AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

MONDAY, MAY 11, 2015

1:30 P.M. - STATE CAPITOL ROOM 4202

VOTE ONLY

ITEM	DESCRIPTION	
4140	**OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT**	
ISSUE 1	RECEIPT OF NON-STATE GRANTS APRIL 1 PROPOSAL	2
4260	**DEPARTMENT OF HEALTH CARE SERVICES**	
ISSUE 1	NON-EMERGENCY EMERGENCY DEPARTMENT CARE COPAY PROPOSAL	3
4265	**DEPARTMENT OF PUBLIC HEALTH**	
ISSUE 1	RECEIPT OF FEDERAL GRANTS NOTIFICATIONS	3
4440	**DEPARTMENT OF STATE HOSPITALS**	
ISSUE 1	PATTON SECURITY FENCE APRIL 1 PROPOSAL	4

ITEMS TO BE HEARD

ITEM	DESCRIPTION	
0530	**HEALTH & HUMAN SERVICES AGENCY**	
ISSUE 1	OFFICE OF LAW ENFORCEMENT SUPPORT APRIL 1 PROPOSAL	5
4260	**DEPARTMENT OF HEALTH CARE SERVICES**	
ISSUE 1	MANAGED CARE ORGANIZATION TAX	8
ISSUE 2	BUDGET CHANGE PROPOSALS & TRAILER BILL • OFFICE OF HEALTH INFORMATION TECHNOLOGY TECHNICAL ASSISTANCE PROGRAM • MEDI-CAL ELIGIBILITY DATA SYSTEM • FINANCIAL AUDITS WORKLOAD • 1115 WAIVER ACTIVITIES	12

VOTE ONLY

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

ISSUE 1: RECEIPT OF NON-STATE GRANTS APRIL 1 PROPOSAL

Through a Spring Finance Letter on April 1, 2015, the Office of Statewide Health Planning & Development (OSHPD) requests provisional language to provide OSHPD with the authority to transfer funds between local assistance and state operations within the administration of grants from non-state entities.

Beginning in 2013-14, The California Endowment provided a grant to OSHPD of $52 million over four years for OSHPD healthcare workforce development programs. The grant agreement includes a requirement that OSHPD evaluate program priorities each year and make changes to the program reflecting changing priorities. OSHPD asserts that they need the flexibility to make these changes, which might involve the shifting of funds from state operations to local assistance or vice versa, without the burden of seeking and receiving approval from the Legislature. OSHPD notes that these changes would need to be approved by Department of Finance. In 2015-16, $850,000 in grant funding would be transferred as follows:

- CalPostBac: $300,000. CalPostBac provides grants to post-baccalaureate educational entities whose efforts will support under-represented minority undergraduates re-apply to medical schools.

- CalSEARCH: $400,000. CalSEARCH provides grants to clinics and community health centers to support externships, internships and clinical rotations for community health workers/promotores, frontline workers, as well as primary care providers.

- California Department of Public Health Fellowship Program: $150,000

Staff Recommendation: Approve

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: ELIMINATE NONEMERGENCY EMERGENCY ROOM COPAY

The Senate Budget Sub-committee #3 proposes to adopt placeholder trailer bill language to eliminate the statutory references implementing a nonemergency emergency room copay in Medi-Cal, as this assumption has been removed from the Medi-Cal estimate. As part of the Medi-Cal estimate, the Governor's budget removes the assumption that the state would implement a copayment for nonemergency emergency room usage pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011 and AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012 which was expected to result in about $34 million ($17 million General Fund) savings. This copay has never been implemented, as it had not received approval from the federal Centers for Medicare and Medicaid. While the budget discontinues this assumption, the Administration did not propose trailer bill language to delete this provision from statute.

Staff Recommendation: Approve

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: NOTIFICATION OF RECEIPT OF FEDERAL GRANTS

The Senate Budget Committee proposes provisional language in order to increase the frequency with which the Department of Public Health is required to provide notice to the Legislature of the receipt of federal grants. The proposed language is the amendment to existing provisional language as shown below:

1. Of the funds appropriated in this item, $61,108,000 shall be available for administration, research, and training projects. Notwithstanding Section 28.00, the State Department of Public Health shall report, no later than 30 days after the end of each quarter, under that section any new project over $400,000 or any increase in excess of $400,000 for an identified project.

Currently, the department is required to report federal grants to the Legislature on an annual basis. This requirement came about in response to the quantity and frequency of the department receiving federal grants; this was an attempt to help the Legislature respond to this information by organizing it into one annual report to the Legislature. However, the Senate Budget Committee now believes that this often creates undue delays between actual receipts of federal funds to notify to the Legislature. This amended provisional language would change the requirement from annual to quarterly.

Staff Recommendation: Approve

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 1: PATTON SECURITY FENCE CAPITAL OUTLAY APRIL 1 PROPOSAL

Through a Spring Finance Letter on April 1, 2015, DSH requests to revert construction authority for the Patton State Hospital Upgrade Security Fencing Project, resulting in savings of $14,517,000 General Fund, which had been appropriated in the 2014 Budget Act.

The Patton State Hospital security-fencing project was proposed to provide improved perimeter sightlines and reduce the number of Department of Corrections and Rehabilitation (CDCR) staff required to provide perimeter security. However, a recent cost estimate prepared by the architectural firm indicates the need for an additional $12.5 - $13.5 million for construction due to various oversights. Given these increased costs, and the loss of savings resulting from reduced CDCR staff which justified the project, DSH believes that the project needs to be reevaluated before moving ahead.

Staff Recommendation: Approve

ITEMS TO BE HEARD

0530 HEALTH & HUMAN SERVICES AGENCY

ISSUE 1: OFFICE OF LAW ENFORCEMENT SUPPORT APRIL 1 PROPOSAL

PANELISTS

- **Health & Human Services Agency**
- **Department of Finance**
- **Legislative Analyst's Office**
- **Public Comment**

BUDGET PROPOSAL

The California Health & Human Services Agency (CHHS) submitted a Spring Finance Letter, on April 1 2015, requesting $1.965 million General Fund, $600,000 one-time reimbursement authority, and 15.0 permanent positions to establish a Professional Standards Section, a Vertical Advocate Unit within the Office of Law Enforcement Support (OLES), and reimbursable services contracts for subject-matter expertise. The 15 positions include 9 investigative unit positions, 4 attorneys and 2 support positions. The $600,000 in reimbursement authority is for service contracts with the California Highway Patrol (CHP) and the Office of the Inspector General (OIG). These contracts will allow the OLES to borrow a lieutenant and sergeant from the CHP and a Senior Assistant Inspector General from the OIG, to help train and mentor the new permanent OLES staff.

BACKGROUND

The 2014 Budget Act includes the creation of the OLES, which came about in response to underperformance by the Office of Protective Services (OPS) within each Developmental Center and State Hospital. CHHS conducted an in-depth analysis of OPS operations within DSH, which revealed the following critical deficiencies:

- Inability to recruit, hire, and retain qualified personnel
- Inconsistent and outdated policies and procedures
- Inadequate supervision and management oversight
- Inconsistent and inadequate training
- Inconsistent and deficient disciplinary processes
- Lack of independent oversight, review, and analysis of investigations
- Inadequate headquarters-level infrastructure
- Lack of experienced law enforcement oversight

OLES was established in 2014 to change the OPS culture and provide oversight, and be directly involved in all OPS operations. The OLES will be organized as follows:

Organizational Development Section

- Training and Policy Development Unit
- Selections and Standards Unit

Professional Standards Section

- Special Investigations Unit
- Investigations Analysis Unit
- Investigations Support Unit
- Serious Misconduct Review Team

In early March 2015, CHHS provided a report to the Legislature, as required in 2014 budget trailer bill, on the creation of the OLES, also approved through 2014 budget trailer bill. The report, *Office of Law Enforcement Support Plan To Improve Law Enforcement In California's State Hospitals and Developmental Centers*, is required to contain specific and detailed recommendations on improving law enforcement functions in a meaningful and sustainable way that assures safety and accountability in the State Hospitals and Developmental Center systems. The report contains a review and evaluation of best practices and strategies, including on independent oversight, effectively and sustainably addressing the employee discipline process, criminal and major incident investigations, and the use of force within state hospitals and psychiatric programs. The report states that inefficiencies in hiring practices and pay disparity led to fewer and less qualified employees, which resulted in more than 270,000 hours of overtime at a cost of $10.1 million in 2013. The report includes the following recommendations for next steps:

1. Establish a Professional Standards Section's Special Investigations Unit to monitor critical incidents, such as those involving sexual assault or other major assaults, and assist with complex investigations involving employee misconduct at state hospitals and developmental centers.

2. Establish a Professional Standards Section's Investigations Analysis Unit to provide quality control and analyses of administrative cases.

3. Hire Vertical Advocates who will ensure that investigations into allegations of employee misconduct are conducted with the thoroughness required for prosecution.

4. Conduct independent, comprehensive staffing studies of law enforcement duties and needs at the state hospitals and developmental centers.

