Cal regulations, policies, and procedures to ensure accurate and timely determination of Medi-Cal eligibility for applicants and beneficiaries. These positions would provide extensive technical program consultation on the implementation requirements of the legislation; assist in the development of policies in the form of All County Welfare Director Letters, Medi-Cal Eligibility Division Information Letters, and regulations in support of the policy changes mandated by the legislation; conduct ongoing policy reviews and analyses of the eligibility requirements; review and interpret ongoing federal guidance; and obtain stakeholder and county perspectives.

The Information Technology Division requests four two-year limited-term positions as follows:

- One Senior Information Systems Analyst Specialist
- One Staff Information Systems Analyst
- One Senior Programmer Analyst Specialist
- One System Software Specialist III

The Information Technology Division (ITSD) provides a secure, reliable information technology environment to support program and administrative objectives of DHCS, the California Department of Public Health (DPH), and the California Health and Human Services Agency.

These positions would provide definition, design, development, implementation and ongoing support of the various Medicaid provisions of the ACA. This work includes provisions contained in AB 1 X1, and will require system enhancements to Medi-Cal Eligibility Data System (MEDS) and related systems including the Statewide Client Index (SCI), and interfaces in the following major areas: eligibility, enrollment, systems integration, and the establishment of performance standards for DHCS, Covered California and SAWS.

LAO Findings and Recommendations

The LAO finds that based on the timelines provided in the proposal, it appears most of the activities that will be performed by the requested positions are scheduled to be complete by June 2015, with many of them completed even earlier. Currently, it is unclear why the department is requesting positions through June 30, 2016 when the activities are scheduled to be completed by June 2015. The LAO recommends the Legislature direct the department to report on the activities these positions will be performing after June 2015, at which point it appears most of the workload associated with this request is scheduled to be complete.

STAFF COMMENTS/QUESTIONS

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

1. Please comment on the LAO's findings that justification for these positions in 2015-16 is unclear. What will these positions perform after June 2015?

Staff Recommendation: Staff recommends holding this open pending clarifications from DHCS on the questions raised by LAO.

ISSUE 5: ACA-HOSPITAL PRESUMPTIVE ELIGIBILITY DETERMINATION SYSTEM (SBX1 1 / XXX) BCP

DHCS requests funding for the information technology consultant costs associated with enhancing the business functionalities and reporting requirements of the Medi-Cal Eligibility Determination System (MEDS) to create a Hospital Presumptive Eligibility gateway and implement the Hospital Presumptive Eligibility (PE) program, as set forth in the Affordable Care Act (ACA) and enacted in SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session.

The costs associated with the implementation is estimated at $1,583,000 ($396,000 General Fund, $1,187,000 Federal Fund) with an on-going cost of $239,000 ($60,000 General Fund, $179,000 Federal Fund) per year. The contracted vendor will assist DHCS to develop the Hospital PE gateway and enhance MEDS, including developing requirements, validation, training, and user ownership.

BACKGROUND

On July 5, 2013, the federal Centers for Medicare and Medicaid Services (CMS) released Part 2 of the Medicaid Final Rule regulations to implement various provisions of the ACA, including final regulations on the implementation of the Hospital PE program established by the ACA at 42 Code of Federal Regulations (CFR) Section 435.1110.

To implement the Hospital PE program, California enacted Welfare & Institutions Code Section 14011.66, as prescribed in SB 1 X1. The Hospital PE program provides temporary no share-of-cost Medi-Cal benefits during a presumptive period to individuals determined eligible by a qualified hospital, on the basis of preliminary information. The Hospital PE program is effective as of January 1, 2014. To ensure compliance with the Hospital PE program's effective date of January 1, 2014, DHCS enhanced the MEDS by leveraging the system functionalities established for the Child Health and Disability Prevention (CHDP) Gateway program. However, this strategy was a short-term approach to meet the mandate; the enhancements do not provide the means to meet critical program requirements on oversight and monitoring, performance standards development, and program integrity and compliance with applicable state and federal policies, statutes, and regulations.

To date, 124 hospitals are providing Hospital PE and 11,000 individuals have been approved to receive Medi-Cal under the Hospital PE program.

STAFF COMMENTS/QUESTIONS

No concerns have been raised with the Subcommittee on this proposal. DHCS developed short-term solutions to ensure that this program was implemented quickly and, as a result, over 11,000 individuals have qualified for Medi-Cal Hospital PE. This proposal will provide for a long-term technology solution to support the Hospital PE program.

Staff Recommendation: Staff recommends approval of this BCP for $1.58 million to implement the Hospital Presumptive Eligibility Determination System.

ISSUE 6: ACA-MANAGED CARE BRIDGE PLANS (SBX1 3 / 034) BCP

DHCS requests four three-year limited-term positions and $460,000 ($229,000 General Fund, $231,000 Federal Trust Fund) to implement the provisions of SB 3 X1 (Hernandez), Chapter 5, Statutes of 2013-14 of the First Extraordinary Session. The bill requires DHCS to ensure that its contracts with Medi-Cal managed care health plans meet various requirements, including providing coverage in bridge plans to Medi-Cal managed care enrollees and other specified individuals.

BACKGROUND

SB 3 X1: 1) requires the California Health Benefits Exchange (known as Covered California) to enter into contracts with and certify as a qualified health plan (QHP) Medi-Cal managed care plans that offer "bridge plan" products meeting specified requirements; 2) specifies the populations that would be eligible to purchase a bridge plan product; and 3) requires DHCS to ensure its contracts with Medi-Cal managed care plans meet specified requirements. A bridge plan product is the individual health benefit plan offered by a licensed health care service plan or health insurer that contracts with Covered California.

The bill requires Covered California to submit an evaluation to the Legislature of the bridge plan program in the fourth year following federal approval and would sunset the bridge plan program five years after federal approval, unless a later enacted statute deletes or extends the dates of operation. The purpose of SB 3 X1 is to improve continuity of coverage for Medi-Cal enrollees and their families, and provide more affordable coverage to low-income individuals.

SB 3 X1 establishes a bridge health insurance plan for low-income individuals, the parents of Medi-Cal and Healthy Families Program-eligible individuals, and individuals moving from Medi-Cal coverage to subsidized coverage through Covered California. The purpose of the bridge is to promote continuity of care, provide an additional low-cost coverage choice to hard-working Californians, and reduce the negative effects of "churning" back and forth between systems of coverage where individuals are required to shift health plans and health coverage programs because of changes in their household income. By allowing individuals to remain within their current health plan when they shift health subsidy programs, SB 3 X1 prevents disruptions in individuals' provider networks and improves continuity of care.

DHCS states that these positions are necessary to provide legal advice, litigation support and regulation development. Additionally, the positions would be needed to address managed care bridge plan policy implementation and to avoid potential negative consequences including noncompliance with state and federal mandates, the loss of federal funding, and litigation.

Legislative Analyst Findings and Recommendations

The LAO finds that the workload appears to be based on an assumption that a significant number of Medi-Cal managed care plans will be offering a Bridge Plan product. The federal government has yet to approve the state's Bridge Plan proposal and—even assuming the proposal is approved by the federal government—it is unclear how many Medi-Cal plans will offer Bridge Plan products. If very few Medi-Cal plans offer Bridge products, the workload for this proposal may be overstated. Second, the authorizing statute (SB 3 X1) gives DHCS the authority to delegate much of the implementation responsibility to Covered California. Currently, it is unclear why DHCS chose to implement these activities rather than delegate these activities to Covered California. The LAO recommends the Legislature direct DHCS to report on the following: 1) how many Medi-Cal plans they expect to offer Bridge Plan products; 2) the degree to which the number of plans offering Bridge Plan products affects the workload associated with this proposal; 3) which Bridge Plan implementation activities are being delegating to Covered California; and 4) why the department is requesting resources to implement the activities described in this proposal, rather than delegating the activities to Covered California.

STAFF COMMENTS/QUESTIONS

DHCS recently indicated that they are not ready to move forward with this proposal, and therefore request the Subcommittee reject it at this time.

Staff Recommendation: Staff recommends rejection of this BCP for $460,000 for implementation of SB 3 X1.

ISSUE 7: ACA-ENHANCED SUBSTANCE USE DISORDER SERVICES (SBX1 1 / 033) BCP

DHCS requests $2,748,000 ($1.3 million General Fund, $1.4 million Federal Fund) and 10.0 permanent and 12.0 2-year limited-term positions to implement SB 1 X1 (Hernández), Chapter 4, Statutes of 2013-14 First Extraordinary Session, which implements ACA-created enhanced mental health and substance use disorder (SUD) services in Medi-Cal.

BACKGROUND

Prior to 1996, California offered a larger array of substance use disorder treatment services to Medi-Cal beneficiaries. However, these benefits were optional benefits for states and were eliminated due to budget constraints.

