AGENDA

PART I

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

WEDNESDAY, MAY 22, 2013

9:00 AM - STATE CAPITOL ROOM 4202

VOTE-ONLY CALENDAR

ITEMS TO BE HEARD

VOTE ONLY

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 1: MEDI-CAL MANAGED CARE RURAL EXPANSION SUPPLEMENTAL MAY REVISE PROPOSAL

Department of Managed Health Care (DMHC) requests a 0.8 two-year limited term position and $298,000 for 2013-14 and $290,000 for 2014-15 to address workload attributable to an additional three plans that are now part of the Medi-Cal managed care expansion into 28 rural counties. This request includes $195,000 for consultant services to perform annual medical surveys of the three additional plans.

The proposal will be funded by 50 percent Managed Care Fund and 50 percent reimbursement from the Department of Health Care Services seeking the federal match. The position requested would be assigned to the Help Center and assist with annual medical surveys of the five plans for the first two years. The DMHC is asking for a 0.8 limited-term position to augment the permanent positions requested in the department's January Budget Change Proposal (BCP) that the Subcommittee heard on April 22, 2013 and approved on May 6, 2013. The January BCP included a request to address workload based on providing consumer assistance and conducting annual medical surveys of two plans for the Medi-Cal Managed Care Rural Expansion.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MEDI-CAL ESTIMATE UPDATE – TECHNICAL ADJUSTMENTS

It is requested that the technical adjustments noted below be made to the following budget bill items to reflect a variety of caseload and cost changes not highlighted in the other Medi-Cal proposals:

1. Item 4260-101-0001 be increased by $579,114,000 and reimbursements be decreased by $907,993,000
2. Item 4260-101-0236 be decreased by $30,000
3. Item 4260-101-0890 be increased by $4,353,324,000
4. Item 4260-101-3168 be increased by $1,419,000
5. Item 4260-101-3213 be increased by $436,646,000
6. Item 4260-104-0001 be increased by $3,531,000
7. Item 4260-105-0001 be decreased by $29,140,000
8. Item 4260-106-0890 be decreased by $8,202,000
9. Item 4260-107-0890 be decreased by $164,000
10. Item 4260-113-0001 be increased by $28,086,000
11. Item 4260-113-0890 be increased by $41,275,000
12. Item 4260-117-0001 be increased by $2,317,000
13. Item 4260-117-0890 be increased by $4,709,000

This is a technical adjustment and it is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been, or will be, taken.

ISSUE 2: BREAST & CERVICAL CANCER TREATMENT PROGRAM RESOURCES REQUEST

The May Revision requests the extension of six full-time limited-term positions for the Breast and Cervical Cancer Treatment Program (BCCTP), until December 31, 2014. The existing limited-term positions expire December 31, 2013. The total cost of these positions is $369,000 ($185,000 General Fund and $184,000 federal funds).

Since the program's inception in 2002, BCCTP has received 45,744 applications; the active BCCTP caseload has continued to increase from 5,000 cases in the first year of operation to 14,500 active cases as of March 1, 2013. Of these active cases, there are 5,337 federal cases that are overdue for an annual redetermination and another 1,324 federal cases that are currently due for an annual redetermination, which amounts to almost 7,000 cases needing a redetermination.

According to DHCS, the ongoing workload associated with initial eligibility determinations, annual redeterminations, and the processing of requests by applicants for retroactive coverage makes it essential that these six positions be extended. DHCS is not proposing to make these positions permanent as it is unclear what impact the implementation of the Affordable Care Act (ACA) will have on caseload, workload, and the backlog.

ISSUE 3: MENTAL HEALTH SERVICES TECHNICAL ADJUSTMENT

The May Revision requests a technical adjustment to align federal fund authority for mental health services grants with the actual amount of grant funding received from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This is a technical adjustment.

ISSUE 4: FAMILY HEALTH PROGRAMS ADJUSTMENTS

The May Revision requests adjustments to the California Children's Services (CCS), Child Health and Disability Prevention Program (CHDP), and the Genetically Handicapped Person's Program (GHPP).

These changes reflect revised expenditure estimates based on caseload adjustments, the use of federal Safety Net Care Pool funding and medical rebate funding, to offset General Fund, and other technical changes in program expenditures. Approximately $65 million is still available for Designated State Health Programs in the Safety Net Care Pool.

Caseload projections are estimated to be 20,062 for CCS (a 44.6 percent decrease over the revised current year forecast, primarily reflecting the transition of children from Healthy Families CCS to Medi-Cal CCS), 26,547 for CHDP (a 12.7 percent increase over the revised current year forecast), and 944 for GHPP (a 4.9 percent increase over the revised current year forecast).

California Children's Services (CCS)

2012-13 GF at November Estimate: $81,590,000
2012-13 GF at May Revision: $29,205,000

2013-14 GF at Gov Budget: $53,683,000
2013-14 GF at May Revision: $11,511,000

Major Adjustments (non-caseload related):

- A decrease of $35.1 million in 2012-13 by correcting erroneous payments for Medi-Cal claims. The department discovered its system erroneously paid Medi-Cal claims with General Fund from the CCS State-Only ($16.1 million) and CCS Healthy Families programs ($19 million). The department will shift the costs paid by CCS programs to Medi-Cal.

- A decrease of $22.5 million in 2012-13 and $38.8 million in 2013-14 due to additional federal funds from the California Bridge to Reform Section 1115(a) Medicaid Demonstration to offset General Fund costs. The demonstration allows the department to claim federal funds using certified public expenditures of approved designated state health programs. The department has received additional certified public expenditures, resulting in additional federal funds to offset General Fund costs in CCS.

Child Health and Disability Prevention (CHDP) Program

2012-13 GF at Gov Budget: $1,759,000
2012-13 GF at May Revision: $1,601,000

2013-14 GF at Gov Budget: $1,780,000
2013-14 GF at May Revision: $1,769,000

Genetically Handicapped Persons Program (GHPP)

2012-13 GF at Gov Budget: $52,700,000
2012-13 GF at May Revision: $43,667,000

2013-14 GF at Gov Budget: $75,026,000
2013-14 GF at May Revision: $24,339,000

Major Adjustments (non-caseload related):

- A decrease of $12.8 million in 2012-13 and $20.8 million in 2013-14 due to additional federal funds from the California Bridge to Reform Section 1115(a) Medicaid Demonstration to offset General Fund costs. The demonstration allows the department to claim federal funds using certified public expenditures of approved designated state health programs. The department has received additional certified public expenditures, resulting in additional federal funds to offset General Fund costs in GHPP.

- A decrease of $34.2 million in 2013-14 from a one-time transfer from the Children's Medical Services Rebate Fund. The fund was created to deposit all rebates for the delivery of health care, medical supplies, pharmaceuticals, including blood replacement products, and equipment for clients enrolled in the GHPP and California Children's Services (CCS) program. Monies in the fund are to be used to cover the cost of the GHPP and the CCS program. The department has typically only spent what it expects to receive each year. However, receipts frequently exceed their estimates and this has resulted in a significant reserve balance. The May Revision Estimate assumes transfer of this reserve balance on a one-time basis to cover GHPP General Fund costs.

ISSUE 5: EVERY WOMAN COUNTS MAY REVISE ADJUSTMENT & FISCAL REPORTING REQUIREMENT– SENATE PROPOSAL

The following shows the adjustments to the Every Woman Counts estimate, comparing May Revision to the January budget for both the current fiscal year and budget year (2013-14):

2012-13 GF at Gov Budget: $4,002,000
2012-13 GF at May Revision: $8,413,000

2013-14 GF at Gov Budget: $13,960,000
2013-14 GF at May Revision: $21,298,000

Major Adjustments (non-caseload related):

- An increase of $3.4 million n 2012-13 and $3.1 million in 2013-14 due to an error in the methodology in November Estimate. The EWC program has up to two years to pay its claims because it's on an accrual accounting basis. In the November Estimate, the department estimated the program's costs on a cash accounting basis and did not account for claims of service that will be paid in future years. The May Revision Estimate corrects this error.