The 2014 Budget Act includes resources for 6.0 positions within the new OLES. These positions are focused on support functions such as hiring, recruitment, training, policies and procedures. Agency reports that they anticipate all policies and procedures to be revised by July 2015, and training will follow shortly thereafter. The OLES is not intended to replace the individual departments' investigations, but rather to support and improve those investigations, and to provide separate investigations for the most serious incidents.

Legislative Analyst's Office

The LAO expresses concerns and recommends modifications to the proposal. Specifically, the LAO states that the proposal structure lacks the independence necessary for effective oversight. Therefore, the LAO recommends the Legislature:

1. Approve of $600,000 for the four proposed attorneys (vertical advocate positions);

2. Shift the requested investigative resources from OLES to the OIG and require the OIG to provide oversight over DSH and DDS; and

3. Deny the requested reimbursement authority of $600,000 for contracts with the OIG and CHP.

STAFF COMMENTS/QUESTIONS

Subcommittee staff requests Agency to present this proposal and respond to the following:

Please describe the distribution of the requested resources between DDS and DSH efforts, particularly in light of potential future closures of developmental centers.

Staff Recommendation: Subcommittee staff recommends holding this proposal open to allow for additional time for review and analysis.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MANAGED CARE ORGANIZATION TAX

PANELISTS

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

BUDGET PROPOSAL

The Administration proposes to create a new managed care organization (MCO) tax. This tax is projected to generate about $1.72 billion in revenue and offset $1.13 billion in General Fund expenditures. The Administration cites the following goals of this proposal: 1) raise the same amount of non-federal funding for the Medi-Cal program as the current MCO tax ($1.13 billion); 2) raise an additional $215.6 million in revenues (to be matched with federal funds) to fully restore the seven percent reduction in IHSS hours; and 3) meet federal broad-based and uniform provisions and no hold harmless requirements for health care-related fees/taxes. The Administration indicates that it will likely seek a federal waiver of certain broad-based and uniform requirements in order to have the lowest net financial impact on health plans. $1.72 billion in MCO tax revenue would be generated and deposited into the Health and Human Services Fund. This revenue would be used as follows:

- $371 million to pay Medi-Cal MCOs (matched to get an additional $371 million federal funds).
- $215.6 million to restore the IHSS seven percent reduction (matched to get an additional $215.6 federal funds).
- $1.13 billion in General Fund offset in the Medi-Cal program.

BACKGROUND

The state's current MCO tax imposes a sales and use tax rate of 3.9375 percent on Medi-Cal managed care plans' gross receipts effective July 1, 2013 through June 30, 2016. This tax was approved by the federal government as a component of the state's Duals Demonstration Project (Coordinated Care Initiative). The revenues are deposited into the Children's Health and Human Services Special Fund. Half of the MCO tax revenues are used to draw down federal Medi-Cal funds and then used to pay back Medi-Cal managed care plans in order to "make them whole". The other half of these funds is used to offset General Fund expenditures for Medi-Cal managed care rates for children, seniors and persons with disabilities, and dual eligibles. For 2015-16, the current MCO tax is projected to generate $1.13 billion in non-federal funding for the Medi-Cal program.

Recent Federal Guidance on Health Care Related Taxes. On July 25, 2014 the federal Centers for Medicare and Medicaid Services (CMS) issued guidance clarifying the treatment of health care-related taxes (provider taxes) and their effect on federal matching funding for Medicaid (Medi-Cal in California) and the Children's Health Insurance Program (CHIP). CMS clarified that provider taxes must:

- **Broad-Based -** Be broadly based, so as not to specifically target one group (must include providers that do not receive Medicaid funding).

- **Uniform -** Be uniformly imposed, meaning levied equally across all providers in that provider type.

- **No Hold Harmless -** Not hold providers harmless from the burden of the tax, meaning that states cannot guarantee taxed dollars will be returned to affected providers.

The provisions of broad-based and uniform requirements can be waived by the federal government if the tax program structure meets the standard to waive these requirements (referred to as the B1/B2 test). The hold harmless requirement cannot be waived.

States that have provider taxes that do not meet these criteria must take action in the state's next legislative session to redesign the tax to meet these requirements. California's current MCO tax does not meet these criteria because it is not broad-based as it applies to only Medi-Cal managed care plans and not all managed care plans in the state.

In-Home Supportive Services (IHSS) Settlement Agreement. As part of a 2013 settlement agreement between the Administration and labor unions and disability rights advocates, the Administration is required to submit to the Legislature proposed legislation authorizing an assessment on home care services, including but not limited to home health care and IHSS. The new assessment would be used to offset the seven percent reduction in authorized IHSS service hours currently in effect for the program, which was authorized by the 2013 settlement agreement. (This settlement agreement was in response to lawsuits regarding IHSS budget reductions in the 2009, 2010, 2011, and 2012 budgets.) This assessment proposal was required to be submitted to CMS by October 1, 2014.

On August 28, 2014, the Administration sent a letter to the Legislature indicating that it had worked in good-faith to develop a federally-compliant proposal authorizing an assessment but, given the new federal guidance on health care related taxes, it would not be able to meet the October 1, 2014 deadline. The letter indicated that the Administration would work with all parties on viable legislation early in the 2015-16 Legislative Session.

The Governor's Budget proposes to use $216 million from a restructured managed care organization (MCO) tax to provide the nonfederal share of funding needed to restore service hours from the 7 percent reduction enacted in 2013-14. The total cost to restore service hours from the 7 percent reduction is estimated to be $483 million in 2015-16. This Subcommittee heard this portion of this proposal on March 11, 2015 and approved restoration of the 7 percent reduction in hours effective July 1, 2015. This action to restore the reduction is independent of the future of the MCO tax.

This proposal would apply to all full-service managed care plans regulated by the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS), except two plans that provide international coverage. There are about 45 plans that meet these criteria and would be subject to this tax, of which 22 are Medi-Cal managed care plans. The proposed tax would be calculated based on the following:

- The tax would be assessed based on total plan enrollment.
- Medicare (including D-SNP) and plan-to-plan (for the subcontracted plan) enrollees would be excluded from this assessment of total plan enrollment.
- It is estimated that this would apply to 277 million member months or about 23 million MCO members.

The tax would be assessed based on a tier-structure that is intended to ensure no plan has a disproportionate tax based on its relative size and that targets the tax on plans with higher numbers of Medi-Cal enrollees, as follows:

- Taxing Tier 1 – For enrollment up to 125,000 member months at $3.50 per enrolled member month.
- Taxing Tier 2 – For enrollment of 125,001 through 275,000 member months at $25.25 per enrolled member month.
- Taxing Tier 3 – For enrollment of 275,001 through 1,250,000 member months at $13.75 per enrolled member month.
- Taxing Tier 4 – For enrollment of 1,250,001 through 2,500,000 member months at $5.50 per enrolled member month.
- Taxing Tier 5 – For enrollment greater than 2,500,001 member months at $0.75 per enrolled member month.

The Administration estimates that the net impact to MCOs, after accounting for the Medi-Cal reimbursement, is $658 million (0.48 percent of total plan revenue).

LAO Findings and Recommendation. Generally, the LAO is supportive of this proposal given that the state must restructure its existing MCO tax, but notes that the Legislature should carefully consider its impacts. Additionally, the LAO finds that such a tax should not be authorized on a permanent basis.

STAFF COMMENTS/QUESTIONS

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

1. Please explain how the tax would operate in future years, per this proposal.

2. Is DHCS willing to share the details of its modeling in terms of the specific impacts on each managed care plan?

Staff Recommendation: Subcommittee staff recommends holding this proposal open to allow for additional time for review.

ISSUE 2: BUDGET CHANGE PROPOSALS & TRAILER BILL

PANELISTS

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

BUDGET CHANGE PROPOSALS

Office of Health Information Technology Technical Assistance BCP

Budget Issue. DHCS requests the extension of two limited-term positions for two years (July 1, 2015 through June 30, 2017) and the conversion of six limited-term positions to permanent positions for the Medi-Cal Electronic Health Records (EHRs) Incentive Technical Assistance Program. The positions will continue efforts to advance the adoption and meaningful use of EHRs and the establishment of a provider technical assistance program. These positions have never been filled because DHCS was unable to secure external funding to support these positions.

Additionally, DHCS requests funding for a consulting contract with subject matter experts on federal/state administrative oversight and reporting relative to the technical assistance program with a cost of $200,000 per year ($20,000 MRMIF, $180,000 Federal Fund) for 2015-16 through 2017-18. Total annual costs for the positions and contract funding are $1,162,000 ($117,000 Major Risk Medical Insurance Fund (MRMIF) and $1,045,000 Federal Fund).

These requests are made to support the funding ($3.75 million MRMIF) authorized by SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014, to support the Medi-Cal Electronic Health Records Incentive Program and to receive $37,500,000 million in federal funds for a statewide provider technical assistance program for eligible providers.