SB 1 X1 addressed the "essential health benefits" requirement of the ACA by specifying that Medi-Cal would provide the same services for its members that they could receive if they bought a non-grandfathered health plan in the state's individual and small group markets for mental health and substance use disorder services. SB 1 X1 expanded new substance use disorder services to all Medi-Cal beneficiaries beginning January 1, 2014. Specifically, SB 1 X1 expands residential SUD treatment services, intensive outpatient services, and voluntary medically-necessary inpatient detoxification to all Medi-Cal beneficiaries. It also provides preventive screenings and brief interventions for alcohol misuse for adults in primary care settings.

DHCS reports that the number of Medi-Cal beneficiaries currently receiving limited SUD services ranges between 60,000 and 68,000 individuals. This population will have access to the new services, and DHCS anticipates that nearly 20,000 will meet the medical necessity and acuity for SUD residential services, and that 24,000 will meet the criteria for intensive outpatient services. DHCS also states that 757,000 individuals will be newly eligible for Medi-Cal in 2014-15, and based on the national prevalence rate for SUD services, nearly 75,000 will have have SUD needs. Over 19,000 of these newly eligible can be expected to seek SUD services.

DHCS anticipates that small counties that currently do not have certified providers within their boundaries will begin operating the Drug Medi-Cal program, including development of the necessary infrastructure and staffing to participate in the program. DHCS also expects that existing providers will seek to begin offering the newly reimbursed/covered services.

New Workload
DHCS expects new temporary and permanent workload as a result of implementation of expanded SUD benefits as follows:

Temporary Workload -- certification, appeals, and monitoring of additional DMC providers; and information technology needs to make changes to billing, claiming and provider enrollment systems to accommodate new providers.

Permanent Workload -- ongoing certification, monitoring, program and financial audits and appeals, and investigations of the increased volume of providers; and ongoing audits and investigations of the increased number of providers.

Positions Requested
To address this new workload, DHCS is requesting the following positions:

Temporary (12.0 2-year)
- Associate Governmental Program Analysts (5.0)
- Health Program Auditors IV (2.0)
- Senior Information System Analysts (2.0)
- Senior Programmer Analysts (2.0)
- Systems Software Specialist (1.0)

Permanent (10.0)
- Associate Governmental Program Analysts (3.0)
- Staff Services Manager I (1.0)
- Health Program Specialist I (1.0)
- Nurse Evaluators II (2.0)
- Investigator (1.0)
- Health Program Auditors II (2.0)

Funding
Funding for the non-federal share of new and expanded SUD services will be state General Fund. Counties will be responsible for funding the existing services for the currently eligible population, through funds deposited into the Behavioral Health Subaccount created by the 2011 Public Safety Realignment.

STAFF COMMENTS/QUESTIONS

No concerns have been raised with this proposal, and additional resources seem appropriate to ensure the effective implementation of enhanced benefits, particularly given recent challenges in Drug Medi-Cal.

Staff Recommendation: Staff recommends approval of this BCP for $2.7 million and 10.0 permanent and 12.0 limited-term positions to support enhanced substance use disorder services.

ISSUE 8: ACA-MEDI-CAL ELIGIBILITY INTEGRATION WITH CALHEERS (MCED14-02 / 030) BCP

DHCS requests the extension of 12.0 2-year limited-term positions, which expire June 30, 2014, and $1,777,000 ($314,000 General Fund, $857,000 Federal Funds, $606,000 Reimbursements from Covered California) to support the ongoing implementation and maintenance of the Medi-Cal Eligibility Data System (MEDS) changes and integration with the California Health Benefit Exchange ("CalHEERS") and county eligibility consortia systems.

BACKGROUND

The ACA required the Health Benefit Exchanges to be operational by January 1, 2014. Functions of the Exchange include eligibility determinations for Exchange products and insurance affordability programs including Medi-Cal and Children's Health Insurance Programs (CHIP). Federal regulations and state law require coordination between the Exchange, Medi-Cal and CHIP programs to ensure a seamless, integrated process for individuals seeking health coverage. This integration requires interfaces with CalHEERS, the systems solutions designed for the Exchange functions, the three county eligibility consortia that determine Medi-Cal eligibility and MEDS, the statewide database that includes eligibility information for Medi-Cal, CalWORKS, and CalFRESH.

The 2013 Budget Act provided 12.0 2-year limited-term positions to support the planning, design, development, implementation, and ongoing maintenance of the Medi-Cal eligibility and enrollment system changes and integration with the California Health Benefit Exchange and county eligibility consortia systems. However, there have been significant scope and functionality delays in the timelines, and hence this request to extend these 12 positions for another two years.

Positions Requested

The Medi-Cal Eligibility Division (MCED) is requesting to extend 3.0 positions to support the planning, development, implementation and evaluation of Medicaid eligibility rules and enrollment simplification provisions as required by the ACA.

The Information Technology Services Division (ITSD) is requesting to extend 9.0 positions to support the planning, design, development, implementation and ongoing maintenance of the MEDS changes and integration with CalHEERS and the county systems.

STAFF COMMENTS/QUESTIONS

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

1. Please describe the delays and other challenges experienced in the development of the CalHEERS interfaces.

2. What challenges have Covered California consumers and Medi-Cal beneficiaries faced as a result of these challenges?

3. What is being done to address these challenges?

Staff Recommendation: Staff recommends holding this item open to allow for more time for discussions with the administration and stakeholders about CalHEERS.

ISSUE 9: BUDGETING METHODOLOGY FOR COUNTY ADMINISTRATION (SB 28 / 028) BCP

DHCS requests $1,485,000 for 7.0 3-year limited-term positions and contract services to implement requirements of SB 28 (Hernández & Steinberg), Chapter 442, Statutes of 2013, to design and implement a new budgeting methodology for county administrative costs that reflects the impact of the ACA on county administrative work, and present that methodology to the Legislature no later than March 2015.

BACKGROUND

The state's 58 counties perform eligibility determinations for applicants to the Medi-Cal program as well as case maintenance activities. Currently, counties are budgeted for their activities based on claimed expenditures from previous years, and there is no county share of cost for administrative activities in the Medi-Cal program. DHCS states that, therefore, historically, there has been no incentive for counties to maximize efficiency or to control their administrative costs. According to DHCS, the new methodology will seek to use a performance and outcome-based system to determine accurate county funding levels, reward increased county efficiency, and determine effectiveness of county efforts.

DHCS intends for the development of the new county budget methodology to be a comprehensive overhaul that will include specific reviews of annual time studies, claimed expenditures, and other data metrics. The administration believes that most of this work should be done by Audits and Investigations (A&I) as they have the experience, expertise and skills necessary to perform these activities. However, DHCS states that A&I lack certain critical expertise in the area of monitoring and evaluation of time studies. Hence, DHCS proposes to hire contract staff with specific knowledge to develop the new methodology, create an ongoing monitoring plan and train A&I staff on monitoring and evaluation of time studies.

Positions Requested

DHCS is requesting the following positions for this proposal:

Medi-Cal Eligibility Division (MCED) (2.0 total):

- Associate Governmental Program Analyst (1.)
- Staff Services Manager (1.0)

Audits & Investigations (A&I) (5.0 total):

- Health Program Auditor III (4.0)
- Health Program Audit Manager 1 (1.0)

Stakeholder Concerns

The County Welfare Directors Association (CWDA) is opposed to this proposal primarily due to the fact that the majority of positions being requested are auditor positions, and CWDA points out that developing a new budgeting methodology is not an auditing function. DHCS explains that they believe that auditors have the most appropriate expertise for this purpose, even though they will not be engaged in auditing.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal and to respond to CWDA's concerns about hiring auditors for the purpose of developing a new budgeting methodology.

Staff Recommendation: Staff recommends holding this item open to allow for more discussion with stakeholders.

ISSUE 10: MEDI-CAL COUNTY COST OF LIVING ADJUSTMENT (TBL)

DHCS is proposing trailer bill language to discontinue the annual cost of living adjustment (COLA) in statute for counties for their administration of Medi-Cal eligibility determinations and related functions.

BACKGROUND

DHCS reimburses counties for the costs they incur by performing administrative activities associated with the Medi-Cal eligibility process. Existing Welfare and Institutions Code Section 14154 states the Legislature's intent to provide the counties with a COLA annually. Nevertheless, the COLA was suspended for the following four fiscal years: 2009-10, 2010-11, 2011-12, 2012-13. Furthermore, AB 12 (Evans) Chapter 12, Statutes of 2009-10, 4th Extraordinary Session, added Government Code Section 11019.10 that prohibits automatic COLAs.

The 2013 Budget Act included supplemental funding for the counties reflecting the substantial increase in workload expected as a result of implementation of the Affordable Care Act. Related, and as discussed in the prior issue on this agenda, SB 28 (Hernandez & Steinberg) Chapter 442, Statutes of 2013, requires DHCS, in consultation with stakeholders, to create a new methodology for budgeting and allocating funds for county administration for the Medi-Cal program, and for this new methodology to be implemented in 2015-16.