- An increase of $1.0 million in 2012-13 and $4.2 million in 2013-14 to cover the cost of case management for women receiving additional services as a result of notification of dense breast. Chapter 458, Statutes of 2012 (SB 1538), required health facilities that provide mammography, including those covered by the EWC and Medi-Cal programs, to provide notices to women whose mammograms indicate dense breast tissue. The November Estimate assumed 50 percent of the estimated 166,870 women who receive the notice will request an additional ultrasound screening test, which costs $49. In the May Revision Estimate, the department assumes each physician ordering additional screening will be able to claim a $50 reimbursement for case management, resulting in these additional General Fund costs.

The EWC program provides cancer screening services for low-income, under-insured and uninsured women. Through EWC, women receive free clinical breast exams, mammograms, other breast cancer diagnostic testing, pelvis exams, and Pap tests, with the intended outcome to reduce breast and cervical cancer deaths. EWC enrolls women age 25 and older for cervical cancer prevention screening and women age 40 and older for breast cancer screening and diagnostic services.

Senate Proposal

The 2012 budget transferred EWC from the Department of Public Health (DPH) to DHCS. The EWC budget documentation does not include certain fiscal information that DPH had provided, such as expenditures for various clinical service activities. This information provided transparency as to how much EWC funding was allocated for office visits and consults, screening mammograms, diagnostic mammograms, case management, and other services.

Therefore, the Senate adopted placeholder trailer bill language to require supplemental EWC fiscal information regarding clinical service activity expenditures to be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions.

ISSUE 6: LONG TERM CARE QUALITY ASSURANCE FUND – BORROWABLE FOR CASH FLOW

The May Revision proposes trailer bill language to make the funds available in the Long Term Care Quality Assurance Fund borrowable for General Fund cash flow purposes.

The Administration notes that this language is common practice to assist with General Fund cash flow management, and that the proposed language is boiler-plate language used with most special funds that was overlooked inadvertently when the fund was created in statute in 2012.

ISSUE 7: MENTAL HEALTH AND DRUG MEDI-CAL FISCAL REPORTING – SENATE PROPOSAL

In order to increase the fiscal transparency of Medi-Cal mental health services and the Drug Medi-Cal program, both recently transferred to DHCS from other departments, the Senate approved of placeholder trailer bill as follows:

Mental Health: To require supplemental fiscal information be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions. This placeholder language would be consistent with Welfare and Institutions Code Section 14100.5 that requires DHCS to prepare and submit detailed information regarding Medi-Cal program assumptions and estimates for the budget.

Drug Medi-Cal: To require summary Drug Medi-Cal fiscal charts and unique caseload information be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions.

ISSUE 8: TRANSFER OF MENTAL HEALTH LICENSING FROM DEPARTMENT OF SOCIAL SERVICES

The Administration is proposing to transfer mental health licensing (of Psychiatric Health Facilities and Rehabilitation Centers) and quality improvement functions, including 12.0 permanent positions and expenditure authority of $728,000 ($337,000 GF, $391,000 SF, $396,000 FF), from the Department of Social Services (DSS) to DHCS. *The Subcommittee heard this proposal at its hearing on March 18, 2013.*

The 2012 Budget Act implemented the elimination of the Department of Mental Health (DMH), including the relocation of various community (non-state hospitals) mental health functions and activities to other state departments. The majority were transferred to DHCS, however, licensing and quality improvement functions were transferred to DSS. DHCS explains that moving licensing to DSS was based on the fact that DSS had substantial experience and involvement with licensing of other types of facilities, and therefore it was believed that DSS was better suited to take on this DMH function. Nevertheless, over the past year the Administration has changed its perspective on this and now believes that these functions should be located at DHCS. DHCS explains that its own expertise on mental health and Medi-Cal certifications is more critical to the licensing process than is the licensing expertise at DSS. For the same reasons, the Administration is proposing to transfer substance abuse treatment facility licensing functions from DADP to DHCS, as a part of that department reorganization. According to the Administration, DSS licensing staff have relied heavily on clinical staff at DHCS in the licensing process, requiring an inter-agency agreement, and therefore moving this function will create efficiencies and a smoother, easier process for both the state and mental health facilities.

Proposed Trailer Bill

The Administration has proposed budget trailer bill to accomplish this transfer. The proposed trailer bill has two major components: 1) changes the department references in all of the relevant sections of law from DSS to DHCS; and, 2) shifts from DSS to DHCS the responsibility for providing approval to facilities to provide a 72-hour involuntary hold on individuals, under the authority of the Lanterman Petris Short Act.

ISSUE 9: EMERGENCY PREPAREDNESS BUDGET CHANGE PROPOSAL

DHCS requests three permanent full-time Health Program Auditor IV positions, effective July 1, 2013, to conduct audits of local health departments' use of federal public health emergency funds. *The Subcommittee heard this proposal at its hearing on May 6, 2013*.

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

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

DPH also submitted a BCP in January related to emergency preparedness resources, requesting authority to extend limited-term positions for another four years, aligning with the timeframe of the federal grant. The Subcommittee heard and approved the DPH BCP on March 4, 2013. DHCS has requested these related positions to be permanent.

ISSUE 10: ADULT MEDICAID QUALITY GRANT SPRING FINANCE LETTER

DHCS has been awarded a federal grant of $2 million by the Centers for Medicare and Medicaid Services (CMS), for the period of December 2012 to December 2014, with funding made available under the ACA. *The Subcommittee heard this proposal at its hearing on May 6, 2013.*

For the DHCS project, titled *Medi-Cal Adult Quality Care Improvement (MAQCI): Diabetes Management, Maternal Health and Birth Outcomes, and Mental Health Medication Management,* DHCS requests six two-year, limited-term positions over the life of the grant, $530,000 expenditure authority in 2012-13, $937,000 in 2013-14, and $533,000 in 2014-15 to increase DHCS capacity for reporting on quality measures and performing associated quality improvement activities. A current year request for increased federal fund expenditures of $530,000, as a result of this grant, was submitted to the Joint Legislative Budget Committee in March.

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

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

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

ISSUE 11: LABORATORY RATES DELAY TRAILER BILL

AB 1467 and AB 1494 (2012 budget trailer bills) allowed DHCS to develop a new rate reimbursement methodology for clinical laboratory and laboratory services. The proposed methodology would develop rates that are based on the lowest amounts other payers are paying for similar clinical laboratory services.

Until the implementation of the new methodology, payments for clinical laboratory services would be subject to an additional 10 percent reduction (on top of the 10 percent payment reductions pursuant to AB 97 (2011)).

As required by AB 1467, DHCS has been working with stakeholders on the development of the new rate methodology; however, this process has taken longer than anticipated and the new rate methodology has not yet been approved by the federal CMS.

Therefore, stakeholders have requested trailer bill language to extend the time period for which laboratory service providers have to submit data reports specifying their lowest amounts other payers are paying. This is necessary as the process to develop the new rate methodology has taken longer than anticipated. This proposal has no impact on the General Fund savings anticipated with the change in methodology, and DHCS has indicated that it has no concerns with this proposed trailer bill language.

ISSUE 12: MEDI-CAL STATE PLAN AMENDMENTS & WAIVER TRANSPARENCY REQUIREMENTS – SENATE PROPOSAL

When California wants to make significant changes to its Medicaid program (Medi-Cal), it must take one of two steps: either 1) amend its State Medicaid Plan; or 2) receive an exemption or Medicaid waiver from portions of Title XIX of the Social Security Act by the U.S. Department of Health and Human Services (DHHS).

State Plan Amendment (SPA). The state's Medi-Cal program is governed by the requirements set forth in the state's Medicaid State Plan. The State Plan is a comprehensive written document created by California that describes the nature and scope of its Medicaid (Medi-Cal) program. It serves as a contractual agreement between California and the federal government. The State Plan contains all information necessary for the federal Centers for Medicare and Medicaid Services (CMS) to determine if the state can receive federal financial participation (i.e., federal funding). Changes to the State Plan are submitted as amendments. The SPAs must be approved by CMS.