DHCS also requests the following budget bill language to allow SB 870's funding to be available for encumbrance or expenditure until June 30, 2018:

4260-490 – Reappropriation, Department of Health Care Services. Notwithstanding any other provision of law, as of June 30, 2015, the amounts specified in the following citations are reappropriated for the purposes provided for those appropriations and shall be available for encumbrance or expenditure until June 30, 2018:
0313 ---- Major Risk Medical Insurance Fund,

(1) Up to $3,750,000 in Section 15, Chapter 40, Statutes of 2014, for purposes of electronic health records technical assistance in accordance with the State Medicaid Health Information Technology Plan as specified in Section 14046.1 of the Welfare and Institutions Code.

Background. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorizes the outlay of federal money estimated to be roughly $4.5 billion for California and $45 billion nationally for Medicare and Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade and use electronic health records in accordance with the act's requirements. The goal of HITECH is to improve the quality, safety, and efficiency of health care through "meaningful use" of EHRs. HITECH will result in a significant increase in provider adoption and use of EHR systems, resulting in HITECH's desired health care improvements, and an overall improvement in public health. The use of EHR technology in this manner includes the use of electronic prescribing (ePrescribing), submission of clinical quality measures, reporting to immunization and disease registries, and exchanging health information among Medi-Cal providers, hospitals and DHCS to improve the quality of patient care.

The Medi-Cal EHR Incentive Program is a multi-year program that began on October 3, 2011 for eligible hospitals, November 15, 2011 for groups/clinics, and January 3, 2012 for eligible providers. The incentive program will operate through December 31, 2021. Since the implementation of the Medi-Cal EHR Incentive Program, DHCS has authorized more than 20,000 incentive payments to over 15,000 providers and 260 hospitals. This has resulted in more than $1 billion in incentive payments made to date. DHCS expects to distribute between $100 and $200 million per year for the remainder of the program. DHCS has estimated approximately $2 billion will be distributed to providers over the course of the ten year program.

DHCS's Office of Health Information Technology (OHIT) received federal approval for 90/10 reimbursement for the implementation of a $37.5 million direct technical assistance program for advancement of EHR adoption and provider participation in the Medi-Cal Incentive program that is similar to the sun setting REC program. As part of the 2014 budget, $3.75 million from MRMIF was provided to DHCS to draw down the $37.5 million in federal funds. This funding will allow OHIT to procure vendors for the statewide provider technical assistance effort as well as fund state staff and consulting services necessary to implement the program. The program will primarily target providers and specialists not previously supported by the RECs. As discussed above, due to existing workload, current OHIT staff cannot perform the additional work necessary to implement the additional technical assistance program that has been approved by CMS.

According to DHCS, the approval of this proposal will provide the state with resources needed to continue and further advance the Medi-Cal EHR Incentive Program through technical assistance to providers as described in the Project Book above. Advancement of the program constitutes workload above and beyond what OHIT can support without these positions. Without sufficient resources to coordinate and conduct these activities, the department may be unable to continue meeting the requirements for state participation in the program, which is expected to result in a total distribution of $2 billion in federal incentive funds to California providers, and ensure continued enhanced federal funding for administration of the program.

Medi-Cal Eligibility Data System (MEDS) BCP

Budget Issue. DHCS requests the conversion of ten limited-term positions to permanent and two-year extension of one limited-term position. The expenditure authority requested for the 11 positions is $1,497,000 ($714,000 General Fund and $783,000 federal funds). The resources are necessary to perform 1) the ongoing workload of managing, protecting, and securing confidential Medi-Cal eligibility information, 2) ensuring compliance with requirements of the federal Social Security Administration (SSA), and 3) monitoring access to the Medi-Cal Eligibility Data System (MEDS). The 11.0 limited-term positions are scheduled to expire on June 30, 2015.

Background. DHCS is the single state agency which administers the Medi-Cal program, and as such, has interagency agreements in place with other departments to administer select components of the program. DHCS must authorize access to and monitor MEDS access by other departments and agencies. MEDS is a robust database containing over 25 million records which include SSA data, personal health information, and other confidential data. MEDS provides eligibility information to agencies including county welfare departments and other health and welfare agencies throughout the state. DHCS must ensure that no user has authorized access to MEDS or SSA data unless they have a verified and justifiable need directly related to the administration of the Medi-Cal program in compliance with SSA access requirements. DHCS' Information Security Office has investigated where unauthorized access either has occurred and where there was the potential for unauthorized access. Since MEDS is a key data repository for DHCS in terms of SSA data, the required SSA compliance review demonstrate we have high standards for tracking and monitoring MEDS access. MEDS is one of the most critical applications supporting Medi-Cal and numerous other public assistance programs. Many organizations, including other state departments and all 58 counties, require access to MEDS.

To obtain access to data from the SSA, DHCS must enter into a data-sharing agreement with the SSA and comply with all SSA requirements. In 2007, as a result of directives from the federal Office of Management and Budget (OMB), the SSA made substantial changes in the data-sharing agreement. This agreement focused on limiting access to SSA data to only authorized employees who need it to perform their official duties and the security procedures relating to protecting the privacy of SSA personally identifiable information.

Since 2008-09, DHCS has received staffing authority to establish limited-term positions to perform the activities necessary to maintain compliance with the SSA agreement and retain access to SSA data. With this proposal, DHCS requests the conversion of ten limited-term positions to permanent, and the extension of one limited-term position for two years effective July 1, 2015. According to DHCS, the resources will ensure the privacy and security of Medi-Cal eligibility information and MEDS data. This work is ongoing and permanent in nature.

Financial Audits Workload BCP

Budget Issue. DHCS requests 21 positions (nine permanent and 12.0 two-year limited term) and expenditure authority of $3,094,000 ($844,000 General Fund , $1,544,000 federal funds and $706,000 reimbursements) to address new audit workload associated with Intermediate Care Facilities for the Developmentally Disabled Nursing/Habilitative (ICF-DDN/H) and AB 959 (Frommer), Chapter 162, Statutes of 2006, public clinics. Specifically, the new workload stems from the following mandated work:

- **ICF-DDN/H -** Revisions made by State Plan Amendment (SPA) 13-019 which changed the reimbursement methodology for the ICF-DDN/H programs

- **AB 959 -** AB 959's expansion of Welfare & Institutions (W&I) Code, Section 14105.965 to include supplemental Medi-Cal outpatient reimbursement to state veteran homes and clinics operated by the state, a city, a county, the University of California system and public healthcare systems.

The resources will be utilized between three DHCS Divisions/Offices: Audits & Investigations/Financial Audits Branch (FAB), Office of Administrative Hearings and Appeals (OAHA), and Office of Legal Services (OLS).

Background-SPA 13-019 Facility-Specific Reimbursement Rates (ICF DDN/H). Medi-Cal Long-Term Care reimbursement rates are established under the authority of Title XIX of the federal Social Security Act. The specific methodology is described in the State Plan, and when changes to such methodologies are requested, DHCS must submit a SPA for approval by the Centers for Medicare and Medicaid Services.

SPA 13-019, approved by CMS on December 4, 2013, revised the way ICF-DDNs/Hs are reimbursed. Pursuant to the SPA, DHCS must use facility-specific audited costs to calculate the rates for audited facilities. The ICF/DD-H and the ICF/DD-N programs are now reimbursed by Medi-Cal with a methodology that is based on a per diem basis, also called a "client day." Prior to SPA 13-019, the facility payment rate per day was established by using the 65th percentile of the facility's respective peer group. Previously, the number of audits conducted was determined by statistical analysis, which equated to approximately 150 to 200 audits per year.

The new methodology creates facility-specific rates based on reported costs and sets a floor and a ceiling for the Medi-Cal per diem rate. A facility cannot be paid more than or less than the range specified by the established floor and ceiling. Any facility whose costs fall within the established floor and ceiling will have their reimbursement rate set based on the actual audited costs. If a facility's costs fall below the floor, they will receive the established floor rate. If a facility's costs are above the ceiling, they will receive the established ceiling rate. This facility specific methodology has created an increase in the number of audits performed as the new program is implemented, requiring new positions to perform the additional audit oversight and post-audit activities.

Moreover, when audit adjustments are issued, the providers are accorded both informal and formal hearing rights. In the past, reimbursement to ICF-DD-H/N was not based upon audited allowable costs of each specific facility, but rather on an applied statistical analysis that would establish a per diem rate. However, with the changes made to the reimbursement methodology by SPA 13-019, every facility now has a specific and direct interest in ensuring that its cost report is accepted as submitted. Consequently, DHCS anticipates a sharp rise in filed appeals. A conservative estimate is that DHCS will receive 165 informal appeal requests and 85 formal appeal requests.

To implement this methodology change, the number of audits DHCS must complete is expected to increase from approximately 150-200 audits pre-SPA 13-019 to approximately 300-350 audits per year. According to DHCS, the significant increase in the number of audits performed requires new positions to complete the additional audit oversight and post-audit activities.