County Medi-Cal Administration Funding			
	2012-13 Estimate	**2013-14 Estimate**	**2014-15 Proposed**
State Funds	$769,798,100	$823,786,850	$677,786,750
Federal Funds	$1,861,293,900	$2,798,698,150	$2,684,125,250
Total Funds	**$2,631,092,000**	**$3,622,485,000**	**$3,361,912,000**

The administration indicates that it is the administration's policy and practice to end all automatic annual COLAs, consistent with Government Code Section 11019.10. Consistent with this policy, AB 8 X4, (Evans), Chapter 8, Statutes of 2009-10, Fourth Extraordinary Session, eliminates the automatic annual COLA for the State Supplemental Payment (SSP) program and for the CalWORKS program.

Stakeholder Opposition

The County Welfare Directors Association opposes this proposed trailer bill language, stating that it is premature at best. CWDA points out that the need or justification to modify or eliminate the annual COLA can and should be considered within the context of developing the new budgeting methodology, per SB 28 (as discussed in the prior issue). Until that time, the Legislature and Governor have the ability to suspend the COLA on an annual basis, as has occurred in the past several years.

Legislative Analyst Concerns

The LAO raises the same concerns as those raised by CWDA, and therefore also argues that this proposed trailer bill is premature. The LAO also provided information that describes a much more complex picture of the role of COLAs in state programs than as described by the administration.

STAFF COMMENTS/QUESTIONS

As raised by both CWDA and the LAO, DHCS is on the cusp of launching a "comprehensive overhaul" (as DHCS describes it) of the budgeting methodology for counties. Given that the Legislature and Governor have the ability to continue suspending the COLA annually, as they deem necessary and appropriate, it seems premature to eliminate it altogether at this time, rather than to consider its role within the context of developing the new methodology.

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends denying this proposed trailer bill language to eliminate the county Medi-Cal administration COLA.

ISSUE 11: COMMUNITY MENTAL HEALTH SERVICES OVERVIEW

The January budget assumes 2014-15 costs for the Medi-Cal Specialty Mental Health Program of $3.4 billion, a 4.5 percent increase over the current year budget of $3.2 billion. This does not account for mental health costs associated with two components of the Affordable Care Act, as follows:

- Medi-Cal expansion up to 138 percent of the Federal Poverty Level for single, childless adults -- $183 million Total Funds (all Federal Funds)

- Enhanced mental health benefits -- $300 million ($119 million General Fund, $181 million Federal Funds)

BACKGROUND

County Mental Health Plans

California has a decentralized public mental health system with most direct services provided through the county mental health system. Counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs.

Specifically, counties are responsible for: 1) all mental health treatment services provided to low-income, uninsured individuals with severe mental illness; 2) Medi-Cal Specialty Mental Health Services for adults and children; 3) mental health treatment services for individuals enrolled in other programs, including and CalWORKs; and 4) programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Medi-Cal Specialty Mental Health Services Program

California provides Medi-Cal "specialty" mental health services under a federal waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21.

County Mental Health Plans are the responsible entity that ensures specialty mental health services are provided. Medi-Cal enrollees *must* obtain their specialty mental health services through the county. Medi-Cal enrollees may also receive certain limited mental health services, such as pharmacy benefits, through the Fee-For-Service system.

Specialty Mental Health Services include: adult (18-20 years) crisis residential services, adult residential treatment services, crisis intervention, crisis stabilization, day (half & full-day) rehabilitation, day treatment intensive, medication support, psychiatric health facility services, psychiatric inpatient hospital services, targeted case management, therapeutic behavioral services, and therapy.

California's Medi-Cal Specialty Mental Health Services Waiver is effective until June 30, 2015. See below for budget summary.

Specialty Mental Health Services Program Children & Adult Service Costs – Accrual Comparison			
	2013-14 Estimate	**2014-15 Proposed**	**Difference**
General Fund	$28,981,000	-$6,000,000	-$34,981,000
Federal Funds	1,624,436,000	1,743,169,000	118,732,000
County Funds	1,593,828,000	1,655,616,000	61,789,000
TOTAL FUNDS	**$3,247,245,000**	**$3,392,985,000**	**$145,740,000 (4.5%)**

In 2014-15, it is projected that 242,843 adults and 261,507 children will receive Medi-Cal Specialty Mental Health Services (using the accrual methodology). It should be noted that these projected caseload estimates do not include the anticipated caseload growth as a result of the optional Medi-Cal expansion as provided by AB 1 X1 (Pérez), Chapter 3, Statutes of 2013-14 of the First Extraordinary Session.

ACA Expansion to Mental Health Benefits

SB 1 X1 (Hernández), Chapter 4, Statutes of 2013 requires Medi-Cal to cover mental health services that are included in the essential health benefits package that the state adopted into statute, including group mental health counseling. Effective January 1, 2014, these services are now offered through managed care plans.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to provide an overview of the Medi-Cal Specialty Mental Health Waiver program, including the impacts of the ACA, and any other significant changes or updates to the program and budget.

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

ISSUE 12: 2011 REALIGNMENT – BEHAVIORAL HEALTH SUBACCOUNT GROWTH ALLOCATION

The formula to allocate 2011 Realignment Behavioral Health Subaccount Growth funds has not yet been determined. These growth funds are estimated at $27.9 million in 2012-13, $52.8 million in 2013-14, and $184.3 million in 2014-15.

The Department of Finance, in consultation with the appropriate state agencies and the California State Association of Counties, is required to develop a schedule for the allocation of these funds to the counties.

The Administration indicates that it is still in discussions with counties to finalize the Behavioral Health Subaccount Growth schedule. As part of these discussions, the Administration is looking at the most recent expenditure data available to determine which counties are over and under Behavioral Health Subaccount allocations and where growth funding could fund entitlements.

BACKGROUND

SB 1020 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2012, created the permanent structure for 2011 Realignment. SB 1020 codified the Behavioral Health Subaccount which funds Medi-Cal Specialty Mental Health Services (for children and adults), Drug Medi-Cal, residential perinatal drug services and treatment, drug court operations, and other non-Drug Medi-Cal programs. Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs and counties have a responsibility to provide for these entitlement programs.

Government Code Section 30026.5(k) specifies that Medi-Cal Specialty Mental Health Services shall be funded from the Behavioral Health Subaccount, the Behavioral Health Growth Special Account, the Mental Health Subaccount (1991 Realignment), the Mental Health Account (1991 Realignment), and to the extent permissible under the Mental Health Services Act, the Mental Health Services Fund. Government Code Section 30026.5(g) requires counties to exhaust both 2011 and 1991 Realignment funds before county General Fund is used for entitlements. A county board of supervisors also has the ability to establish a reserve using five percent of the yearly allocation to the Behavioral Health Subaccount that can be used in the same manner as their yearly Behavioral Health allocation, per Government Code Section 30025(f).

Consistent with practices established in the 1991 Realignment, up to 10 percent of the amount deposited in the fund from the immediately preceding fiscal year can be shifted between subaccounts in the Support Services Account with notice to the Board of Supervisors, per Government Code Section 30025(f). This shift can be done on a one-time basis and does not change base funding. In addition, there is not a restriction for the shifting of funds within a Subaccount, but any elimination of a program, or reduction of 10 percent in one year or 25 percent over three years, must be duly noticed in an open session as an action item by the Board of Supervisors, per Government Code Section 30026.5(f). Government Code Section 30026.5(e) also requires 2011

Realignment funds to be used in a manner to maintain eligibility for federal matching funds.

DHCS issued Mental Health Services Division Information Notice 13-01 on January 30, 2013, to inform counties that 2011 Realignment did not abrogate or diminish the responsibility that, "they must provide, or arrange for the provision of, Medi-Cal specialty mental health services, including specialty mental health services under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit." As noted above, Government Code Section 30026.5(k) specifies fund sources for Medi-Cal Specialty Mental Health Services. The Administration continues to work with the California State Association of Counties and the California Mental Health Directors Association to ensure all counties are aware that entitlement programs and clients cannot be denied services.

Additionally, the Administration cites that Section 1810.226 of the California Code of Regulations defines a mental health plan to be an entity that contracts with DHCS to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county as provided in Chapter 11 of Title 9 of the California Code of Regulations. The Department has executed contracts with the county mental health departments to be the mental health plans for Medi-Cal where the county agrees to provide directly or arrange and pay for the provision of Medi-Cal specialty mental health services to beneficiaries in a county. Statute also provides DHCS the ability to investigate complaints and the authority to impose sanctions on counties that do not fulfill its obligations as a mental health plan. Those sanctions may include fines or penalties.

Stakeholder Concerns

Stakeholders and advocates have expressed grave concerns regarding both funding levels and inadequate access to mental health services. Of particular concern is the alleged perception that at least some counties believe that funding for mental health services is capped, and therefore services can be limited based on this funding cap. Advocates also argue that the growth allocation for EPSDT must be treated differently from the rest of the growth and must be allocated to reflect actual utilization rather than a base percentage of revenues with a formula for growth.