Waivers. Waivers allow states to wave certain Medicaid requirements and to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. The federal government has the discretion to approve or reject waiver proposals. California has multiple Medi-Cal waivers. Waiver amendments are proposals to change an existing approved waiver.

Proposed State Plan Amendments (SPAs) are important documents that explain to the federal government how the state plans to change the Medi-Cal program. Similarly, waiver amendments and waiver renewals are documents that explain to the federal government how the state plans to change (or renew) a Medi-Cal waiver.

Proposed SPAs, wavier amendments, and waiver renewals are not available on the DHCS website and in the past have not been routinely shared with the Legislature or the public. Consequently, the affected stakeholders have not had ample opportunity to assess the accuracy of the state's representations to the federal government about a proposed change.

Senate Proposal

DHCS has indicated that it is in the process of posting this information and is looking at ways to improve its communication and transparency. Given the importance of these documents and the importance for stakeholders, including Legislative staff, to have a complete understanding of how DHCS proposes to implement changes to the Medi-Cal program, the Senate has adopted placeholder trailer bill language to require DHCS to post on its website proposed SPAs, waiver amendments, and waiver renewals that it has submitted to the federal government. This would provide legislative staff and stakeholders with the opportunity to review and comment on the state's implementation of policy.

ISSUE 13: ELIMINATE SUNSET FOR SPECIALTY PROVIDER CONTRACTING

The May Revision proposes trailer bill language to eliminate the sunset date for specialty provider contracting. The elimination of this sunset date achieves ongoing $6.9 million General Fund savings.

AB 1183 (Statutes of 2008) allows DHCS to enter into contracts with providers who distribute and provide care for specialty drugs and services. This law allows DHCS to restrict payment of specialty drugs and services to a limited number of providers. AB 1183 also included an annual reporting requirement after the first and second years after implementation and a sunset provision of July 1, 2013.

According to DHCS, most chain and non-specialty retail pharmacies are unwilling or incapable of providing the drugs currently provided by specialty pharmacy providers. If the specialty provider contracting provisions sunset, beneficiaries in need of blood factor, drugs used for HIV, cancer, hepatitis, inborn errors of metabolism, pulmonary hypertension, transplants, for example, would be forced to obtain these services through utilization of hospital emergency departments, extended stays in acute and sub-acute care settings, or via increased medical interventions in acute care settings. Additionally, DHCS notes that provision of these services in an outpatient pharmacy setting has been demonstrated to be less costly on the national level.

This proposal would remove the July 1, 2013, sunset date and allow DHCS to continue to contract with providers of specialty drugs and services. The proposed language also would delete an annual reporting requirement that DHCS has already met.

ISSUE 14: MANAGED CARE EFFICIENCIES PROPOSAL WITHDRAWAL

The Governor's January Budget assumes savings in 2013-14 of $134,641,000 to be achieved by implementing efficiencies in the managed care program, which would be reflected in lower rates paid to managed care plans through the Medi-Cal program.

The impetus for this proposal was the ten percent provider rate reduction, approved through AB 97 (budget trailer bill) in 2011 that the Administration plans to implement later in 2013 (as discussed in more detail later in this agenda). The rate reduction will be retroactive to June 2011 for fee-for-service providers, however a retroactive reduction cannot be applied to managed care.

The May Revision includes the withdrawal of this proposal by the administration, and therefore an increase of $134.6 million in the Medi-Cal budget to reflect this change.

4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: PROGRAM CASELOAD UPDATES

The May Revision requests the following:

- **County Health Initiative Matching (CHIM) Caseload Update (DOF Issue 106)** – An increase of $45,000 in the CHIM fund and $88,000 in federal funds due to a slight increase in projected enrollment. This county funded program allows the use of matching federal dollars to provide health coverage for children between 250 percent and 400 percent of the federal poverty level (FPL) and who otherwise meet federal eligibility criteria.

- **Healthy Families Program Caseload Update (Issue 104)** – A net increase of $6.7 million General Fund (and other technical budget adjustments) as a result of the increased enrollment months for infants linked to the Access for Infants and Mothers (AIM) program, the transfer of Single Point of Entry related costs to the Department of Health Care Services (DHCS), and increased Healthy Families Program (HFP) administrative vendor costs.

- **Access for Infants and Mothers Program Caseload Update (Issue 105)** - An increase in $2.2 million federal funds (and corresponding technical adjustments) to reflect the net effect of a decrease in estimated caseload, an increase in administrative vendor costs, an increase in capitation and lump-sum birth event and post-partum rates, and an increase in costs associated with covering beneficiaries under a single statewide health care service plan.

ITEMS TO BE HEARD

4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: PRE-EXISTING CONDITIONS INSURANCE PROGRAM UPDATE

MRMIB was notified recently that the federal government plans to take over the administration of PCIP on July 1, 2013. MRMIB is in the process of assessing the implication of this change. Its preliminary assessment indicates that deductibles under the federally-administered program will be higher and there will be a change in premiums (some individuals may have a lower premium and some individuals may have a higher premium). MRMIB anticipates sending notices to PCIP subscribers by the end of this week.

PANELISTS

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

BACKGROUND

As a result of the federal Affordable Care Act (ACA), California, via MRMIB, has a contract with the federal Department of Health and Human Services to establish a federally-funded high-risk pool program to provide health coverage for eligible individuals. The program had been slated to operate until December 31, 2013, when the national health reform is set to begin. After that date, there will no longer be a need for high-risk pools because federal rules will not allow insurers to reject persons with pre-existing conditions or charge them higher rates than those without such conditions.

The federally-funded program is called the California Pre-Existing Condition Insurance Plan (PCIP). The PCIP offers health coverage to medically-uninsurable individuals who live in California. The program is available for individuals who have not had health coverage in the last six months. The California PCIP is run by the Managed Risk Medical Insurance Board (MRMIB).

The federal government notified all state-administered PCIPs to close to new enrollments after March 2, 2013. As the contractor that operates PCIP in California for CMS, MRMIB has closed PCIP enrollment except for persons coming into California with PCIP from another state and for persons who applied prior to March with applications that were missing information. As of July 1, 2013, all PCIP enrollees will be moved to the federal pre-existing conditions insurance program, which was created for states not choosing to establish their own programs.

Approximately 16,500 individuals are enrolled in PCIP. California has the largest PCIP program in the nation. California's PCIP has incurred costs of about $529 million of its $761 million federal allocation.

In addition to the risks that this additional transition creates for the PCIP beneficiaries, MRMIB also has 28 state employees on contract specific to this program through several months of 2014.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked MRMIB to describe this update on PCIP and respond to the following:

1) Please describe any safeguards being considered to ensure a smooth transition for this population from the state to the federal PCIP.

2) Please describe what MRMIB knows at this point about how the administration will accommodate the 28 PICP staff.

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

ISSUE 1: TRANSFER OF AIM-LINKED INFANTS TO DEPARTMENT OF HEALTH CARE SERVICES

The Administration is proposing to transition Access for Infants and Mothers (AIM)-linked infants from MRMIB to DHCS, beginning October 1, 2013. This transition is expected to result in a reduction in the MRMIB budget, and an equivalent increase in the DHCS budget, of $33.3 million ($11.6 million General Fund, $21.7 million federal funds).

The Administration will transition infants whose mothers have incomes up to 250 percent of the federal poverty level (FPL) into Medi-Cal, beginning August 1, as a part of the overall transition of children in the Healthy Families Program. This proposal is to transition children with mothers who have incomes between 250 and 300 percent FPL to DHCS (not Medi-Cal) beginning October 1, 2013.