Background-AB 959 Supplemental Payment Audits (Public Clinics/Veteran Homes). AB 959 expanded Welfare and Institutions Code (WIC) Section 14105.965 to include supplemental Medi-Cal outpatient reimbursement to:

- State veteran homes that provide services to Medi-Cal beneficiaries, and

- Clinics that are operated by the state, a city, a county, the University of California system or public healthcare systems that were enrolled as Medi-Cal providers retroactive to 2006-07.

AB 959 allows state veteran homes and public clinics to obtain increased federal funding reimbursement without the use of state General Funds. Based on current law, supplemental Medi-Cal outpatient payments are made from Medi-Cal federal funds that are available to AB 959 public clinics that provide local funding, referred to as Certified Public Expenditures (CPEs). The federal funds are drawn down by applying the clinic's CPEs. The AB 959 program is funded using 50 percent federal funds and 50 percent CPE. The eligible facilities will reimburse DHCS for the costs of administering the program.

AB 959 requires an eligible facility veteran home or clinic to reimburse DHCS for the cost of administering the expansion of WIC Section 14105.965 as a condition of receiving supplemental reimbursement. In enacting this section, the Legislature intended to provide the supplemental reimbursement described without any expenditure from the General Fund.

This proposal seeks resources related to the implementation of AB 959 regarding public clinics, as the implementation of AB 959 for veteran homes has already occurred. Although AB 959 was enacted in 2006, DHCS did not receive approval from CMS to implement it for public clinics until August 2012 and will be making payments retroactive to 2006. DHCS anticipates that this will result in short-term increase in work load and there is requesting that 12 of the 21 positions be two-year limited-term.

1115 Waiver Activities BCP

Budget Issue. DHCS requests to convert 15 limited-term positions to full-time permanent positions and an annual $1 million contract at a cost of $2,311,000 ($812,000 General Fund and $1,499,000 federal funds) in 2015-16. The $3,000,000 in expenditure authority is over a three-year period ($1 million annually, $250,000 General Fund and $750,000 federal funds) for the External Quality Review Organization (EQRO) contract. According to DHCS, these 15 positions will continue to support the activities and programs that provide ongoing support of critical functions of "California's Bridge to Reform" 1115 Waiver. The positions are being requested as permanent positions because the department anticipates a subsequent waiver starting in 2015-16. Each waiver is five years in length and the department anticipates a continued need for waiver funding; consequently, DHCS finds that this workload will continue in the foreseeable future.

Background. The 1115 "Bridge to Reform" Demonstration Waiver Renewal became effective on November 1, 2010. To support the new workload associated with this 1115 waiver, 15 temporary positions were established in 2010-11 and in 2011-12 to operationalize the transition of the seniors and persons with disabilities (SPD) population to Medi-Cal managed care. According to DHCS, the conversion of these positions to permanent full-time permanent is necessary to continue the transition of new populations to Medi-Cal managed care, along with the ongoing monitoring, oversight and reporting for a number of different population groups. DHCS indicates that recruitment of qualified candidates for these classifications, with the duties required, is considerably more challenging when only offered on a limited-term basis. The nature of the workload associated with these positions is complex and requires an extensive working knowledge of the programs. The retention of knowledgeable and experienced staff is essential to the program.

California's Request for Renewal of Section 1115 Waiver Demonstration. On Friday, March 27, 2015, DHCS submitted a request to renew the state's section 1115 Medicaid Waiver for a new five-year term. The new waiver, "Medi-Cal 2020," seeks approximately $17 billion in federal investment to further the achievements California has made in health care reform through a set of payment and delivery system transformation strategies. The application and concept paper (attached) is available on the DHCS website. DHCS is seeking approval of the Waiver from the Centers for Medicare and Medicaid Services (CMS) by November 1, 2015. Over the next few months, DHCS and CMS will collaborate on the terms and conditions of the new Waiver. DHCS has engaged in an extensive stakeholder process over the past four months, using primarily foundation funding. Concurrently, DHCS states it will continue to engage stakeholders, along with Administration and Legislative partners in the refinement of the waiver concepts.

AB 72 (Bonta and Atkins) and SB 36 (Hernandez and De León) pending in this session are intended to contain the necessary statutory changes to implement the 2020 waiver once the Special Terms and Conditions (STCs) are negotiated with CMS.

Hospital Quality Assurance Fee Act of 2014 BCP

Budget Issue. DHCS requests extending 9.5 limited-term positions and expenditure authority, set to expire on December 31, 2015, to December 31, 2018. DHCS also requests $350,000 in additional limited-term expenditure authority for two contracts to calculate and actuarially certify increased capitation rates as well as for high level counsel and assistance for federal submissions associated with the Hospital Quality Assurance Fee (HQAF) program.

The HQAF program has been statutorily extended through December 31, 2016, with the option of extending the program another three years. The positions requested are necessary to facilitate the program. The total cost is $983,000 ($492,000 HQAF Fund and $491,000 federal funds) for 2015-16; $1,416,000 ($708,000 HQAF Fund and $708,000 federal funds) annually for 2016-17 and 2017-18; and $983,000 ($492,000 HQAF Fund and $491,000 federal funds) for 2018-19.

The previous HQAF programs covered the periods between April 1, 2009 and December 31, 2013, and provided supplemental payments in the amount of $23.4 billion to California hospitals. DHCS requests the extension of these positions due to the renewal of the program and to complete administrative duties that continue beyond the duration of the HQAF program on December 31, 2016.

Background. In 2010, the department implemented California's first hospital provider fee and supplemental payment program under AB 1383 (Jones), Chapter 627, Statutes of 2009, for the period of April 1, 2009 through December 31, 2010. The program resulted in fee collections of $3.046 billion, hospital payments of $5.63 billion, and $560 million retained for health care coverage for children. This program requires most California's general acute hospitals (except county and UC general acute hospitals) to participate. However, the provider fee program requires only private hospitals that were not considered small and rural to pay the fee. Approximately 405 hospitals participated in this program, 318 were private hospitals. Both public and private hospitals received payments from this program. The program was extended under SB 90 (Steinberg), Chapter 19, Statutes of 2011, an additional six months for the period of January 1, 2011 through June 30, 2011.

In 2011, SB 335 (Hernandez), Chapter 286, Statutes of 2011, extended the HQAF program from July 1, 2011 through December 30, 2013 to draw down additional federal funds and increase supplemental payments to hospitals participating in the Medi-Cal program.

SB 239 (Hernandez) Chapter 657, Statutes of 2013, extended the HQAF program, and establishes the framework for a second phase and permanent continuation of the program under future legislation or a constitutional amendment. The first phase, January 1, 2014 through December 31, 2016, is estimated to generate $13.3 billion in funds from hospitals during the program period, of which approximately $12.5 billion would be used to draw down an equal amount in federal funds and used to increase Medi-Cal payments to hospitals. Generating these funds pay out an estimated $23 billion to the hospital community and $2.4 billion for health care coverage for children, a

savings to the general fund. Thedepartment resubmitted State Plan Amendments (SPA) 14-001 and 14-002 formally to the Centers for Medicare and Medicaid Services (CMS) on November 21, 2014, for CMS approvals.

According to DHCS, continuation of the HQAF program requires significant workload for DHCS, which is distributed to staff in limited-term positions in the Safety Net Financing Division (SNFD), Third Party Liability and Recovery Division (TPLRD), Capitated Rates Development Division (CRDD), and the Office of Legal Services (OLS). Additional actuarial contract resources are needed to continue support for the program and rate build through the new period of the HQAF. In addition, while the first phase of the program payment period ends December 31, 2016, the HQAF program workload extends further to December 31, 2018. There are significant work activities needed to settle HQAF program payments that extend after the HQAF program payment period, such as, obtaining CMS necessary approvals for capitation HQAF payments, collecting delinquent fees, and necessary reconciliations.

SNFD is responsible for significant workload involving negotiations with CMS for approval of the HQAF model, the upper payment limit (UPL) models, the SPAs, and the amendment to the hospital financing waiver (all required to implement the program). In addition to this workload, SNFD is responsible for calculating the HQAF, notifying the hospitals of the HQAF amounts owed, and issuing the grant payments. This work requires the implementation and maintenance of program structures, processes and procedures, and databases for tracking status correspondence, and communications with the hospitals and external stakeholders. DHCS also has to monitor and ensure the integrity of the Hospital Quality Assurance Revenue Fund.

In order to maintain the program, TPLRD performs administrative activities relating to accounting, monitoring, processing payments as well as collecting the HQAF. In addition TPLRD monitors for delinquent payments, and the requisite administrative remedies that will continue past the end of the program. TPLRD is also responsible for a system of checks and balances to ensure the integrity of the Fund.

CRDD validates timely and accurate distribution of funds to hospitals by reviewing the plans' records. The HQAF funds are built into the plans' capitation rates for the purpose of providing additional funding to the hospitals. Each separate QAF program requires new capitation rates. Ensuring that the plans receive the appropriate funding under this program and that the plans are appropriately disbursing funds to the hospitals is a critical and substantial ongoing workload.