STAFF COMMENTS/QUESTIONS

The Administration has not yet released its proposed formula. Key considerations when evaluating the proposed formula include:

2. Does the proposed formula reflect actual expenditures for Medi-Cal Specialty Mental Health and Drug Medi-Cal?

3. Does the proposed formula make it clear to counties that funding for entitlement programs is not capped and that counties need to provide the entitled services?

4. Does the proposed allocation of growth funds incentivize improvement in the delivery of services?

5. Will the allocation of growth funds be done on a timely basis so counties can budget and rely on the prompt allocation of these funds?

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

1. Please provide an overview of this item and an update on when the Administration will release the proposed allocation formula.

2. Please confirm that Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs that the counties must fully fund. How does the state monitor to ensure that counties are not capping services and are not providing less comprehensive services for these entitlement programs?

Staff Recommendation: Staff recommends holding this item open.

ISSUE 13: COUNTY MENTAL HEALTH PLANS OVERSIGHT (MHSD14-02 /013) BCP

DHCS requests $1,145,000 ($314,000 GF, $831,000 FF) and 7.0 permanent positions to increase the scope, frequency and intensity of monitoring and oversight by DHCS of County Mental Health Plans (MHP), in response to federal CMS concerns.

BACKGROUND

The federal Centers for Medicare and Medicaid Services (CMS) sent a letter, dated June 27, 2013, to DHCS approving of DHCS's Specialty Mental health Services (SMHS) Waiver Renewal Application, however the approval was provided for two years, rather than the requested five years, reflecting a host of concerns raised about the operation of the program, including:

1. Timely access to services;

2. The availability of interpreter services, especially for Spanish speaking beneficiaries;

3. Significantly elevated rates of non-compliance observed during DHCS compliance system reviews of County MHP operations, California External Quality Review Organization (EQRO) reviews;

4. The continuing high rates of claim disallowance resulting from both outpatient and inpatient medical record reviews; and

5. Ineffective use of sanctions, especially extrapolation, in response to high levels of noncompliance and disallowance.

CMS clearly expects DHCS to take effective remedial action immediately to reduce the levels of non-compliance and claims disallowance to acceptable levels, stating that a rate above 3 percent is considered high. California's current disallowance rates are:

- The average MHP non-compliance rate for system reviews of MHPs for fiscal years 2011-12 and 2012-13 was 23 percent.

- The average MHP disallowance rate for outpatient medical record reviews for fiscal years 2011-12 and 2012-13 was 32 percent.

- The average MHP disallowance rate for the 18 Short-Doyle/Medi-Cal acute psychiatric inpatient hospitals resulting from inpatient medical record reviews from 2002 to the present was approximately 50 percent.

Positions Requested

- *Program Oversight and Compliance Branch—Compliance (4.0 Positions):* To increase scope, intensity, and frequency of oversight and monitoring of the County MHPs and identified providers by the Program Oversight and Compliance Branch. DHCS states that this proposal would increase the frequency of performance reviews of the MHPs from once every three year to once every two years, and it would make follow-up monitoring possible.

- *Program Policy and Quality Assurance Branch—County Support (2.0 Positions):* To increase the level of monitoring and technical assistance provided to the MHPs by the County Support Unit, including clinical technical assistance in order to ensure they are in compliance with State and Federal Requirements, and increasing the level of follow-up when out-of-compliance areas are identified. DHCS states that the Quality Assurance Unit has no staff possessing a mental health professional license.

- *Program Policy and Quality Assurance Branch (PPQAB)—Appeals (1.0 Position):* To establish staffing for appeals within the PPQAB which includes licensed clinical staff who will be responsible for reviewing appeals and making appeal decisions. According to DHCS, the current staffing level limits the ability of the County Support Unit to perform in-depth and comprehensive assessments of the needs of the 56 MHPs or to provide the intensity of training, follow-up and other remedial functions which are needed to reduce levels of non-compliance and disallowance observed during the triennial reviews.

STAFF COMMENTS/QUESTIONS

DHCS has indicated that this proposal is in direct response to federal CMS concerns and expectations with regard to the need for significant program improvements. No one has raised any concerns related to this proposal with the Subcommittee.

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

1. Please explain how California's non-compliance and disallowance rates have gotten to be so high?

Staff Recommendation: Staff recommends approval of this BCP for $1.1 million and 7.0 positions within the Mental Health Services Division to respond to CMS concerns.

ISSUE 14: PERFORMANCE OUTCOME SYSTEM PLAN (MHSD14-03 / 014) BCP

DHCS requests $563,000 ($242,000 General Fund, $321,000 Federal Funds) and 4.0 permanent positions to implement the Performance Outcome System (POS) Plan, released with the Governor's Budget, as required by SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012, to improve Medi-Cal Specialty Mental Health services and to meet federal requirements.

BACKGROUND

Trailer bill language included in the 2012-13 budget package requires DHCS to develop a POS for Medi-Cal specialty mental health services for children and youth. DHCS released the required POS Implementation Plan with the Governor's January Budget and is requesting the resources needed for implementation and on-going operation through this BCP.

The purpose of the POS is to improve outcomes for individuals, programs and systems, and to inform fiscal decision-making related to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (i.e., mental health services for children). SB 1009 imposed the following three requirements on DHCS: 1) convene a stakeholder advisory committee by September 1, 2012; 2) submit to the Legislature by October 1, 2013 a POS Plan; and 3) submit to the Legislature by January 10, 2014 a POS Implementation Plan. DHCS has completed all three of these requirements.

The POS Plan sets forth a framework from which specialty mental health services outcomes may be measured and describes next steps that must be taken to identify an evaluation methodology and to develop a continuous reporting and quality improvement process between the state, counties, and their providers. The POS will enable state and county administrators, behavioral health care providers, and the general public to access web-based reports using aggregated data that may be used to track specialty mental health service trends, including the progress that children and youth make in various aspects of their lives. Findings from outcomes reporting will inform the development of quality improvement plans that aim to ensure that consistent, high quality, and fiscally effective services are provided to children, and that these services improve all areas of their lives, such as school performance, home environment, safety, and juvenile justice.

Positions Requested

DHCS states that currently there is no capacity within the department to support this new POS. DHCS states that research and information technology staff is needed to support the development of the POS evaluation methodology as well as to extract, compile and analyze data to produce reports. Technical assistance and quality improvement staff is needed to provide counties with support for interpreting reports and developing strategies to monitor and improve local performance and outcomes. Therefore, DHCS is requesting 1.0 of each of the following positions: 1) Research Program Specialist III; 2) Staff Programmer Analyst/Specialist; 3) Health Program Specialist II; and 4) Consulting Psychologist.

STAFF COMMENTS/QUESTIONS

No concerns have been raised with the Subcommittee regarding this proposal. The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends approval of this BCP for $563,000 and 4.0 positions to implement the Performance Outcome System Plan.

ISSUE 15: INVESTMENT IN MENTAL HEALTH WELLNESS IMPLEMENTATION (SB 82 – SB 364 / 044) BCP

DHCS requests the authority to establish three permanent, full-time positions due to the enactment of SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, the "Investment in Mental Health Wellness Act of 2013," and the enactment of SB 364 (Steinberg), Chapter 567, Statues of 2013, which broadens the types of facilities that can be used for the purposes of 72-hour treatment and evaluation under Welfare and Institutions Code (WIC) Section 5150.

The cost for these positions is $353,000 ($177,000 General Fund, $176,000 Federal Fund). Two positions would support the workload related to SB 82 and one position would support the workload related to SB 364.

BACKGROUND

SB 82 – Investment in Mental Health Wellness Act of 2013. SB 82, the Investment in Mental Health Wellness Act of 2013, set goals of adding at least 25 mobile crisis support teams, and 2,000 crisis stabilization and/or treatment beds for use in California communities over the next two years; 835 beds will be added in the first round of grant awards and priority was given to proposals that were community-based versus institution-based.

DHCS finds that SB 82 would increase its workload related to: 1) conducting initial and annual site certifications for residential facilities; 2) conducting initial and triennial certifications of mobile crisis teams and crisis stabilization units; and 3) carrying out tasks related to DHCS approval of 5150 designated facilities related to the new facilities that are added through SB 82.

SB 364 – 72-Hour Treatment Facilities. SB 364 broadens the types of facilities that can be used for 72-hour treatment and evaluation under WIC 5150. WIC 5150 provides that, “when a person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, he or she may, upon probable cause, be taken into custody by a peace officer, member of the attending staff of an evaluation facility, designated members of a mobile crisis team, or other designated professional person, and placed in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services.”

DHCS contends that implementation of SB 364 would increase workload related to: 1) maintaining a statewide list of all 5150-designated facilities; 2) updating 5150 regulations; 3) conducting statewide site-reviews of these facilities; and 4) investigate complaints related to these facilities.