PANELISTS

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

BACKGROUND

The 2012 Budget Act approved of the transition of all children in the Healthy Families Program to Medi-Cal in 2013, a transition which is in progress. The statute did not address the transition of "AIM-linked infants," 0-2-year olds born to mothers in the AIM program, and who are currently provided two years of coverage through Healthy Families. Per last year's statute approving of the Healthy Families transition, Medi-Cal eligibility for children now goes to 250 percent FPL.

For the 1,886 infants between 250 and 300 percent FPL, the Administration describes this transition as a "lift and shift," meaning the program at MRMIB will be transferred, as is, to DHCS, which will operate the program in the exact same way and with the same rates. However, these kids are currently in the Healthy Families Program, so DHCS will have to establish a new, small stand-alone program for them. The Administration believes that this will be more feasible for DHCS, than it would be for MRMIB, given the size and resources of this much larger department. Moreover, the Administration is proposing the elimination of MRMIB, as discussed in the next issue below.

STAFF COMMENTS/QUESTIONS

This proposal requires statutory changes although the Administration has yet to provide any proposed language.

The Subcommittee staff has asked DHCS or MRMIB to present this proposal and to respond to the following questions:

1) How exactly will DHCS operate a small, separate program for the infants between 250 and 300 percent FPL?

ISSUE 2: ELIMINATION OF THE MANAGED RISK MEDICAL INSURANCE BOARD

The Administration is proposing the elimination of MRMIB, effective July 1, 2014. The proposed May Revision includes no information or detail on this proposal.

PANELISTS

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

BACKGROUND

The only information provided by the Administration on this proposal includes the following timeline for transitioning MRMIB programs.

Proposed Timeline of Transition of MRMIB Remaining Programs

AIM-Infants: 1. AIM-Linked Infants between 200-250% FPL in Phase 1, 2, and 3 Counties Transition to Medi-Cal August 1, 2013 with Phase 3 Counties.

2. AIM-Linked Infants between 200-250% FPL in Phase 4 counties, will transition to Medi-Cal with Phase 4 on September 1, 2013.

3. AIM-Linked Infants between 250-300% of FPL in *ALL* Counties will transition to DHCS on October 1, 2013.

MRMIB and DHCS will work collaboratively to draft a Title XXI State Plan Amendment to establish a CHIP program under DHCS for AIM-linked Infants.

AIM Moms: AIM contracts expire January 1, 2014. MRMIB will continue to administer the AIM program for the mothers until June 30, 2014 and on July 1, 2014 the program will be transitioned to DHCS where DHCS will become the executor of the AIM contracts. MRMIB and DHCS will work collaboratively to develop any necessary federal approvals and state plan amendments.

CHIM: ACA requires that all CHIP eligibility that existed prior to ACA must continue or be in violation of the CHIP MOE. Therefore, California will be required to operate CHIM in its current three counties. MRMIB will continue to administer the CHIM program until June 30, 2014 and on July 1, 2014 the responsibilities of CHIM will be transitioned to DHCS. MRMIB and DHCS will work collaboratively to develop any necessary federal approvals and state plan amendments.

MRMIP: The Administration is not proposing to eliminate MRMIP at this time. MRMIP will stay with MRMIB and continue to run as it currently does and on July 1, 2014, responsibility for MRMIP will transition to DHCS. MRMIB in 2013-14 will have to work with Covered

California in order to share data and provide notification to subscribers of their options on in Covered California. While the program will remain open in 2013-14, it is voluntary. Many current subscribers may seek coverage through Covered California or the private market.

PCIP: Effective July 1, 2013 the state will no longer operate a state-run PCIP program on behalf of the federal government. Those in the state-run PCIP program will transition to the federal program from July 2013 through December 2013 at which time PCIP is expected to sunset. Beginning January 1, 2014 the population served by PCIP will transition to Covered California or the private market. The federal government will be responsible for the transition of PCIP subscribers to Covered California. MRMIB will conduct program closeout activities of the state-run PCIP until June 30, 2014 and on July 1, 2014 any remaining closeout activities of PCIP will be transitioned to DHCS.

Board: The Board will continue to operate throughout FY 2013-14 to oversee the remaining transition of Phase 3 and 4 of Healthy Families as well as the AIM-linked infants. They will also oversee AIM, CHIM, MRMIP and the closeout of state-run PCIP throughout 2013-14. It is anticipated the Board will be dissolved effective July 1, 2014 with remaining program activities transitioning to DHCS.

Staff: MRMIB is working with Covered California to help those staff that work on the PCIP program find employment at Covered California. Staff that remain at MRMIB administering the ongoing programs through 2013-14 until closeout will be transitioned to DHCS effective July 1, 2014.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS or MRMIB to present this proposal, describe the Administration's goals in proposing this elimination, and explain the nature of including a significant proposal such as this one in the May Revision without any detail.

1) When will the administration provide proposed language for the implementation of this proposal?

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: MANAGED CARE ORGANIZATION TAX

The May Revision includes a revised proposal to re-establish the Gross Premiums Tax on Managed Care Organizations, often referred to as the "MCO Tax." Specifically, the May Revision proposes that the 2012-13 tax amount will be equal to the gross premiums tax, and in 2013-14 and on-going, the tax rate will be equal to the state sales tax rate. The MCO tax will result in current year General Fund savings of $128.1 million for the Managed Risk Medical Insurance Board (Healthy Families Program), and $342.9 million in General Fund savings in 2013-14 for Medi-Cal.

The Administration's January estimate included approximately $136 million in General Fund savings in 2012-13 and $233 million in General Funds savings in 2013-14.

PANELISTS

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

BACKGROUND

AB 1422 (Bass), Chapter 157, Statutes of 2009 extended the State's existing 2.35 percent gross premium tax on insurance (all types) to Medi-Cal Managed Care Plans. This tax became effective January 1, 2009, and was then extended to July 1, 2011 by SB 853 (Budget and Fiscal Review Committee), Chapter 717, Statutes of 2010. Subsequently, AB 21 X1 (Blumenfield), Chapter 11, Statutes of 2011 extended the sunset date to July 1, 2012, and included provisions that made the extension of the tax inoperable should any eligibility changes be made to the Healthy Families Program.

Revenues from this tax are matched with federal funds and have been used to:

- Provide a reimbursement rate increase to Medi-Cal Managed Care Plans;
- Provide a reimbursement rate increase to health plans participating in the Healthy Families Program; and,
- Fund health care coverage for children through the Healthy Families Program.

AB 1422, and subsequent bills extending the tax, required the State to allocate 38.41 percent of the tax revenue to DHCS to provide enhanced rates to Medi-Cal Managed Care Plans. The remaining 61.59 percent of the tax revenue went to the Managed Risk Medical Insurance Board for essential preventive and primary health care services through the Healthy Families

Program. The Medi-Cal Managed Care Plans affected by the tax included: 1) Two Plan Model (Local Initiatives); 2) County Organized Health Systems (COHS); 3) Geographic Managed Care; 4) AIDS Healthcare; and, 5) SCAN.

The Administration proposes to direct tax revenue to the Healthy Families Program in the current year, consistent with past use of the revenue, and in the budget year and beyond the revenue would fund children's health services through the Medi-Cal program, given the elimination of the Healthy Families Program agreed to through the 2012 budget. This proposal also seeks to redirect some MCO revenue to the Coordinated Care Initiative.

STAFF COMMENTS/QUESTIONS

At this point in time, health plans oppose this proposal in its current form. Generally, the plans state that they must know more about the managed care rates that will result from this tax in order to remove their opposition. They also argue that MCO tax revenue should not be used only as a General Fund offset. Finally, the plans argue that the tax should have a sunset rather than being established permanently. They are currently in discussions with the Administration on these issues.

Subcommittee staff has asked DHCS to present this proposal and respond to the following:

1) Please describe what the MCO revenue is proposed to support?

2) Please provide an update on discussions with the health plans on rate setting.

ISSUE 2: HOSPITAL QUALITY ASSURANCE FEE SAVINGS

The Governor's January budget assumes $310 million in General Fund savings in 2013-14 that will result from revenue from a proposed 3-year extension to the Hospital Quality Assurance Fee (QAF), which is set to sunset on December 31, 2013. The May Revision makes no changes to this estimate.