OLS attorneys will be required to help draft the SPAs and related public notices, as well as assist with preparing responses to CMS' Requests for Additional Information which routinely accompany the SPAs. OLS attorneys will also be required to participate in discussions with the participating hospitals regarding the implementation and ongoing administration of the Program. This is especially true given the nature of the fee model and the necessity of its compliance with federal regulations. Redirection of existing staff resources is not feasible.

In addition, DHCS requests funding for the following contracts:

- Covington and Burling Contract - Provide high level advice and counsel regarding development of quality assurance fees, SPAs, fee models, UPL calculation, the federal B1/B2 test, and conformance with federal regulations.

- Mercer Contract - Calculate and actuarially certify increased capitation rates that would be paid to managed care plans.

Intergovernmental Transfer Growth & SB 208 Reconciliations BCP

Budget Issue. DHCS requests two new permanent positions, the conversion of three limited-term positions to permanent, and $467,000 expenditure authority ($120,000 federal funds and $347,000 reimbursements). The requested staffing resources would address the additional and ongoing workloads from Medi-Cal managed care expansion and mandated statutory requirements to implement SB 208 (Steinberg) Chapter 714, Statutes of 2010. The three limited-term positions are set to expire on October 31, 2015. Starting in 2016-17, and on-going, the requested expenditure authority would be $540,000 ($164,000 federal funds and $376,000 reimbursements).

Background. DHCS is responsible for calculating and setting the capitation rates for managed care organizations, and ensuring certification that capitation rates for managed care health plans are determined in compliance with federal requirements. Managed care serves more than eight million Medi-Cal beneficiaries in 58 counties, which is more than 70 percent of the total Medi-Cal population. In California, there are six models of managed care: 1) County Organized Health Systems (COHS); 2) Two-Plan Model (TPM); 3) Geographic Managed Care (GMC); 4) Regional Model; 5) San Benito and 6) Imperial. There are currently more than 12 million Medi-Cal members.

Background - Intergovernmental Transfer (IGT) Program. According to DHCS, the rate range intergovernmental transfer (IGT) program, authorized by Welfare and Institutions (W&I) Code 14164 and 14301.4, has grown significantly as more health plans and eligible providers (also known as funding entities) have decided to participate in this voluntary program. An IGT is a transfer of funds from an eligible governmental entity such as a public hospital or county clinic to the DHCS for the purpose of providing the non-federal share of Medi-Cal payments. Federal law generally authorizes the use of IGTs. IGTs are currently used by the Medi-Cal program in a variety of areas, including the Disproportionate Share Hospital (DSH) program, and to finance portions of Medi-Cal managed care payments. The actuarially sound health plan capitation rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to, but not exceeding the upper bound of the range. Technical agreements between a health plan and the funding entity, as well as DHCS and the funding entity, are required for this purpose including supporting documentation that requires significant DHCS review. The rate range IGT program has substantially increased over the years as more health plans and funding entities have chosen to participate in an increasing number of counties. DHCS charges an administrative fee authorized by W&I Code 14301.4 to support program operations. The fee is 20 percent of the IGT

contribution from the funding entity. The fee is expected to generate approximately $70 million in General Fund savings in 2014-15, for plan services in the 2012-13 rate year.
This IGT rate range program has grown significantly over time. When the program first began in 2006-07, only two health plans and two providers participated. Due to increased interest, DHCS expanded health plan participation to Geographic Managed Care (GMC) county plans and providers for the 2011-12 rate year. Today, a number of health plans and providers now participate. For example, the number of rate range IGT related plan-provider agreements from Two-Plan Models, increased from 17 for rate year 2010-11 to 35 for rate year 2011-12 (the last year for which complete IGT participation data).

DHCS anticipates continued growth in this program generally in existing participating counties as well as a result of managed care expansion in rural areas. As a result of the growth of this program, DHCS requests two new permanent associate governmental program analysts who will review financial information to ensure appropriateness of reimbursement and reconciliations of contributions to outgoing capitation payments; conduct high level analysis of IGT transactions, provide technical assistance and policy review; and process submissions for federal approvals.

Background - SB 208 IGT Program. SB 208 authorized components of the state's 1115 Medicaid Bridge to Reform Waiver and many Medi-Cal programmatic changes including mandatory enrollment of seniors and persons with disabilities (SPDs) into managed care and a related IGT program. This SB 208 IGT program enables Medi-Cal health plans to compensate Designated Public Hospitals in amounts no less than what they would have received for providing services to beneficiaries under fee-for-service (FFS). Since the non-federal share of the funding related to the SPD population historically was financed through Certified Public Expenditures (CPEs), the IGT program was created to avoid a significant General Fund impact due to the transition of this population into managed care. Specifically, SB 208 permits IGTs to provide financial support of the non-federal share of risk-based payments to managed care health plans to enable those health plans to sufficiently compensate DPHs. DHCS staff continues to work on reconciling the IGT transactions, review the flow of funds between the plans and hospitals, ensure the accuracy of transactions, and respond to and collaborate with stakeholders regarding this complex program.

Three limited term positions were originally authorized for the IGT workload associated with implementation of SB 208 in 2011-12 and were extended in 2013-14 to align with the timing of the Bridge to Reform waiver. However, this is permanent workload required by statute that does not sunset with the waiver. Therefore, DHCS requests to make these positions permanent.

Medi-Cal Office of the Ombudsman BCP

Budget Issue. DHCS's Medi-Cal Managed Care Office of Ombudsman (OMB), requests nine two-year limited term full-time positions and expenditure authority of $1,045,000 ($522,000 General Fund and $523,000 Federal Fund) to support the increased workloads as a result of the growth in the managed care program. As distinguished from other ombudsman offices, such as the Long-Term Care Ombudsman at the Department of Aging, this office primarily assists Medi-Cal only enrollees of Medi-Cal managed care plans.

Currently, the Medi-Cal Office of the OMB has nine permanent staff, seven who answer phone calls and two who perform clerical support. Additionally, DHCS has redirected 14 temporary staff to OMB to help with the call volume on a limited-term basis.

DHCS acknowledges that with the present staffing levels, staff is unable to answer between 250-350 calls on a daily basis. The inability to answer these calls results in unreported cases of possible inappropriate denials of medically necessary services, inability to effectuate rights to continuity of care or medical exemptions, and poses a potential threat to the health and safety of Medi-Cal beneficiaries. DHCS states that it is requesting limit-term positions because it finds that it is unclear whether the increase in call and case volume is related to initial enrollment into managed care or if it is indicative of ongoing workload.

Background. OMB serves as a resource for Medi-Cal managed care members and helps solve problems; from a neutral standpoint to ensure that members receive all medically-necessary covered services. In addition to assisting Medi-Cal beneficiaries, OMB provides guidance and assistance to county eligibility workers, the Legislature, stakeholders, other state departments, and various associations (foster children, pregnancy related, etc.). OMB currently receives approximately 25,000 calls a month, creating 13,000 new cases requiring detailed investigation.

The OMB works each call completely through resolution. According to DHCS, frequently a caller has already contacted their county, their provider, Health Care Options, the Fiscal Intermediary (Xerox) or others without any resolution. Consequently, OMB often handles complex calls that require coordination with multiple entities and OMB staff performs research, coordination, and may call multiple outside entities with the caller on-line to find a resolution. OMB call handling times range from two minutes to more than an hour.

In addition to handling and researching calls, the OMB processes disenrollment or enrollment for the current or past months of eligibility. This function assures continuity of care for members either with their health plan or in fee-for-service Medi-Cal. On a monthly basis, the OMB averages 1,900 emergency enrollments and disenrollments for managed care members.

Since January 2011, the Medi-Cal managed care program has doubled in enrollment from approximately 4 million enrollees to about 8 million in August 2014. Additionally, over the last few years, recorded call volume has increased between 5 to 15 percent each year with case volumes increasing between 25 to 50 percent each year. Call volumes increased 40 percent between December 2013 and June 2014 and continue to increase sharply. The number of cases logged by OMB staff has increased by 100 percent since the beginning of the calendar year 2014.

New Telephone System. DHCS is in the final phases of implementing an updated telephone system for OMB, with the system expected to be implemented by June 30, 2015. This Voice over IP (VOIP) system is expected to increase the office's ability to respond to the concerns of beneficiaries significantly. For example, according to DHCS, the current system operates without redundancy leaving the call center at risk of becoming non-operational, while the new system will have built in redundancy and will be able to continuously service beneficiaries. Additionally, with the current system, a caller must wait on the line before they can leave a voicemail for call back; on the new system, the caller has an option to leave a call back number and not lose their place in the cue. There will also be an increased queue capacity from the current 30 callers to more than 500 callers. DHCS finds that this new phone system will increase the functionality, capacity, and responsiveness of the Ombudsman when compared to the system currently in place. Additionally, according to DHCS, this new phone system provides the ability to collect data regarding wait times, call times, abandonment rates, and other full call center monitoring functions and provides supervisors the ability to adjust resources.