STAFF COMMENTS/QUESTIONS

Part of the estimated workload for these proposed positions is based on the assumption that 2,000 crisis beds would be up in 2014-15; however, awards to develop only 835 have been recommended by the California Health Facilities Financing Authority (CHFFA). Additionally, it is estimated that SB 82 and SB 364 would increase the workload related to the 5150 designation, however, it is not clear if this workload would materialize given that: 1) the CHFFA grants are focused on community-based residential treatment; and 2) it is not clear if DHCS has received any requests related to the broadening of facility types that can be used per WIC 5150 as allowed by SB 364.

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends holding this item open to allow additional time for implementation to inform the need for resources.

ISSUE 16: COMMUNITY MENTAL HEALTH PROPOSALS

Community mental health advocates propose that DHCS be required to establish stakeholder workgroups in order to address two significant deficiencies in mental health care in California: 1) insufficient integration of mental and physical health care; and 2) excessive paperwork requirements for mental health care providers.

BACKGROUND

The following background information was provided by advocates:

Physical & Mental Health Care Integration

Six years ago a study of eight states' Medicaid populations showed that people with severe mental illnesses had five times the average Medicaid rates for heart disease, hypertension, diabetes, and obesity and died on average 25 years younger than other Medicaid enrollees. That led to a number of pilot programs which developed new models for integrated mental health and physical health care, as well as findings by DHCS and Medi-Cal health plans that their physical health costs are highest for people with Schizophrenia and other severe mental illnesses. Many studies and pilot programs show that providing better physical health care to this population can reduce health care costs and improve health.

Relying on the primary care delivery system as the hub of physical health care has not worked well for this population. They do not easily get to primary care settings and when they do, they can be difficult to serve. It has become a best practice across the country that to serve this population effectively requires health plans to send primary care professionals to see these individuals where they receive mental health care services, as that is seen as the best "health home" for this population.

Advocates also state that the health home option, which the state has authority to apply for but has not yet done so, should be considered. It increases access to federal funds for some care coordination activities that would not otherwise be Medicaid reimbursable. It is designed for people with severe mental illness, and that is how most other states have focused it. However, it can also be applied to anyone with two chronic conditions, one of which could be severe mental illness but mental illness is the only condition that qualifies by itself.

Advocates propose that the Legislature require DHCS to develop a work group to develop findings and present related proposals to the Legislature in March 2015 with expected start-up July 2015.

Paperwork Reduction

Community mental health agencies have been complaining for years about the extreme costs of documentation that California requires. A leading consultant who has helped many states reduce paperwork noted that California is interpreting federal requirements in ways that significantly add to this burden that providers estimate as reflecting over 40 percent of the cost of service. One community agency indicates that the California requirements make each mental health outpatient session take 20 minutes to complete the documentation while in other states it is only five minutes.

Advocates propose that the Legislature require DHCS to develop a workgroup, and to contract with expert consultants, in order to minimize paperwork on par with other states.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the LAO to briefly present these proposals and to provide any responses they may have to these issues.

The Subcommittee requests DHCS to respond to these proposals and to respond to the following:

1. What is known about the potential savings that could be achieved for the state or health plans as a result of increased integration of physical and mental health care?

2. What is the state doing to increase integration of physical and mental health care?

3. What is the state doing to analyze and potentially reduce paperwork requirements for mental health care providers?

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

ISSUE 17: COORDINATED CARE INITIATIVE OVERSIGHT & IMPLEMENTATION (SB 94 / 04) BCP

The Governor's budget includes a net General Fund savings of $159.4 million in 2014-15 (DHCS budget only) as a result of the CCI, including the General Fund savings from the sales tax on managed care organizations (MCO). Without the MCO tax revenue, CCI would have a General Fund cost of $172.9 million in 2014-15.

On February 28, 2014, the Department of Finance (DOF) provided the following statutorily required update on overall General Fund savings across all departments: The CCI is expected to result in a net General Fund savings of $84.1 million in 2013-14 and $65.4 million in 2014-15. DOF also states that this will be updated again at May Revise.

DHCS also is requesting 4.0 3-year limited-term positions and $760,000 ($380,000 General Fund, $380,000 Federal Fund) of which $300,000 is to be added to the existing Mercer Health and Benefits LL contract for actuarial services, to implement provision of SB 94 (Committee on Budget & Fiscal Review), Chapter 37, Statutes of 2013, related to the use of "risk corridors."

BACKGROUND

The 2012 budget authorized the Coordinated Care Initiative (CCI), which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits in eight counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara). CCI is composed of three major parts:

- **Long-Term Supports and Services (LTSS) as a Medi-Cal Managed Care Benefit**: CCI includes the addition of LTSS into Medi-Cal managed care. LTSS includes nursing facility care (NF), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Community Based Adult Services (CBAS). This change impacts about 600,000 Medi-Cal-only enrollees and up to 456,000 persons eligible for both Medicare and Medi-Cal who are in Cal MediConnect.

- **Cal MediConnect Program**: A three-year demonstration project for persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system (health plan). No more than 456,000 beneficiaries would be eligible for the duals demonstration in the eight counties. This demonstration project is a joint project with the federal Centers for Medicare and Medicaid Services (CMS).

- **Mandatory Enrollment of Dual Eligibles and Others into Medi-Cal Managed Care.** Most Medi-Cal beneficiaries, including dual eligibles, partial dual eligibles, and previously excluded Seniors and Persons with Disabilities (SPDs) who are Medi-Cal only, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits.

The purpose and goal of CCI is to promote the coordination of health and social care for Medi-Cal consumers and to create fiscal incentives for health plans to make decisions that keep their members healthy and out of institutions (given that hospital and nursing home care are more expensive than home and community-based care).

Under the current system (prior to CCI), dual eligibles must access services through a complex system of disconnected programs funded by different government programs (e.g., federal CMS, DHCS-Medi-Cal, IHSS-county based). This fragmentation often leads to beneficiary confusion, delayed care, inappropriate utilization, and unnecessary costs.

Cal MediConnect

Cal MediConnect is a three-year demonstration for persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive coordinated medical, behavioral health, and long-term supports and services through a single organized delivery system. No more than 456,000 beneficiaries would be eligible for the duals demonstration in the eight counties. This demonstration project is a joint project with CMS. The state and CMS entered into a Memorandum of Understanding3 (MOU) on March 27, 2013 for this project. Additionally, CMS, DHCS, and each health plan entered into a three-way contract for this project. See chart below for information on Cal MediConnect counties and health plans.

County	Dual Eligible Population	Health Care Plan(s)
Alameda	32,533	• Alameda Alliance for Health • Anthem Blue Cross
Los Angeles	288,399[a]	• Health Net • L.A. Care[b]
Orange	65,537	• CalOptima
Riverside	40,040	• Inland Empire Health Plan • Molina Healthcare
San Diego	55,798	• Care 1st • Community Health Group • Health Net • Molina Healthcare
San Mateo	12,371	• Health Plan of San Mateo
San Bernardino	41,930	• Inland Empire Health Plan • Molina Healthcare
Santa Clara	37,739	• Santa Clara Family Health Plan • Anthem Blue Cross
TOTAL	**574,347[c]**	

a 288,399 are estimated to be eligible for Cal MediConnect in Los Angeles; however, enrollment in Los Angeles County was capped at 200,000 in the MOU.

b L.A. Care will be subcontracting with CareMore and Care 1st Health Plan.

c Enrollment into Cal MediConnect is capped at 456,000 per the MOU.

Passive Enrollment. For Cal MediConnect, the state will passively enroll dual eligibles into a health plan that combines their Medicare and Medi-Cal benefits. Passive enrollment is when the state assigns an individual to a Cal MediConnect health plan unless the individual actively chooses not to join and notifies the state of this choice. An individual may opt out of the Cal MediConnect health plan by making this selection on the 60-day notification, calling Health Care Options (HCO), or calling a toll-free Medicare phone number. (HCO assists in Medi-Cal enrollment.)

Dual eligibles who enroll in a Cal MediConnect health plan may opt out or change health plans at any time. If a dual eligible chooses to opt out of Cal MediConnect, it only applies to opting out of Medicare benefits. Dual eligibles, under CCI, must still receive their Medi-Cal benefits through managed care.

Populations Excluded from Passive Enrollment in Cal MediConnect. The following populations may voluntarily enroll, but may not be passively enrolled into Cal MediConnect:

- Individuals residing in certain rural zip codes in San Bernardino County in which only one Cal MediConnect Plan operates;

- Individuals enrolled in Medicare Advantage, including Dual Eligible Special Needs Plans (D-SNPs) in 2014;

- Individuals in one of the following programs may enroll only after they have disenrolled from the following 1915(c) waivers: Nursing Facility/Acute Hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver; and,

- Individuals may enroll in Cal MediConnect only after they have disenrolled from the Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation.

Mandatory Enrollment into Medi-Cal Managed Care

Enrollment. Dual eligibles and most other previously excluded Medi-Cal enrollees (e.g., those receiving long-term services in a nursing facility) must enroll in Medi-Cal managed care for their Medi-Cal benefits. This change impacts about 600,000 Medi-Cal-only enrollees and up to 456,000 persons eligible for both Medicare and Medi-Cal who are in Cal MediConnect.