PANELISTS

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

BACKGROUND

Federal law authorizes states to levy fees on health care providers if the fees meet federal requirements. Many states (including California) fund a portion of their share of Medicaid Program costs through a fee on health care providers. Under these funding methods, states collect funds (through fees, taxes, or other means) from providers, which are then matched to allow increased Medicaid reimbursement to providers. To prevent states from levying an assessment on only Medicaid providers, federal law requires provider fees to be "broad based" and uniformly applied to all providers within specified classes of provider and states are prohibited from having a provision that would ensure providers are "held harmless" from the impact of the fee. Health care related provider fees may only be imposed on 19 particular classes of health care items or services. Federal approval through CMS is required. In addition to the hospital QAF, California currently has a QAF for intermediate care facilities for the developmentally disabled, and a separate QAF for skilled nursing facilities.

California first enacted a Medi-Cal Hospital Provider Fee in 2009. AB 1383 (Jones), Chapter 627, Statutes of 2009, and AB 188 (Jones), Chapter 645, Statutes of 2009, enacted the framework for a Medi-Cal hospital provider fee, established fee payment amounts, a methodology for calculating and paying supplemental payments to private and district hospitals, supplemental payments to Medi-Cal managed care (MCMC) plans for hospital services, and allocated funds for children's health care coverage, DHCS administrative costs, and grants to public hospitals from the funds collected by the fee. AB 1383 was to become effective upon receipt of CMS approval and become inoperative on January 1, 2011. These measures generated $3.1 billion in revenue from hospitals paying the QAF. The QAF drew down an additional $3.2 billion in federal funds, and provided an overall benefit to the hospital industry of $2.6 billion. In addition, over the 21 month period in which AB 1383 and AB 188 applied, the QAF provided $560 million for children's health coverage, and $513 million in unmatched direct grants to DPHs.

SB 90 (Steinberg), Chapter 19, Statutes of 2011 established a new QAF and hospital supplemental payment program for the period between January 1, 2011 and June 30, 2011 that is similar to the previous fee and supplemental payment program. The most significant changes made to the funding distribution in SB 90 was the elimination of supplemental payments to the 48 NDPHs and grants to the 21 DPHs, and an increase in the per quarter amount for children's coverage (from $80 million per quarter to $105 million per quarter). In addition, SB 90 established an Inter-Governmental Transfer (IGT) program that allows the 48 NDPHs and 21 DPHs to use IGTs to increase the Medi-Cal capitation rate to MCMC plans with which they contract. According to the California Hospital Association (CHA), of the 357 licensed general acute care hospitals in the state, 237 pay the QAF under SB 90. Of the 237 hospitals paying the QAF, 15 independent hospitals and four hospital systems pay more in QAF than they receive back in supplemental payments. Across all private hospitals, SB 90 was estimated to provide $858 million in payments to private hospitals above the amounts paid in QAF by these hospitals.

Children's Coverage

California's QAF revenue has always been dedicated to supporting children's health care services. SB 335 (Hernández), Chapter 286, Statutes of 2011 extended the sunset again, and governs the current QAF. The CHA is the sponsor of this year's bill, SB 239 (Hernández and Steinberg) to extend the QAF again.

History and Proposed State General Fund Savings Based on Hospital QAF Revenue

Time Frame	Quarterly General Fund Savings
April 1, 2009 – Dec. 21, 2010	$80 million
Jan. 1, 2011 – June 30, 2011	$105 million
July 1, 2011 – June 30, 2012	$85 million
July 1, 2012 – June 30, 2013	$134 million
July 1, 2013 – Dec. 31, 2013	$155 million
Proposed: Jan. 1, 2014 – June 30, 2014	$155 million
Proposed: July 1, 2014 – Dec. 31, 2016	$?

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to provide a brief update on the progress of discussions on extending the fee.

ISSUE 3: HEARING AIDS REIMBURSEMENT POLICY

On January 15, 2013, the Department of Health Care Services (DHCS) administratively implemented a change in the Medi-Cal reimbursement policy for hearing aids. The new policy required the state to reduce the reimbursement by the amount of discounts or rebates, provided by manufacturers to hearing aid providers, when reimbursing for the cost of the hearing aids, thus ending the long-standing practice of reimbursing for the full amount paid prior to discounts or rebates. This new policy resulted in a substantial reduction in reimbursement to Medi-Cal and California Children's Services (CCS) hearing aid providers.

After substantial discussion with hearing aid providers, DHCS suspended the new policy and began a stakeholder process to develop a new reimbursement policy that would accomplish the administration's goal of creating a more accountable and transparent reimbursement policy, including eliminating the state's coverage of rebates and discounts, without resulting in a substantial reduction to providers. DHCS has put forth at least two revised proposed policies, both of which were viewed by providers as leading to substantial reductions.

Hearing aid providers, therefore, are proposing statutory changes (i.e., trailer bill) to establish a new hearing aid policy. They share the administration's goals of eliminating the state's coverage of rebates while not reducing payments to providers. They believe that their proposal is neither a significant decrease or increase for providers, and therefore is budget neutral. The actual proposed language is included at the end of this issue.

The Subcommittee discussed this issue at its February 28, 2013 oversight hearing.

PANELISTS

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

BACKGROUND

Current Law & Regulations

The Medi-Cal reimbursement policy for hearing aids is established in statute. Welfare and Institutions Code Section 14105.49 states (in bold):

(b) The maximum reimbursement rate for hearing aids shall not exceed the lesser of the following:

(1) The maximum allowable amount established by the department.

DHCS established the maximum allowable amount in regulations (Title 22, Section 51517) at:

1. Monaural (single hearing aid) - $883.80

2. Binaural (pair of hearing aids) - $1,480.32

(2) The one-unit wholesale cost, plus a markup determined by the department.
According to DHCS, the lesser of the four options is almost always this one. The policy change instituted by DHCS on January 15, 2013 made a change to the definition of "one-unit wholesale cost," a definition that DHCS develops and implements within the Medi-Cal Provider Manual or bulletin, per authority provided to them to do so within this same section of law (WIC Section 14105.49). The definition was and is as follows:

- Prior to January 15, 2013: The "unit price" or the "single unit price" as identified in the manufacturer's wholesale catalog not including rebates, discounts, taxes, or any other factors.

- Post January 15, 2013: The "unit price" or the "single unit price" as identified in the manufacturer's wholesale catalog, *less rebates, discounts, or other reductions in price and not including taxes.*

DHCS states that the markup is intended to cover the costs of an average of 6 visits with each patient. DHCS has established the markup at:

1. Monaural - $256.37
2. Binaural - $326.08

Therefore, the one-unit wholesale cost, plus markup, is approximately:

1. Monaural - $811.62
2. Binaural - $1,363.79

(3) The billed amount.
DHCS states that the billed amount is never the lowest of the four options. Relevant to this option, regulations (Title 22, Section 51517) state the following:

> "(a) Reimbursement for hearing aids, accessories, and related services shall be the usual charges made to the general public not to exceed the maximum reimbursement rates listed in this section."

As described below, the "usual charges made to the general public" far exceed Medi-Cal reimbursements; however, DHCS states that "the billed amount" is the equivalent to "usual charges made to the general public" which is never the lowest amount (of the four options), and therefore is not taken into consideration. However, DHCS also stated in an April 2012 letter to Assemblymember Blumenfield that: "The Department does not have a method to obtain the usual charges for hearing aids that providers charge the general public."

(4) The rate established by the department's contracting program.
DHCS does not have contracts with hearing aid providers, and therefore this does not figure into the reimbursement rate.

Cost of Hearing AIDS

As stated above, the usual reimbursement for a pair of hearing aids in the Medi-Cal program is approximately $1,363.79. This is considerably lower than the private market and the "usual charges made to the general public," as evidenced by the following:

- According to a National Institutes of Health 2010 fact sheet, "The average price of a digital hearing aid is about $1,500, with top-of-the-line devices costing $3,000-$5,000."