Martin Luther King Jr. BCP

Budget Issue. DHCS requests two full-time permanent positions and $745,000 ($373,000 Federal Fund and $372,000 Reimbursement) including annual contract funding of $500,000. This request is needed to meet the department's workload requirements related to Welfare and Institutions Code (WIC) Section 14165.50 to facilitate the financial viability of a new private nonprofit hospital that will serve the population of South Los Angeles. This population was formerly served by the Los Angeles County Martin Luther King, Jr. – Harbor Hospital.

Statute requires reimbursement to this new hospital based on one hundred percent of Medi-Cal projected costs for inpatient services in fee for service (FFS) and managed care, subject to a variety of requirements outlined in the law. The statute provides for the County of Los Angeles to reimburse the state for the nonfederal share of staffing and administrative costs directly related to implementation of its provisions.

Background. Currently, Medi-Cal reimburses hospitals for acute inpatient services using a Diagnosis Related Group (DRG) methodology. The DRG payment system operates on a reimbursement related to the recipient's assigned diagnosis or diagnoses. The diagnoses and procedures must be documented in the patient's medical record. The information is then coded in the claim. The coding process is extremely important since it essentially determines what DRG and reimbursement will be assigned for a patient. Each DRG category is designed to be "clinically coherent", and all patients

assigned to a specific DRG are deemed to have a similar clinical condition requiring similar interventions and the same number of days of inpatient stay. The payment system is based on paying the average cost for treating patients in the same DRG. This reimburses hospitals for actual services and resources utilized based on the acuity level of a patient.

Pursuant to WIC Section 14165.50, the cost-based reimbursement methodology for FFS and managed care Medi-Cal payments to the new MLK hospital will provide compensation at a minimum of 100 percent of the projected costs for each fiscal year, contingent upon federal approvals and availability of county funding.

Under the statute, the State General Fund (GF) is obligated to provide each fiscal year through fiscal year 2016-17 a guaranteed level of 77 percent of the projected Medi-Cal cost for inpatient hospital services. Managed care rates must be adjusted to reflect the actuarial equivalent of those costs, subject to specified requirements. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 77 percent of projected Medi-Cal costs, GF appropriations are required to fund the non-federal share of the additional payments up to the 77 percent of costs.

Beginning in fiscal year 2017-18, and subsequent fiscal years, this GF obligation is reduced to 72 percent of projected Medi-Cal costs. If current Medi-Cal private hospital reimbursement methods results in funding that is less than 72 percent of projected Medi-Cal costs, the GF will be required to fund the non-federal share of the additional payments up to 72 percent of the costs.

In order to enable reimbursement for the new MLK hospital to reach 100 percent of projected costs, the remaining non-federal share amounts may be transferred by the County of Los Angeles via voluntaryintergovernmental transfers (IGTs). Any public funds transferred shall be expended solely for the non-federal share of the supplemental payment. Additionally, the department shall seek further federal approval to enable MLK to receive Medi-Cal supplemental payments to the extent necessary to meet minimum funding requirements. Further reimbursement exceeding the 100 percent minimum funding requirement may be sought through additional supplemental programs upon federal approval.

The requested staff would be responsible for policy development and implementation of the FFS interim rate setting process for MLK, verification and acceptance of the projected costs submitted by the county on a yearly basis, as well as detailed monitoring to ensure funding requirements are met. These activities are vital so that the amount of funding from the GF is kept to a minimum. Additionally, the proposed staff would be responsible for the development of managed care policy as it relates to rate setting, and will be required to oversee the development of the methodology, data gathering process, and consultation with stakeholders, to ensure the appropriate cost methodology is captured and used for rate development purposes. The proposed contracted actuaries will be responsible for the development and adjustment of the rates to ensure compliance with the statute.

CalHEERS MAGI Sunset Trailer Bill

Budget Issues. DHCS proposes trailer bill language to remove the sunset provision to allow for continued electronic verification of Medi-Cal eligibility information.

Background. As part of the Affordable Care Act, the Department of Health Care Services (DHCS) and the California Health Benefit Exchange (Covered California) built the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). CalHEERS is the system that assesses an individual's eligibility for insurance affordability programs, including eligibility for modified adjusted gross income (MAGI) Medi-Cal and to purchase health insurance through Covered California.

If an applicant can be determined MAGI Medi-Cal eligible using only electronic verifications, CalHEERS determines MAGI Medi-Cal eligibility and the case information is sent to the applicant's county of residence for ongoing case management services. If an applicant cannot be determined MAGI Medi-Cal eligible using only electronic verifications, CalHEERS electronically sends the case information to the applicant's county of residence for a MAGI Medi-Cal eligibility determination. Upon receiving the MAGI Medi-Cal case, the counties collect necessary information to complete the applicant's MAGI Medi-Cal eligibility determination. This process, codified in Section 14015.5 of the Welfare and Institutions Code, sunsets on July 1, 2015. The purpose of this trailer bill language is to remove the sunset provision.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS to briefly present all of the budget change proposals and trailer bill proposals presented in this section of the agenda and respond to questions of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends the following actions:
Medi-Cal Eligibility Data System BCP – **Hold Open**
Financial Audits Workload BCP – **Hold Open**
Office of Health Information Technology BCP – **Approve**
1115 Waiver Activities BCP – **Approve**
Hospital Quality Assurance Fee Act of 2014 BCP – **Approve**
Intergovernmental Transfer Growth & SB 208 Reconciliations BCP – **Approve**
Medi-Cal Office of the Ombudsman BCP – **Approve**
Martin Luther King Jr. BCP – **Approve**
CalHEERS MAGI Sunset Trailer Bill – **Approve of placeholder trailer bill**

ISSUE 3: ASSEMBLYMEMBER PROPOSALS

PANELISTS

- **Assemblymember Waldron**
- **Assemblymember Gipson**
- **Assemblymember Gaines**
- **Department of Health Care Services**
- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**
- **Public Comment**

BUDGET PROPOSALS

Prescriber Prevails Policy (Waldron)

Assemblymember Marie Waldron requests that the budget committee adopt the "prescriber prevails" policy for the Medi-Cal program. Specifically, this policy:

1. Would require, if any drug from a specified therapeutic drug class is prescribed by a Medi-Cal beneficiary's provider, the drug to be covered in the Medi-Cal program.

2. Specifies the affected drug classes are antiretrovirals for AIDS/HIV, antipsychotics, immunosuppressants for anti-rejection, and epilepsy/anti-convulsants.

3. Would require a Medi-Cal managed care plan to cover a drug in the named drug classes if prescribed by a beneficiary's provider. Would require the provider to demonstrate reasonable professional judgment and that the drug is medically necessary and consistent with the federal Food and Drug Administration (FDA) labeling and use rules and regulations as described in at least one of the official compendia named in federal law.

4. Provides that if a Medi-Cal managed care plan chooses not to cover the specified drugs, the drugs are to be carved out of the plan and covered on a fee-for-service basis and the plan's contracted rate shall be reduced accordingly.

According to Assemblymember Waldron, this policy strengthens the doctor and patient relationship by legislating that a doctor's professional and reasonable judgment prevails, for purposes of specific and therapeutic drug classes within the Medi-Cal program. The author argues that new pharmaceuticals and treatments are emerging rapidly and individuals are losing access to pharmaceuticals that may best control their condition.

Drug benefits are provided through the Medi-Cal fee-for-service delivery system, and through managed care. Managed care enrollees generally get their drugs through their managed care plan, which often subcontracts with a pharmaceutical benefits manager for provision of the drug benefit. Some drugs are carved out of managed care and only offered through the FFS system. Both managed care plans and the state maintain separate lists of preferred drugs, or formularies, and impose utilization controls on drugs not contained on the formulary. This proposal would require Medi-Cal FFS and managed care plans to cover drugs for which a prescriber prescribes a drug in a manner consisted with FDA guidelines for use of the drug, and for which the prescriber demonstrates reasonable professional judgment that the drug is medically necessary. In this way, it allows the prescriber to potentially side-step a plan's or the state's utilization controls.

There are some existing patient continuity of care and medical necessity protections within Medi-Cal, including that plans, and FFS Medi-Cal, are required to pay for all drugs deemed medically necessary, regardless of the formulary. Furthermore, patients can contest denials of service through various means, including the state fair hearing/grievance process and through independent medical review.

The Assembly Appropriations Committee analyzed a policy bill (AB 1814, Waldron, 2014) that proposed this same policy, and assumed costs exceeding $10 million. Assemblymember Waldron believes that the costs would be significantly lower than this estimate. Subcommittee staff also has requested a cost estimate for this proposal from the Department of Finance.

Personal Needs Allowance Increase (Gipson)

Assemblymember Mike Gipson is requesting an increase in the Personal and Incidental Needs Allowance (PNA), from $35 to $80, which the state provides to nursing facility patients/residents for various routine expenses such as clothing, reading materials, toiletries and stationery. The PNA was established through the Social Security Act Amendments of 1972, initially with a cap of $25 per month, which was then increased to $30 in 1987. States have the option to increase the amount, which California does by $5 per month, which makes California's PNA one of the lowest in the nation. The last increase in California occurred in 1984. According to information provided to the Subcommittee, $35 in 1985 is equivalent to $79.07 in today's dollars, per the U.S. Bureau of Labor Statistics. Assemblymember Gipson believes that the PNA is critical to the independence and dignity of seniors living in nursing facilities. The administration estimates the cost of the proposal to be $13.4 million General Fund.