The Medi-Cal-only enrollees will receive only Medi-Cal benefits from the health plan. These enrollees include full dual eligibles excluded from Cal MediConnect, partial dual eligibles, and senior and persons with disabilities. See table below for enrollment projections by county.

County	Number of Eligible Medi-Cal-Only Enrollees
Alameda	48,000
Los Angeles	317,000
Orange County	51,000
Riverside	46,000
San Bernardino	54,000
San Diego	64,000
San Mateo	14,000
Santa Clara	38,000
Total	**632,000**

Populations Excluded from Mandatory Enrollment into Medi-Cal Managed Care. The following populations are excluded from mandatory enrollment into Medi-Cal managed care:

- Individuals under age 21;
- Medi-Cal only individuals exempted from managed care due to an approved Medical Exemption Request;
- Individuals living in certain rural zip codes;
- Individuals receiving services through intermediate care facilities for the developmentally disabled in all counties except Orange and San Mateo;
- Individuals residing in one of the Veterans' Homes of California;
- Individuals in the Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation.

Individuals with HIV/AIDS and American Indian Medi-Cal enrollees will be enrolled into Medi-Cal managed care, but can opt out at any time.

Enrollment Timeline. The January budget proposes changes to the implementation timeline. (The CCI timeline has been delayed multiple times since enacted in 2012.) Generally, the updated timeline reflects:

- Cal MediConnect dual eligibles in Medicare fee-for-service will be passively enrolled for Medicare and Medi-Cal benefits beginning on April 1, 2014, in Riverside, San Bernardino, San Diego, and San Mateo counties. Cal MediConnect individuals in these counties received a 90-day notification in January about this change.

- In Los Angeles County, dual eligibles may voluntarily enroll in Cal MediConnect or opt out, beginning April 2014; and the remaining dual eligibles will be passively enrolled into Health Net beginning in July 2014 and into L.A. Care no sooner than December 2014.

- Alameda and Orange Counties will passively enroll dual eligibles no sooner than January 2015.

- Santa Clara will passively enroll dual eligibles no sooner than January 2015.

Recent Changes. On March 25, 2014, DHCS announced the following changes:

- "Aligning Cal MediConnect and Managed Medi-Cal Long-Term Services and Supports (MLTSS) Enrollment: Moving forward, beneficiaries who are in Medi-Cal FFS (fee-for-service) will not transition to MLTSS ahead of their Cal MediConnect passive enrollment date. This will reduce the number of plan choices a beneficiary will need to make, and reduce confusion.

- MLTSS Transition for FFS Population to Start in August: To ensure that the MLTSS 90 day notices have had appropriate quality reviews, DHCS will not start MLTSS enrollment for Medi-Cal FFS populations (non-duals or duals excluded from Cal MediConnect) until August 2014. The previous enrollment schedule was to have the population begin in July.

- Changes in timeline in Alameda and Orange Counties: Enrollment in Alameda and Orange Counties is being delayed until no sooner than January 2015 to allow more time to achieve plan readiness."

Medicare Managed Care Plans

Within the 8 Cal MediConnect counties, approximately 168,000 frail, elderly, low-income seniors are currently enrolled in comprehensive, integrated Medicare managed care plans, for which the state's contracts expire on December 31, 2014. The administration intends to transition this population into plans participating in Cal MediConnect. However, as discussed above, CCI implementation has experienced significant delays, thereby potentially creating an unstable situation within which to transition this vulnerable population.

If these Medicare contracts are not extended, dual eligibles covered by these Medicare plans may have their care interrupted and some may even return to fee-for-service Medi-Cal. This same situation existed last year, resulting in the adoption of budget trailer bill that requires DHCS to offer contracts to existing Medicare Advantage Special Needs Plans (D-SNP plans), and exempted Medicare Advantage and D-SNP beneficiaries from the Cal MediConnect enrollment provisions, though allowed them to enroll voluntarily. Federal legislation was signed this week authorizing the continuation of these plans through 2016.

Proposed BCP

The Capitated Rates and Development Division (CRDD) of DHCS perform risk adjustment and rate setting processes involving Medi-Cal managed care beneficiaries. Medi-Cal enrollment into managed care is expected to grow by 2 million beneficiaries, from 5.7 million to 7.7 million, thereby substantially increasing the workload for CRDD.

SB 94 allows the mandatory enrollment of persons eligible for Medicare and Medi-Cal into Medi-Cal managed care, and for the integration of MLTSS into managed care in the 8 CCI counties to proceed separately from the Cal MediConnect demonstration project. SB 94 also requires DHCS to include risk corridor provisions in its contracts with managed care health plans in the 8 CCI counties, for populations that are subject to mandatory enrollment for their MLTSS and who are not enrolled in the Cal MediConnect Demonstration project. Risk corridors are a method of risk sharing that may limit the financial risk of misaligning the payments associated with a contract to furnish long-term services and supports pursuant to a contract under the CCI on an at-risk basis. The risk corridors would be in place for 24 months commencing with mandatory enrollment of beneficiaries into Medi-Cal managed care for their long-term services and supports.

The risk corridors are to protect the managed care health plans from significant underpayments and to protect the state from significant overpayments by providing for the sharing in either additional costs or profits resulting from the capitated rates paid by DHCS to the managed care plans. In order to do this, the CRDD will have to develop, establish and direct activities regarding collecting, tracking, monitoring, evaluating, and reconciling financial information provided by the plans. Specifically, the workload includes:

- Developing the reconciliation process;
- Testing the reconciliation process;
- Establishing financial information submission standards;
- Developing and evaluating risk corridor policy;
- Working with the plans;
- Obtain and validate enrollment and claims data; and
- Reconcile claims and capitation payments to the Health Plan records.

DHCS is requesting the following 4.0 3-year limited-term positions for this purpose:

- Health Program Audit Manager II – 1.0 position
- Health Program Audit Manager I – 1.0 position
- Health Program Auditor II – 2.0 positions

STAKEHOLDER CONCERNS

Several consumer advocacy organizations request the suspension of implementation of CCI in all counties other than San Mateo until DHCS and CMS can demonstrate that an enrollment process is in place that provides seniors and people with disabilities the information and resources they need to make informed decisions about their Medicare and Medi-Cal benefits. In a letter, dated February 21, 2014, advocates raised all of the following concerns regarding the implementation of CCI:

- Many required notices have not yet been finalized;
- The notices that have been finalized are inadequate and confusing;
- Notices have not yet been translated;
- Notices are not yet available in alternate formats;
- Notices have not been tested with beneficiaries and are not written at a sixth grade level;
- Notices are being sent to people who should not receive them;
- Medicare notices related to Cal MediConnect have not been revised to be California specific;
- Health Care Options is not ready;
- Plan websites do not have required materials posted;
- The Health Insurance Counseling Programs (HICAPs) have not yet received their funding;
- The Los Angeles enrollment strategy is not yet finalized; and
- Federal authority for components of the CCI has yet to be provided.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to:

1. Provide an overview of CCI implementation including a clear summary of the timelines;

2. Present the proposed BCP;

3. Provide a response to stakeholder concerns listed above; and

4. Respond to the following questions.

D-SNP Contracts

1. What is the administration's thinking and planning with regard to the D-SNP contracts?

Multi-Services Senior Program (MSSP)

1. How do MSSP programs get paid if a participant voluntarily enrolls in Cal Medi-Connect before MSSP has been fully transitioned to managed care in his or her county?

2. In the situation described in the question above, how can a MSSP program bill the state for FFS given that MSSP costs have been incorporated into the CCI capitation rates for health plans?

Health Care Options

1. How is the state providing oversight over the Health Care Options contract?

Care Plan Optional Services

1. How is the state providing oversight over Care Plan Optional Services?

2. How are the plans using Care Plan Optional Services?

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

ISSUE 18: COMMUNITY BASED ADULT SERVICES WORKLOAD (LTCD14-01) BCP

DHCS requests authority to extend 3.0 limited-term positions (expiring August 31, 2014) for one year, and 2.0 limited-term positions (expiring June 30, 2014) for two years, and $540,000 ($241,000 General Fund, $299,000 Federal Funds) to complete required work related to the Community-Based Adult Services (CBAS) Settlement Agreement and 1115 Waiver.

BACKGROUND

Adult Day Health Care (ADHC), a Medi-Cal optional benefit, was eliminated as a part of the budget package passed and signed by the Governor in March of 2011. In June 2011, ADHC participants filed a motion in federal court to stop the elimination of ADHC "unless and until adequate replacement services were in place," asserting that the elimination of the benefit would place beneficiaries at risk of unnecessary institutionalization. The parties reached a settlement, which allowed for the elimination of ADHC and required establishment of the CBAS program to provide similar services to seniors and adults with disabilities.

DHCS previously requested and received 5.0 limited-term positions for the time-period January 1, 2013 through June 30, 2014 to establish, structure, and assist in transitioning CBAS benefits into managed care plans (reflecting the Settlement Agreement which provided that CBAS would be only a managed care benefit) and the expansion to rural counties.