- The Better Hearing Institute stated that in 2008, the average out-of-pocket costs for a pair of hearing aids was $3,350.

- In 2009, Consumer Reports noted that their survey of hearing aid consumers showed a median price of $3,352 per pair.

- AARP reported in 2011 that the approximate price of a pair of hearing aids is $3,600.

State Savings

As stated above, the Governor's proposed January budget assumes General Fund savings from this policy change of $392,280 for 2012-13 and $1,099,480 for 2013-14, however the May Revision eliminated this savings. This estimate seemed questionable given the following:

1. DHCS has stated that its goal in instituting this new policy is to ensure that the state only pays the actual costs of hearing aids, rather than also covering the costs of rebates and discounts that manufacturers give to providers after they pay the full cost. However, manufacturers may not continue to offer these rebates to providers knowing that the state is effectively taking the rebates. If manufacturers stop offering rebates, the state will realize no savings from this policy change. Only manufacturers would experience savings by no longer paying the rebates.

2. In January, DHCS stated that only approximately half of all hearing aid providers would be affected by the new policy, as only approximately half of the hearing aid claims involve a rebate. However, subsequently, DHCS acknowledged that the claims data that was the basis for this assertion was faulty given that not all of the claims reflect the rebates even when they have been part of the transaction. Hearing aid providers collected data and provided it to DHCS that showed that nearly 100 percent of the hearing aid purchases involve rebates, and therefore virtually all providers and all claims would be affected.

Providers & Stakeholders

Hearing aid providers have expressed strong and sustained objection to this new policy, explaining that many providers will not continue to participate as Medi-Cal providers due to the substantial reduction that will occur as a result of this new policy. In general, providers explain that the rebates and discounts that they receive from manufacturers make up for inadequate reimbursements from the state. According to Supertone Hearing Aid Center, the new policy will reduce the reimbursement from $1,363 to approximately $699. Supertone states that there are many unreimbursed costs associated with providing hearing aids to

Medi-Cal patients and therefore the lower rate will result in a $14 loss on each hearing aid. Supertone reports the following under-reimbursements:

- Hearing tests – no reimbursement
- Custom ear-molds – reimbursement is less than the acquisition cost
- Repairs (out of warranty) – reimbursement is equal to acquisition costs

Hearing Solutions and Hearing HealthCare Providers also state that this new policy will result in an approximately 50 percent reduction to the hearing aid reimbursement.

Access to Hearing Aids

The new hearing aid policy has the potential to result in a significant loss of access to hearing aids for Medi-Cal beneficiaries, should many providers choose to leave the Medi-Cal program based on this new reimbursement policy. DHCS has stated that they will be monitoring access and can take swift action should they become aware of a significant reduction in access. Several concerns have been raised:

CCS Children

According to CCS hearing aid providers, there has been a significant access problem in the CCS program for many years, which has remained unaddressed by DHCS. In 2008, Assemblymember (now State Insurance Commissioner) Dave Jones organized a meeting with DHCS, the CCS program, the California Academy of Audiology, and Packard Children's Hospital to discuss the myriad of billing problems that audiologists and hearing aid providers face, making participation in the program nearly intolerable for many of them. In fact, in July 2008, the Redding Hearing Institute sent a letter to Assemblymember Jones stating that they would no longer be accepting CCS/Medi-Cal patients. Their letter states: "Issues that have led us to this decision include slow reimbursement, improperly adjusted claims, repeated "take backs" or "recoveries," and repeated 10 percent reimbursement cuts." CCS providers are not aware of any substantial changes or improvements to the billing process as a result of this 2008 meeting.

DHCS Monitoring

DHCS intends to monitor access by monitoring claims, provider participation, and beneficiary calls. Nevertheless, already there is evidence of a growing number of providers leaving Medi-Cal in response to this new policy. For example:

- The California Academy of Audiology conducted their own informal survey (SurveyMonkey) of Medi-Cal and CCS providers on their reactions to the new reimbursement policy. Approximately 250 providers responded to the survey, and 61.3 percent of the respondents stated that they intend to stop serving CCS/Medi-Cal kids altogether or will only serve existing patients but no new patients.

- HearWell Hearing Aid Center provides hearing aids to Medi-Cal beneficiaries in skilled nursing facilities (SNFs) and is the only provider to 60 SNFs in San Diego County. HearWell sent a letter to the Governor stating that they will no longer serve Medi-Cal should this new policy be implemented.

- Hearing Solutions sent a letter to DHCS Director Toby Douglas stating that this new policy will result in a 50 percent rate cut which is unsustainable for them, and therefore that not only will they no longer serve as Medi-Cal providers but that they will be closing their doors altogether. Hearing Solutions states that there is only one other audiologists who serves Medi-Cal in San Jose who also plans to close.

- The California Speech-Language-Hearing Association states that "this policy change will make it financially impossible for many audiologists and hearing aid dispensers to treat Medi-Cal beneficiaries because the cost of providing the treatment will exceed the reimbursement the provider receives.

- DHCS hosted a meeting of stakeholders on February 13, 2013 to discuss the new hearing aid policy, at which several other providers announced their intent to leave Medi-Cal and/or close their businesses entirely. Providers also indicated that there will be a lag time of three months in claims and other paperwork; therefore, by the time the reduction in access is detectable, many providers will have left the program, and state that they will not return.

STAFF COMMENTS/QUESTIONS

Hearing aid providers have proposed the following statutory changes to be included in trailer bill:

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.]

(Division 9 added by Stats. 1965, Ch. 1784.)

PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.]

(Part 3 added by Stats. 1965, Ch. 1784.)

CHAPTER 7. Basic Health Care [14000. - 14198.2.]

(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

ARTICLE 3. Administration [14100. - 14124.11.]

(Article 3 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14105.49.

(a) (1) The department shall establish a list of Healthcare Common Procedure Coding System (HCPCS) codes billable to the Medi-Cal program and reimbursement rates, subject to Section 51319 of Title 22 of the California Code of Regulations, hearing aids, and the list shall be published in the Medi-Cal Provider Manual.
(2) The department may implement this section by provider manual or bulletin. Notwithstanding the provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code), actions of the department under this section shall not be subject to the rulemaking provisions of the Administrative Procedure Act or to the review and approval of the Office of Administrative Law.

(b) The maximum reimbursement rate for hearing aids shall not exceed the lesser of the following:

(1) The maximum allowable amount established by the department ***but not less than the amount established by the department and published in the provider manual in 2001.***

(2) ~~The one-unit wholesale cost, plus a markup determined by the department~~.
Dispensing fees and warranty services to be determined by the department but not less than $650.00 for monaural and $1,050 for binaural, plus the net acquisition cost of the hearing aid/s.

(3) The billed amount.

(4) The rate established by the department's contracting program.

(c) The maximum reimbursement rate for hearing aid supplies and accessories shall not exceed the lesser of the following:

(1) The retail price.

(2) The wholesale cost, plus a markup determined by the department.

(3) The billed amount.

(4) The rate established by the department's contracting program.

(d) The maximum reimbursement rate for molds or inserts shall not exceed the lesser of the following:

(1) The maximum amount allowable established by the department.

(2) The billed amount.

(3) The rate established by the department's contracting program.

(e) The maximum reimbursement for repairs, subsequent to the guarantee period, shall not exceed the lesser of the following:

(1) The invoice cost plus a markup determined by the department.

(2) The billed amount.

(3) The rate established by the department's contracting program.

(Amended by Stats. 2006, Ch. 74, Sec. 67. Effective July 12, 2006.)

ISSUE 4: PROVIDER RATE REDUCTION

The 2011 Budget Act, through AB 97, approved of a ten percent Medi-Cal provider rate reduction that has yet to be implemented due to litigation. The Administration expects to implement the rate reduction in 2013, and assumes General Fund savings of approximately $366.8 million. The May Revision assumes that the managed care reductions will begin in September and fee-for-service reduction in November, 2013.