Diabetes Grants Position Proposal (Gaines)

Assemblymember Beth Gaines is proposing approximately $150,000 (Proposition 99) to support a position at DPH whose primary responsibility would be for tracking and seeking funding opportunities for diabetes prevention work. The State Auditor released a report in January of 2015 that had originated with a proposal by Assemblymember Gaines, looking at the use of funds for diabetes prevention by the department. The Bureau of State Audits (BSA) report found that while DPH used its existing diabetes

funding appropriately, it nevertheless missed various funding opportunities due to the lack of sufficient staff resources for tracking and applying for grants. Specifically, the BSA states that they identified two grants, each worth up to $500,000 per year, for which DPH was eligible to apply but did not do so. The BSA also found that California's spending on diabetes prevention is lower than most or all other states; in 2012-13, California had the lowest per capita funding for diabetes prevention in the nation. Given this situation, the BSA recommends the Legislature consider providing state resources to support a DPH staff position that would ensure that California not miss opportunities to apply for substantial grants in this area. The BSA states that diabetes is a growing epidemic already affecting 1 in 12 adults in California. The American Diabetes Association estimates that the annual health care and related costs of treating diabetes in California was $27.5 billion in 2012. DPH points out that diabetes prevention work is synonymous with obesity prevention work, and therefore an assessment of California's funding for diabetes prevention should include funding in all areas related to nutrition, physical activity and obesity prevention.

STAFF COMMENTS/QUESTIONS

The Subcommittee invites the Members on the panel to present their proposals and requests DHCS and DPH to share any concerns they have with these proposals and respond to Subcommittee questions.

Staff Recommendation: Subcommittee staff recommends holding open all of these proposals.

ISSUE 4: STAKEHOLDER PROPOSALS

PANELISTS

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

BUDGET PROPOSALS

Restoration of 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 reasons in response to the fiscal crisis. There is considerable support for restoring these benefits to the Medi-Cal program.

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." Although these benefits were "eliminated," there were exceptions for certain facilities and populations for which the benefits continue to be covered; they include: Federally Qualified Health Centers and Rural Health Centers, emergency room services, patients with developmental disabilities, pregnant women, children (i.e. EPSDT) and PACE programs. The chart below shows the various optional benefits that were eliminated in 2009 and the estimated costs to restore the benefits.

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 partially restored adult optional dental benefits on May 1, 2014. The chart below shows the cost to fully restore all dental benefits, including partial dentures which currently are not covered.

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	GF	FFP**
Optional Benefits Restoration:	A	B	A+B		
Acupuncture	$2,725,000	$999,000	$3,724,000	$1,780,000	$1,944,000
Audiology	$3,149,000	$1,154,000	$4,303,000	$2,056,000	$2,246,000
Chiropractic	$394,000	$144,000	$538,000	$257,000	$281,000
Incontinence Cream and Washes	$5,795,000	$5,708,000	$11,503,000	$5,013,000	$6,491,000
Optician / Optical Lab	$8,116,000	$2,106,000	$10,132,000	$4,921,000	$5,210,000
Podiatry	$1,739,000	$637,000	$2,376,000	$1,135,000	$1,240,000
Speech Therapy	$200,000	$73,000	$273,000	$131,000	$143,000
Dental*	$155,590,000	$104,550,000	$260,140,000	$93,122,000	$167,018,000
Grand Total	**$177,708,000**	**$115,281,000**	**$292,989,000**	**$108,415,000**	**$184,573,000**

* Dental: Additional costs to restore all adult dental benefits. Costs for partial restoration are already budgeted in the Governor's budget.
** The Department receives 100% federal financial participation for services provided to Affordable Care Act optional Medi-Cal expansion population.

Caregiver Resource Centers

The Caregiver Resource Centers (CRCs) are requesting restoration of $7.6 million General Fund for the program. The CRCs are legislatively mandated to assist families who provide care for loved ones with Alzheimer's disease, stroke, Parkinson's disease, traumatic brain injury, Huntington's disease, multiple sclerosis and other cognitive disorders that occur after the age of 18. DHCS oversees state funding for the CRCs which experienced a 72 percent funding reduction in 2009-10. The CRCs total allocation has gone from $10,547,013 to the current funding level of $2,918,013.

Legislation in 1984 proposed to establish CRCs in 11 regions of the state. Signed by Governor George Deukmejian on September 30, 1984, the Comprehensive Act for Family Caregivers of Brain-Impaired Adults *(Welfare & Institutions Code Section 4362)* established the statewide California Caregiver Resource Center system under the then-California Department of Mental Health. The CRCs are legislatively mandated to assist families who provide care for loved ones with Alzheimer's disease, stroke, Parkinson's disease, traumatic brain injury, Huntington's disease, multiple sclerosis and other cognitive disorders that occur after the age of 18.

The CRC system in California was the first of its kind in the nation, and was viewed as a model for the development of similar services now available in all fifty states. State funding for CRCs was reduced by 74 percent in 2009. State funding qualifies for a 3:1 federal-state match. While eligibility for CRC services is not means-tested, CRC services are unique and generally not available elsewhere, even for people of middle or high-income who have health insurance. Moreover, individuals pay fees on a sliding scale. As a result of budget reductions to California's CRCs, particularly in 2009, all 11 CRCs maintain waiting lists for various services; the LA CRC has a waiting list of over 900 people just for respite services.

Each CRC serves as a point of entry to services available to caregiving families in every county of California. While each center tailors its services to its geographic area, all CRCs have a core component of programs that provide information, education & support for caregivers. CRCs operate in: Burbank, Chico, Citrus Heights, Colton, Fresno, Fullerton, San Diego, San Francisco, Santa Barbara, Santa Cruz, and Santa Rosa. Core Services include:

- ***Specialized Information***: CRCs provide advice and assistance on caregiving issues and stress, diagnoses and community resources.

- ***Family Consultation & Care Planning***: Individual sessions and telephone consultations with trained staff to assess needs of individuals who are incapacitated and their families, and to explore courses of action and care options for caregivers.

- ***Respite Care***: In-home support to assist families caring at home for an adult with a disabling condition.

- ***Short-term Counseling***: family, individual and group sessions with licensed counselors to offer emotional support to caregivers coping with the strain of the caregiving role.

- ***Support Groups***: Monthly meetings in a supportive atmosphere to share experiences and ideas to ease the stress of caregiving.

- ***Education***: Special workshops on topics such as diagnosis, treatment, long-term care planning and stress management to help caregivers cope with day-to-day concerns.

- ***Legal & Financial Consultation***: Personal consultations with experienced attorneys regarding powers of attorney, estate and financial planning, conservatorships, and other matters.

The CRCs have in past years served 15,000 families annually. Due to the cuts in funding, an estimated 73% fewer new caregivers entering the program will be able to access:

- Depression screening reduction of 76%
- Care planning and consultation reduction of 81%
- Counseling reduction of 76%
- Education/training reduction of 78%
- Support Groups reduction of 59%
- Legal reduction of 85%
- Respite
    - ✓ In-home reduction of 98%
    - ✓ Adult Day Care reduction of 100% (elimination of this service)

Prior to the budget reductions:

- CRCs had 120 staff (FTE) serving every county in California; CRC staffs have been reduced to 36 or 70% statewide.

- There were 24 offices which have been reduced to 14 or 42%; CRCs no longer have a presence in rural areas.

The following summary describes how the cuts affect services:

Total of 11 CRC's				
Units of Service	**Previous**	**Revised**	**% of Reduction**	**Description**
Assessments	3,576	860	76	# of Clients
Consultation	115,334	22,200	81	15 minute units
Counseling	4,815	1,144	76	15 minute units
Education/Training	5,861	1,311	78	Training hours
Intake	6,707	1,747	74	# of Clients
Respite: ADC	2,932	0	100	Days of day care
Respite: In-home	143,132	3,263	98	Hours of in-home care
Support Group	5,994	2,469	59	Hours of group
Psycho-Ed Group	2,334	762	67	Hours
Legal	227	35	85	Hours
Institutionalization			38	# people
Staffing FTE	120	36	70	
Offices	24	14	42	

Medi-Cal Estate Recovery Limitations

Advocates request to limit estate recovery in the Medi-Cal program by requiring collection for only those health care services required to be collected under federal law, to make it easier for individuals to pass on their assets by using a narrower definition of "estate" in federal Medicaid law, and to allow a hardship exemption from estate recovery for a home of modest value. The administration has estimated the cost of this proposal to be $27.4 million General Fund however advocates believe that this is overstated.