DHCS states that the extension of the 3.0 positions in the Long-Term Care Division (LTCD) is necessary to complete all reporting requirements necessary under the Settlement Agreement and the 1115 Waiver. Also, these positions are needed to transition the program to an ongoing managed care benefit. DHCS states: "Extending the LTCD positions allows for completing and transitioning the program where it can be a permanent part of Long-Term Services and Supports.

Finally, DHCS states that the extension of the 2.0 positions in the Medi-Cal Managed Care Division is needed to continue oversight of the health plan compliance in administering CBAS in all counties with the implementation of the Coordinated Care Initiative.

STAFF COMMENTS/QUESTIONS

No issues or concerns with this proposal have been raised with the Subcommittee. The Subcommittee requests that DHCS present this proposal.

Staff Recommendation: Staff recommends approval of this BCP for $540,000 to extend five limited-term positions to continue implementation of CBAS.

ISSUE 19: STATEWIDE OUTPATIENT CONTRACT DRUG LIST (TBL)

DHCS requests trailer bill language to:

1. ***Statewide Formulary*.** Establish a core statewide outpatient Medi-Cal contract drug list (CDL) formulary for all Medi-Cal beneficiaries, including the Family Planning, Access, Care and Treatment Program (FPACT). Any of the drugs on this statewide formulary would be available without a treatment authorization request. Managed care plans would be required to use this core formulary, as a minimum, and could add additional drugs at their discretion.

2. ***Additional State Supplemental Drug Rebates*.** Negotiate supplemental drug rebate contracts with manufacturers for all Medi-Cal programs, including managed care plans and FPACT. The budget estimates General Fund savings of $32.5 million in 2014-15 and annual General Fund savings of at least $65 million as a result of these supplemental drug rebates.

BACKGROUND

DHCS is one of the largest purchasers of drugs in the State. The fee-for-service (FFS) pharmacy program contract drug list formulary (CDL) is established and maintained by DHCS in consultation with the Medi-Cal Contract Drug Advisory Committee (MCDAC) and ongoing recommendations from the Medi-Cal Drug Use Review (DUR) Board. Currently, beneficiaries in Medi-Cal's FFS program have access to drugs listed on the Medi-Cal CDL without having to obtain prior authorization.

However, Medi-Cal managed care plans are only required to establish drug formularies that are comparable in scope to the Medi-Cal CDL. Each managed care plan develops and manages its own formulary, and as a result, Medi-Cal beneficiaries may receive different drug formulary options and be subject to different utilization controls when they move between health plans. Current regulations (California Administrative Code Title 22, § 53854) do not require a plan to include in its formulary every drug listed on the Medi-Cal formulary and do not prevent a plan from performing utilization review to determine the most suitable drug therapy for a particular medical condition.

There are currently more than twenty different Medi-Cal managed care plan formularies. Additionally, beneficiaries under FPACT may receive different drugs because FPACT administers its own outpatient drug formulary which is separate and apart from the Medi-Cal CDL.

The federal Medicaid Drug Rebate Program was created by the 1990 Omnibus Budget Reconciliation Act and requires drug manufacturers to have a national rebate agreement with the federal Department of Health and Human Services in order for states to receive federal funding for outpatient drugs dispensed to Medicaid enrollees. Prior to 2010, drugs provided to enrollees in Medicaid or Medi-Cal managed care plans were excluded from these federal rebates.

The Affordable Care Act modified this and now drug utilization from Medi-Cal managed care plans is subject to the federal drug rebate program. Pursuant to Welfare and Institutions Code Section 14105.33, DHCS is able to also negotiate with pharmaceutical manufacturers for additional rebate revenue (state supplemental rebates) over and above the mandated federal rebates for drugs provided to beneficiaries in the Medi-Cal FFS program and County Organized Health Systems. This state supplemental rebate program excludes drugs provided to beneficiaries in Medi-Cal managed care plans. The expansion of Medi-Cal managed care into all 58 counties and mandatory enrollment of families, children, seniors and persons with disabilities into managed care reduces the ability of the State to obtain the supplemental rebates for drugs provided to these beneficiaries under managed care arrangements.

Reason for Request

DHCS states that historically, its clinical and fiscal benefit design (for its pharmaceutical program) has been based on a FFS foundation for predominantly FFS-weighted pharmaceutical utilization. The shifts in population (e.g., seniors and persons with disabilities) and pharmaceutical utilization from FFS to managed care have highlighted two key issues:

1. **Inequity in the Pharmaceutical Benefit Design –** Each managed care plan develops its own drug formulary. Consequently, as people move from one managed care plan to another plan, Medi-Cal enrollees may receive different drug options and may be subject to various forms of drug utilization controls before they can receive a drug that they were previously prescribed. DHCS contends that this proposal would provide continuity of pharmaceutical benefits when a person changes plans.

2. **Lost Opportunities for General Fund Savings –** DHCS finds the state could obtain additional supplemental drug rebates resulting in General Fund savings if it had the ability to negotiate on the behalf of all Medi-Cal delivery systems, including Medi-Cal managed care plans and FPACT.

According to DHCS, Medi-Cal drug spending includes:

Medi-Cal Fee-For- Service for Pharmacy	$2.1 billion	State supplemental rebates are collected.
Medi-Cal Managed Care Rate Pharmacy Line Item	$1.3 billion	State supplemental rebates are not collected.
Medi-Cal Managed Care Carved Out Pharmacy (e.g., HIV drugs)	$672 million	State supplemental rebates are not collected.

DHCS finds that close to $2 billion in Medi-Cal drug spending could be subject to state supplemental rebates and that DHCS should play a more significant role in the establishment of this benefit.

DHCS recognizes that as a result of the statewide drug formulary, managed care rates may need to be adjusted since managed care plans will not have the same negotiating power and may not have the same ability to managed pharmaceutical utilization. DHCS indicates that the need for this rate adjustment would be evaluated as this proposal is implemented.

DHCS also notes that this proposal makes no changes to the existing Knox-Keene continuity of care protection for drug benefits. If a drug is not on the state's core formulary and not on the health plan's formulary (if it provides supplemental drugs), then the existing treatment authorization process would still occur.

DHCS states that this proposal does not impact the list of drugs (e.g., certain HIV drugs) that are carved out of Medi-Cal managed care.

DHCS anticipates that this process will take 18 months to implement, as federal approval is necessary, but is proposing that the changes related to the state supplemental rebates be retroactive to July 1, 2014.

STAFF COMMENTS/QUESTIONS

This is a very complex issue and discussions with stakeholders have recently commenced. It will be important for the Legislature to carefully consider the potential tradeoffs of this proposal. These tradeoffs include the additional General Fund savings and a core statewide drug benefit compared to restricting some aspects of a managed care plan's ability to control and manage pharmacy benefits, which potentially could lead to pressure for increased managed care rates. It is also not clear whether or how this proposal may interfere with a plan's ability to coordinate and manage the care of enrollees, particularly those with chronic conditions.

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

1. Please provide an overview of the timeline for this proposal and how DHCS intends to work with stakeholders to develop the statewide formulary.
2. Please provide an overview of the existing continuity of care protections related to prescriptions and medication. Do these only apply when an individual changes plans?
3. Please explain how the FPACT drug formulary and the current Medi-Cal FFS drug formulary are different. Please comment on how the Administration plans to evaluate those drugs that are on the FPACT formulary and whether or not they should be included on the new formulary.
4. Please comment on the potential need to adjust Medi-Cal managed care rates as a result of this proposal.

Staff Recommendation: Staff recommends holding this item open as discussions continue on the details of this proposal.

ISSUE 20: PROVIDER PREVENTABLE CONDITIONS (TBL)

DHCS is proposing trailer bill language to provide statutory authority to comply with federal rules that require states to report Provider Preventable Conditions (PPCs) and prohibit Medi-Cal payment for costs of services related to PPCs.

The proposed language would authorize DHCS to exclude from Medi-Cal coverage certain increases in charges billed to the Medi-Cal program that are directly related to the treatment of PPCs, and to recoup any payments made for those excluded charges. The language would also require providers to report PPCs to the department.

BACKGROUND

In 2005, the U.S. Department of Health and Human Services (HHS) was authorized to develop quality measures for the Medicare Program, which included non-payment policies for hospitals for secondary diagnoses associated with a "hospital acquired condition" that was not present on admission. In 2010, the ACA required HHS to prepare similar non-payment practices for Medicaid. The Centers for Medicare and Medicaid Services (CMS) issued its Final Rule (CF, Title 42, Parts 434, 438, and 447) in June 2011, requiring states to institute non-payment practices and reporting for PPCs which include both:

- ***"Other Provider-Preventable Conditions"***
  - Wrong surgical or other invasive procedure performed on a patient;
  - Surgical or other invasive procedure performed on the wrong body part; or
  - Surgical or other invasive procedure performed on the wrong patient.