PANELISTS

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

BACKGROUND

As a result of the state's fiscal crisis, AB 97 (Chapter 3, Statutes of 2011) required the department to implement a 10 percent Medi-Cal provider payment reduction starting June 1, 2011. This 10 percent rate reduction applies to all providers with certain exemptions and variations, including: distinct part adult subacute, distinct part pediatric subacute, hospital inpatient, hospital outpatient, crucial access hospitals, federal rural referral centers, federally qualified health centers/rural health clinics, services provided by the Breast and Cervical Cancer Treatment program, Family Planning, Access, Care, and Treatment programs, hospice services, payments funded by intergovernmental transfers and certified public expenditures, in-home supportive services, and pediatric day health centers. Some of these exemptions are specified in AB 97 and others are a result of an access and utilization assessment that DHCS completed subsequent to passage of AB 97.

Other provider types have a varied implementation of the 10 percent rate reduction, for example, not all Intermediate Care Facility/Developmentally Disabled (ICF/DD) providers receive a 10 percent rate reduction, as a calculation based on cost data is performed each year to determine which ICF/DD facilities receive the reduction.

Additionally, AB 97 requires the 10 percent rate reduction for distinct part skilled nursing facilities to apply to the rates in effect in 2008-09 and freezes rates for rural swing beds to the 2008-09 level.

Federal Approval and Access Monitoring

On October 27, 2011, the federal CMS approved California's State Plan Amendment (SPA) containing this proposal to reduce Medi-Cal provider reimbursement rates for various healthcare services. Prior to implementing the provider rate reductions, CMS required DHCS to: 1) provide data and metrics that demonstrated that beneficiary access to these services (based on geographic location) would not be impacted; and 2) develop and implement a healthcare access monitoring system (for ongoing evaluation).

Consequently, DHCS developed an access monitoring plan that contains 23 measures that will be reported annually, with a subset of four measures to be reported on a quarterly basis. The first annual report will be available in June 2013 and the last quarterly monitoring report was posted on October 2012.

Court Injunctions

After CMS approval of the rate reductions, a U.S. District Court issued preliminary injunctions preventing DHCS from implementing most of the provider payment reductions. On December 13, 2012, a Ninth Circuit Court of Appeals panel reversed the district court's decisions and vacated the preliminary injunctions. On January 28, 2013, the California Medical Association, California Hospital Association, California Dental Association, California Pharmacists Association, National Association of Chain Drug Stores, California Association of Medical Product Suppliers, AIDS Healthcare Foundation, and American Medical Response petitioned the court for a rehearing and; consequently, the state is currently prohibited from implementing the reductions. The Administration anticipates a court decision in August.

Retroactive Savings

Federal approval of the AB 97 rate reductions was obtained in October 2011; however, since the state has been prevented from implementing most of these rate reductions due to court injunctions, there is a retroactive period of savings (generally from June 1, 2011 to present) in addition to the ongoing out-year savings achieved by these rate reductions.

The total amount of fee-for-service savings to be recouped is $998.6 million from the retroactive period. Retroactive savings to managed care cannot be applied.

Federal CMS regulations require that the state pay providers "using rates determined in accordance with the methods and standards specified in an approved State plan" (42 C.F.R. §447.253(i)) and since this reduction is specified in the approved State plan, the state is obligated to pay this rate or would have to use state funds to make up the difference.

Generally, DHCS has proposed to recoup the retroactive savings over a 24 month period. However, DHCS has indicated that it is willing to work with individual providers to develop a schedule to recoup the savings (as long as it falls within the federal CMS requirements regarding recoupments).

STAFF COMMENTS/QUESTIONS

There is substantial opposition to these rate cuts, as well as on-going litigation. The Subcommittee has asked DHCS to present an overview of these reductions and provide any updates, including the May Revision changes.

ISSUE 5: MEDI-CAL COUNTY ADMINISTRATION FUNDING

The Governor's May Revision proposes $755 million General Fund for county administration. Within that amount, the administration proposes a $71.9 million General Fund increase to pay for county administration associated with implementing the ACA, including $65 million for processing applications and eligibility redeterminations for newly enrolled populations, $4 million for training eligibility workers, and $2.9 million for County/Statewide planning and implementation support. In addition, the budget includes a $15.4 million Cost of Living Adjustment for county administration. Finally, the Administration proposes allowing counties to roll-over unspent Medi-Cal administrative funding from the current year, estimated at $15 million.

PANELISTS

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

BACKGROUND

Counties Administer Medi-Cal Eligibility Determinations And Case Management. The state delegates various administrative functions, including intake and eligibility determinations of new Medi–Cal applicants and ongoing eligibility case management activities, to counties—hereafter referred to as county administration. Generally, the state allocates funds to counties based on expected county workload and costs.

LAO Concerns

The Legislative Analyst's Office has expressed concerns regarding this funding proposal. They provided the following comments:

"Net Effect Of The ACA On County Administration Is Uncertain. Certain aspects of the ACA—such as the potentially significant increase in Medi-Cal caseload—will increase costs. On the other hand, ACA provisions that simplify the eligibility determination process will likely reduce the average cost per enrollee across the entire Medi-Cal population. At this time, there is substantial uncertainty about the magnitude of these various fiscal effects and the degree to which potential savings would offset additional costs is unclear.

Administration Has Provided Very Little Detail To Support Estimated County Administration Costs. At the time of this analysis, the administration has provided very little detail to support its estimated county administration costs to implement the ACA. In addition, based on our understanding of the administration's proposal, it does not assume any savings associated with the streamlined eligibility and enrollment process that may at least partially offset additional costs.

LAO Recommendation

Request Additional Information About Estimated County Administrative Costs. We recommend the Legislature require the administration to report at budget hearings and provide more detailed information about the assumptions and methodology used to estimate additional county administrative costs under the ACA and why it does not assume savings from the simplified eligibility process.

County Welfare Director's Association (CWDA)

CWDA is supportive of the May Revise proposal. CWDA conducted its own cost analysis related to ACA implementation and believes that counties will need $120 million in order to implement the ACA efficiently and in a timely manner. Therefore, although CWDA supports the May Revision, they also believe that an additional approximate $20 million will be necessary for counties. In order to achieve this additional $20 million, CWDA proposes the adoption of budget bill language allowing for the one-time rollover of potential unspent funds from the current year CalWORKs single allocation, up to a maximum of $120 million General Fund. Specifically, CWDA proposes budget bill language to:

1) Allow rollover of unspent Medi-Cal administrative funds from current year to budget year, on a one-time basis, and only to the extent that funds are necessary to meet the $120 million General Fund figure after accounting for other funds available in the Medi-Cal budget.

2) Allow the county administration item to be increased with funds rolled over from CalWORKs unspent single allocation from current year, on a one-time basis, and only to the extent that funds are necessary to meet the $120 million General Fund figure after accounting for funding available in the Medi-Cal budget.

STAFF COMMENTS/QUESTIONS

County welfare departments administer the Medi-Cal eligibility function, and have experienced suspended Cost of Living Adjustments and additional reductions through the past 4-5 years of the state's fiscal crisis. Therefore, given this series of reductions and underfunded budgets, coupled with the increased workload associated with the Medi-Cal expansion, and ACA implementation in general, it seems appropriate and critical to provide additional resources to counties for this purpose.

ISSUE 6: ACA IMPLEMENTATION RESOURCES REQUEST

The May Revision requests to make 12 existing limited-term positions permanent and to extend nine existing two-year limited-term positions to continue to support the implementation of the ACA.

The annual cost of the 21 requested positions is $2.3 million ($893,000 General Fund and $1.4 million in federal funds).