Eligibility Increase for Aged & Disabled

Advocates request to increase the amount of income that is disregarded in calculating eligibility for purposes of the Medi-Cal aged and disabled (A&D) program. The Western Center on Law and Poverty notes that the A&D program is a critical part of the Medi-Cal program and it provides free, comprehensive coverage to persons over the age of 65 and those with disabilities while simultaneously allowing them to have a monthly income. The A&D program was enacted in 2000, with an income eligibility standard of 199% FPL plus income disregards, making the eligibility criteria equivalent to 133% of

the FPL. However, the disregards lose real value every year, with the resulting income standard today at only 123% of the FPL. When a senior has even a small increase in their income that puts them over 123% FPL, they are forced into the Medi-Cal Medically Needy program with a high share of cost. The Assembly Appropriations Committee analysis of a policy bill (AB 763, Burke and Bonilla) containing this same proposal contains a cost estimate of $30 million General Fund.

AIDS Waiver Rates Differential

AIDS Project Los Angeles (APLA) proposes a rate increase for the AIDS Medi-Cal Waiver program. It notes that provider reimbursement rates for this program are lower than Medi-Cal rates for the same services outside of the AIDS Waiver. APLA argues that agencies have been forced to either reduce services or withdraw from the program due to inadequate funding. The administration has provided a preliminary cost estimate of $4.8 million General Fund.

Drug Billing for 340b Clinics

Planned Parenthood requests to revise the Medi-Cal and Family PACT reimbursement formula for drugs and supplies dispensed by specified clinics, by requiring the clinic dispensing fee to be the difference between the actual acquisition cost of a drug or supply and the Medi-Cal reimbursement rate, and remove the maximum dispensing fee caps in existing law. Planned Parenthood makes this request because it finds that the current billing system the clinics must use is overly complex, and leads to numerous billing errors which require staff time at both the clinic and the state to resolve. These errors can take months to resolve and chronically deny the clinics Medi-Cal reimbursements to which they are entitled. The administration's preliminary cost estimate for this proposal is $6 million general fund.

Robert F. Kennedy Health Plan

The United Farm Workers request funding to sustain its Robert F. Kennedy Farm Workers Medical Plan. The 2014 budget included $3.2 million special fund to support this health plan. The federal Affordable Care Act (ACA) introduces new standards for employer-sponsored health plans. The implementation dates for these requirements vary based on the plan's effective date, whether the plan is subject to a collective bargaining agreement (CBA), and whether the plan is self-insured or fully insured. Some plans may be "grandfathered". These plans are exempt from some provisions, while other requirements apply on the same date as they apply to other plans. The ACA allowed fully insured plans that are pursuant to a CBA to have certain elements of their plan be "grandfathered." ACA allows multiemployer plans with CBAs to maintain "grandfathered" status with the exception of lifetime and annual limits.

One such plan is the Robert F Kennedy (RFK) Medical Plan, a self-funded, self-insured plan that is subject to a CBA between the United Farmworker's Union (UFW) and multiple agricultural employers (also known as a Taft-Hartley Plan). The employer's contribution is between $2 and $3 per hour depending on the CBA. According to the plan and the UFW, the plan provides benefits that are equivalent or richer than is

required under the ACA in almost every requirement. For instance, the occupational therapy is more generous than is required and all primary and preventive care is provided with very low co-pays and deductibles. According to the plan, about 96 percent of the RFK Plan's budget goes directly to providing benefits to its beneficiaries and their dependents, meeting and exceeding the medical loss ratio requirements.

There is one ACA requirement however, that has proven to be a significant hurdle to the continued existence of the plan, the prohibition on annual and lifetime limits. The plan has determined that it can purchase stop loss insurance to cover any costs that would exceed the current maximum and would then be in compliance with the ACA. As they did last year, the plan argues that there will be off-setting savings in the Medi-Cal program. This is based on an assumption that it will not be financially viable and will therefore not continue without this subsidy. In that case, the plan's consultants assume 50 percent of the plans members would be eligible for Medi-Cal. The cost of Medi-Cal to the state of California for these participants would be at least $4.7 million. In addition to Medi-Cal costs, if the plan were to cease operating, those insured by the plan who are not eligible for Medi-Cal would become uninsured.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Legislative Analyst's Office provide a brief description of each stakeholder proposal in this section, and requests DHCS to share any concerns of the department with these proposals and answer questions of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends holding open all of the stakeholder proposals.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 1: APRIL 1 PROPOSALS

PANELISTS

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

BUDGET PROPOSALS

SB 964 Health Plan Timeliness Standards & Network Adequacy Reviews

Budget Request. Through a Spring Finance Letter on April 1, 2015, the Department of Managed Health Care (DMHC) requests 25.0 permanent positions and $3,802,000 for 2015-16 and $3,594,000 for 2016-17 and ongoing to address the increased workload resulting from the implementation of SB 964 (Chapter 573, Statutes of 2014). This request also includes $230,000 for 2015-16 and ongoing for statistical consulting services to interpret data, develop standards, and determine network trends. The proposed funding is revenue from health plan fees that covers the costs and activities of the department.

Background. The DMHC Office of Plan Licensing (OPL) is responsible for reviewing new license applications, material modifications and amendments to any previously approved documents of licensed health plans in California. This workload includes an assessment of provider networks, new license applicants, service area expansions, block transfer fillings, Covered California annual certification, and every instance a health plan network changes ten percent or more. The OPS also reviews plans' annual reports on compliance with timely access requirements.

SB 964 adds the following new requirements on the OPL:

- Review of health plan compliance with timely access standards and making recommendations for changes annually;
- Review of all full service and mental health plan networks for adequacy and availability of providers -- separately for Medi-Cal, individual market, and all other markets;
- Review of grievances submitted to health plans regarding network adequacy and timely access;
- Posting of approvals for waivers from, or alternate standards for, timely access requirements as of January 1, 2015; and
- Posting of findings from timely access compliance review on website as of December 1, 2015.

DMHC reports that the volume of data to be reviewed for network adequacy each year is unprecedented and that the department lacks the staffing to be able to complete this new workload without additional resources.

Premium Rate Review Federal Grant

Budget Request. Through a Spring Finance Letter on April 1, 2015, the Department of Managed Health Care (DMHC) requests federal spending authority of $589,000 for 2015-16 to implement the Health Insurance Rate Review Cycle IV federal grant.

Background. Pursuant to the Affordable Care Act, the federal government is administering a grant program to assist states with the requirement to monitor and report health insurance premium rate trends to the federal Department of Health and Human Services. In 2010, DMHC was awarded $608,000 for Cycle 1 of this federal rate review grant program. DMCH received $2.2 million for Cycle II. Cycles I and II funds were used to obtain actuarial consulting services, implementation and enhancement of the electronic rate review reporting and filing system, and enhancement of the website to provide transparency of rate filing information and allow public comment on rate filings. On September 19, 2014, DMCH received $589,500 for Cycle IV of the federal rate review grant program. This grant runs through September 18, 2016, and will be used for an IT consultant and actuarial services.

It is recommended to modify the proposed budget bill language to allow DMHC to proceed with procuring a vendor if the Department of Technology does not reject the Feasibility Study Report (FSR) by July 1, 2015. DMHC has until September 2016 to expend and complete all grant activities; consequently, it is recommended to provide the Department of Technology with a timeframe to take action on the FSR to ensure that DMHC is able to complete these activities.

Modified budget bill language:

> Notwithstanding any other provision of law, of the funds appropriated in this item, up to $395,000 is available for the Premium Rate Review Cycle IV Website Enhancement Implementation costs, for expenditure or encumbrance until June 30, 2016. Funding provided pursuant to this provision shall be made available only upon approval of the Department of Finance and approval of a Feasibility Study Report (FSR) or an FSR Reporting Exempt Request by the Department of Technology. **If the Department of Technology does not approve the FSR by July 1, 2015, the Department of Managed Health Care may proceed with the Premium Rate Review Cycle IV Website Enhancement Implementation, assuming all other conditions contained in this Item have been met.**

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present these two proposals and respond to questions of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends approval of both DMHC proposals, including the modified placeholder budget bill language as described above.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 1: METROPOLITAN SECURITY FENCE APRIL 1 PROPOSAL

PANELISTS

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

BUDGET PROPOSAL

Through a Spring Finance Letter on April 1, 2015, the Department of State Hospitals (DSH) requests $1.7 million to add the working drawings phase to the Increase Secured Bed Capacity and Security Fence project at Metropolitan State Hospital. The original proposal is included in the January Budget. This would bring the total funding being requested for this project for 2015-16 to $3,636,000 General Fund.

BACKGROUND

The January budget includes a capital outlay proposal to construct a secure fence at Metropolitan State Hospital, in order to create additional bed capacity for Incompetent to Stand Trial (IST) patients. This proposal was heard by the Subcommittee on March 16, 2015 and the proposal was held open at that time. This proposal expedites the project from four to three years. The administration sites the urgency associated with the growing IST waiting list, as well as mounting pressure from county courts to deal with the waiting list, as the justification for expediting this project. For additional background on the original capital outlay proposal and on the IST waitlist, please see the agenda for the Subcommittee's hearing on March 16, 2015.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal and respond to questions of the Subcommittee.

Staff Recommendation: Subcommittee staff recommends holding open this proposal to allow for additional time for review.