- ***"Health Care-Acquired Conditions"***
  - Foreign object retained after surgery;
  - Latrogenic pneumothorax with venous catheterization;
  - Air embolism;
  - Blood incompatibility;
  - State III and IV pressure ulcers; and
  - Falls and trauma including fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock.

Currently, the exclusion from reimbursement of Health Care-Acquired conditions is limited to services provided by inpatient hospitals, which reflects the minimum federal standard. This proposal would authorize DHCS to extend these non-payment provisions to additional care settings, as permitted under the federal rule, following notification and consultation with appropriate stakeholders.

Under current law, there is no specific authority that requires providers to report PPCs to the State, nor is there specific authority for DHCS to reduce or recoup Medi-Cal reimbursement for costs associated with PPCs. Without statutory authority, the state is at financial risk for both General Fund and Federal Funds claimed inappropriately for unreported PPCs.

STAFF COMMENTS/QUESTIONS

No concerns have been raised with regard to this proposal.

The Subcommittee requests DHCS to present this proposal.

Staff Recommendation: Staff recommends approval of "placeholder" trailer bill language to report PPCs and prohibit Medi-Cal payment for costs of services related to PPCs.

ISSUE 21: MEDI-CAL ENROLLMENT FINGERPRINTING & CRIMINAL BACKGROUND CHECK PROGRAM (TBL)

DHCS seeks statutory authority to receive the results of criminal background checks of applicants and providers from the Department of Justice (DOJ) in order to screen or enroll the Medi-Cal provider applicants and providers.

Trailer bill language is also requested to clarify that applicants/providers will be responsible for reimbursing DOJ the cost to complete the expanded background checks and fingerprinting. The added language provides DOJ with clear legal authority to charge the providers for the fingerprinting and background checks. The cost of the background check is approximately $50.

BACKGROUND

DHCS is responsible for the enrollment and re-enrollment of fee-for-service health care service providers into the Medi-Cal program. There are approximately 150,000 enrolled Medi-Cal providers who serve the medically necessary needs of the Medi-Cal population.

In compliance with 42 Code of Federal Regulations (CFR) §455.434 and provisions of the Patient Protection and Affordable Care Act of 2010 (ACA), DHCS is required to establish a screening process for applicants or providers based on the provider types' categorical risk for fraud, waste, or abuse. The federal regulations establish three screening levels (per 42 CFR §455.450). The screening levels include "limited", "moderate" and "high," under which there are minimum requirements for screening and research to be conducted during the application review process:

- "Limited" categorical risk level providers are subject to license verification and database checks.

- "Moderate" categorical risk level providers are subject to all screening measures applicable to "limited" risk provider types in addition to onsite inspections.

- "High" categorical risk level providers are subject to all screening measures applicable to "limited" and "moderate" risk provider types in addition to the submission of fingerprints for a criminal background check (CBC).

Medi-Cal applicants or providers who CMS or DHCS designates as a "high" risk to the Medi-Cal program, and any individuals who have a five percent or greater direct or indirect ownership interest in the provider, will be required to be screened at a "high" categorical risk level and to submit fingerprints for a CBC within 30 days of a request. Furthermore, if CMS determines that "high" risk providers require federal CBCs, those providers designated as "high" risk would be required to undergo a federal CBC at the time of revalidation, as DOJ does not provide federal update reports as it does for State level CBCs.

Provider types that have been designated as "high" categorical risk by Medicare are required to be screened by Medicaid programs at that same level. Currently, newly enrolling durable medical equipment providers and newly enrolling home health agency providers have been designated as "high" categorical risk by Medicare. In addition to those provider types designated as "high" categorical risk, any applicant or provider will be elevated to the "high" categorical risk level if the provider has a payment suspension that is based on a credible allegation of fraud, waste, or abuse; has an existing Medicaid overpayment based on fraud, waste or abuse; has been excluded by the federal Department for Health and Human Services' Office of the Inspector General or another state's Medicaid program within the previous ten years; or, a moratorium has been lifted within the previous six months prior to applying in the Medicaid program and the applicant/provider would have been prevented from enrolling due to the moratorium. DHCS is to designate all other provider types not recognized by Medicare to an appropriate screening level based on fraud, waste, or abuse.

SB 1529 (Alquist), Chapter 797, Statutes of 2012, sponsored by DHCS, implemented various program integrity provisions required by the ACA, including the provision requiring Medi-Cal applicants or providers, who are required to be screened at a "high" categorical risk level for fraud, waste, or abuse to provide fingerprints for a CBC. Although DHCS currently has statutory authority to require fingerprints for a CBC, the DOJ requires specific statutory authority authorizing DOJ to accept fingerprints and furnish DHCS or its agents with CBC results. As such, this proposal seeks to establish authority for DOJ to provide criminal history information to DHCS for certain applicants or providers in the Medi-Cal program in order to become fully compliant with federal Medicaid requirements.

Need for Statutory Changes

Without the proposed trailer bill language, DHCS indicates it will not be able to implement the ACA requirement for CBCs. States are required to implement within 60 days of final guidance. This trailer bill language is in preparation to meet implementation requirements upon final guidance issuance. DHCS anticipates that guidance will be issued shortly. If California does not implement within the 60 day requirement, there would be an increased risk of losing federal financial participation (FFP) for the Medi-Cal program. State legislation is necessary in order to meet the requirements established by the federal regulations. As the single state Medicaid agency, DHCS is responsible for making sure it is in compliance with the federal regulations. DHCS intends to implement the federal minimum requirements when final guidance is issued.

Federal regulations must be followed in the administration of the Medi-Cal program, in order to guarantee the receipt of FFP dollars, on which the State's Medi-Cal budget heavily relies.

IHSS Providers

Questions have been raised about the applicability of this proposal to In-Home Supportive Services (IHSS) providers. IHSS providers are providers covered under the ACA and are not explicitly designated as a "high" risk provider category. The current

procedures for obtaining and submitting fingerprints and notification by DOJ of criminal record information for IHSS workers is set forth in Welfare and Institutions Code Section 15660(a). The process currently requires a state level CBC but does not require a federal level CBC. DHCS is awaiting final guidance from CMS whether a federal level CBC will be required for "high" risk providers. In the event that final federal guidance does require a federal CBC for "high" risk providers, DHCS will work with Department of Social Services on the steps necessary to meet these requirements.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to present this proposal, and to please explain the nature of the federal guidance that the department anticipates related to this issue.

Staff Recommendation: Staff recommends holding this issue open pending further federal guidance.

ISSUE 22: CALIFORNIA MEDICAL MANAGEMENT INFORMATION SYSTEM CONTRACT/CHANGE ORDER EXEMPTIONS (TBL)

DHCS proposes trailer bill language to establish an expedited contract process to exempt the Fiscal Intermediary (FI) contract from Public Contract Code requirements related to contract amendments and change orders.

BACKGROUND

The California Medicaid Management Information System (CA-MMIS) processes and pays approximately $17 billion a year in Medi-Cal fee-for-service health care claims to providers for medical care services provided to Medi-Cal beneficiaries, as well as the claims for other DHCS health care programs. Each week, CA-MMIS processes over four million claims and disburses on average $330 million to health care provider's statewide. CA-MMIS also provides oversight and ensures the quality management process of Medi-Cal managed care payments. The FI, currently Xerox, operates and maintains the system as a contractor to DHCS.

DHCS states that the Affordable Care Act (ACA) requires numerous critical changes to the operations of CA-MMIS, and therefore to the FI contract. DHCS explains that the large number and complexity of changes, coupled with changing timelines of ACA requirements rest in a large number of contract amendments and change orders which need to be processed expeditiously, not only to comply with changes in federal requirements, such as the Health Insurance Portability and Accountability Act (HIPAA), and to maintain enhanced federal financial participation, but also to reduce state costs that may increase with delays. Without exemptions to the Public Contract Code, these contract amendments and change orders take an unreasonably long time to implement, thereby limiting DHCS's efficiency and effectiveness in implementing the ACA.

Under the Public Contract Code, contracts must adhere to a process that is subject to Department of General Services (DGS) review and approval, State Administrative Manual & State Contracting Manual Guidelines, and DGS purchasing laws and policies. DHCS states that this process does not provide DHCS with the flexibility to implement new federal and state requirements in a timely manner, thereby leading to delays, increased costs, and inefficiencies.

DHCS notes that contract amendments still would be subject to review by both the California Health and Human Services Agency and Department of Finance, and would also require approval by the federal Centers for Medicare and Medicaid Services. Furthermore, this proposal is limited to contract amendments and change orders, and maintains Public Contract Code requirements for the overall process for establishing a contract with an FI in the future.

STAFF COMMENTS/QUESTIONS

Staff is unaware of any concerns about this proposal by stakeholders or others. It seems appropriate to provide DHCS with flexibility with regard to its ability to implement the myriad of health care changes underway, in a timely manner.

Staff Recommendation: Staff recommends approval of "placeholder" trailer bill to exempt contract amendments and change orders to CA-MMIS from Public Contract Code requirements.