PANELISTS

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

BACKGROUND

DHCS is responsible for California's Medicaid program (Medi-Cal), and is responsible for implementing and maintaining new Medicaid program changes relating to the ACA. The requested positions would be responsible for the following ACA-related workload:

Medi-Cal Eligibility Expansion and Interactions with Covered California and Other State Departments

- Office of Legal Services (1 position) – Review and respond to federal proposed rulemaking, follow federal case law, establish benchmark benefits, develop parity for mental health services, review eligibility statutes and regulations and amend accordingly, establish protocol and procedures for working with Covered California, contract with counties for new eligibility workload, develop necessary interagency agreements, and contract monitoring.

- Information and Technology Services Division (1 position) – Provide technical analysis and support information technology changes needed to implement the ACA. This includes changes to MEDS and CalHEERS.

Enhancements to California Medicaid Management Information Systems (CA-MMIS)

- Information Technology Management Branch (3 positions) – Develop business rules and design, develop, and implement CA-MMIS changes required by the ACA.

Changes to Medicaid Drug Rebate Provisions

- Pharmacy Benefits Division's Policy Branch (3 positions) - Implement ACA-related changes regarding pharmacy benefits.

- Pharmacy Benefits Division's Drug Rebate Branch (5 positions) – Implement ACA requirement that the state capture claims data and rebates from managed care organizations for drugs provided to Medi-Cal beneficiaries.

- Capitated Rates Development Division (1 position) – Analyze, monitor, and respond to the financial impacts that the prescription drug rebate program changes have on the capitation rates paid by DHCS to Medi-Cal managed care plans and assist in the development of capitation rates.

Program Integrity – Enhanced Provider Screening

- Provider Enrollment Division (5 positions) – Implement enhanced provider screening under the program integrity requirements of the ACA.

Cross-Cutting ACA Issues Requiring Rates, Regulations, and/or System Changes

- Mental Health Services Division (1 position) – Research, establish, and implement California's mental health and substance use disorder essential health benefits; establish enhanced coordination and integration of mental health, substance use, and primary care services; and implement federal parity requirements.

- Benefits Division (1 position) – Collaborate with other divisions to ensure implementation of ACA provisions, develop State Plan Amendments, convene stakeholder meetings, and serve as the lead with external partners.

DHCS contends that without the positions noted above, it would not be able to implement the ACA. It also states that it cannot redirect existing positions to perform this workload without impacting other high-priority workload.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to present this proposal.

ISSUE 7: ACA MEDI-CAL FEDERAL FUNDING INCREASE FOR PREVENTION SERVICES

The May Revision includes $2.5 million General Fund savings associated with an increase in the federal funding percentage for Medi-Cal preventive services and adult vaccines as provided under the ACA. The proposed savings only reflect the Medi-Cal fee-for-service delivery system and does not include the Medi-Cal managed care delivery system.

Additionally, the May Revision proposes trailer bill language to exempt preventive services and adult vaccines from copayment or cost sharing, in order to implement these savings. The ACA ensures that cost sharing cannot be required for these services.

PANELISTS

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

BACKGROUND

Effective January 1, 2013, the ACA established a one percentage point increase in the Federal Medical Assistance Percentages (FMAP) for Medi-Cal for preventative services and adult vaccines in states that meet certain requirements. In order to qualify for the one percentage point FMAP increase for these services, a state must cover all preventative services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF) and all approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Also, states may not impose beneficiary cost-sharing on such services. The increased FMAP would apply to the applicable services in both fee-for-service (FFS) and managed care.

Medi-Cal currently covers all specified preventive services assigned a grade A or B by the USPSTF and approved adult vaccines recommended by the ACIP and does not impose cost-sharing for these services.

DHCS submitted its state plan amendment (SPA) to the federal government at the end of March indicating that it seeks this FMAP increase. If this SPA is approved, the state would be able to claim the enhanced FMAP retroactively back to January 1, 2013.

Prevention services that would be eligible for this increase in FMAP include: breast cancer screening, colorectal cancer screening, depression screening, HIV screening, and osteoporosis screening, and tobacco use counseling.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to present this proposal and respond to the following question:

1) Will this proposal result in savings in managed care as well as fee-for-service, and if so, does this savings estimate account for savings in managed care?

ISSUE 8: ENTERAL NUTRITION OPTIONAL BENEFIT

The 2011 Budget Act eliminated Medi-Cal coverage of Enteral Nutrition products when taken orally. Medi-Cal still covers these products when a patient must be tube-fed. The General Fund savings estimate in 2011 for the elimination of this benefit was $14.5 million.

PANELISTS

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

BACKGROUND

The federal Medicaid program mandates states to include comprehensive benefits within state Medicaid programs. In addition, the federal program gives states the option to include various additional benefits, typically referred to as "optional benefits," as they are offered at the option of each state. Over the life of California's Medi-Cal program, many optional benefits have been included, and many have been eliminated as well, particularly over the past few years of the state's fiscal crisis. One of the benefits that was eliminated in 2011 was coverage of enteral nutrition products when consumed orally.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to provide a brief review of the history of this benefit in the Medi-Cal program and to respond to the following:

1) For what kinds of conditions are enteral nutrition products typically prescribed?

2) How much savings has been achieved by the elimination of this benefit?

3) What are other impacts of the elimination, if any, is the department aware of?

ISSUE 9: 7 PHYSICIAN VISIT CAP

The 2011 Budget Act approved of the implementation of a "soft cap" on the number of visits that a Medi-Cal beneficiary could have with a physician of seven per year. The 2013 May Revision assumes $9.6 million in General Fund savings from implementation of this policy in 2013-14.

PANELISTS

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

BACKGROUND

This policy was one of a myriad of cost-savings solutions adopted during the state's fiscal crisis. The administration proposed this as a utilization control tool. The policy requires federal approval and DHCS has indicated that they no longer expect to receive federal approval and therefore do not intend to pursue implementation.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to provide an overview of this policy and provide an update on the status of implementation.

ISSUE 10: GARRETT LEE SMITH MEMORIAL ACT SUPPLEMENTAL GRANT

DHCS is requesting $927,969 in federal expenditure authority for 2013-14 in order to implement a Substance Abuse and Mental Health Services Administration (SAMHSA) grant received by the department. The full grant amount, for three years, is $1,378,224 for an LGBTQ Youth Suicide Prevention Project. The grant period is August 1, 2012 through July 31, 2015.

PANELISTS

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

BACKGROUND

The grant will allow DHCS to build a system of suicide prevention in high schools in five counties. The project will promote acceptance of culturally diverse students, particularly LGBTQ youth, increase the capacity of peer and adult gatekeepers to recognize warning signs and risk factors of suicide, and increase knowledge and use of LGBTQ resources specific to this target population. The grant will also increase the number of mental health professionals in California trained to recognize and manage suicide risk among LGBTQ youth.

The implementation of this grant was intended to begin in August 2012, however with the elimination of the Department of Mental Health, which was the entity that originally applied for this grant, some confusion and errors ensued, resulting in this significant implementation delay. As a result, the Administration is proposing to expend both first and second year funds in the second year. DHCS states that they have worked closely with SAMHSA on this solution and that SAMHSA is supportive.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to present this proposal and to provide an overview of the grant implementation delay and resulting solution.

ISSUE 11: MEDI-CAL MANAGED CARE & THE EPSDT PERFORMANCE OUTCOME SYSTEM

DHCS is in the process of developing a performance outcome system for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program mental health services for children, as required by SB 1009 (a 2012 budget trailer bill). As currently designed, this performance outcome system is focusing on the Medi-Cal specialty mental health services provided by the counties.

The measuring and evaluating of Medi-Cal managed care plan screenings for mental disorders and referrals (to Medi-Cal fee-for-service providers and county mental health plans) has not been incorporated into the EPSDT performance outcome system.

DHCS has indicated that it agrees that screening and assessments of children and youth for mental health needs is critical and that it is looking at how it can strengthen managed care plans' screenings of children for these needs as well as their referrals for these services.

PANELISTS

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

BACKGROUND

EPSDT. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's (Medi-Cal in California) comprehensive preventive child health service designed to assure the availability and accessibility of health care services and to assist eligible individuals and their families to effectively use their health care resources.

The EPSDT program assures that health problems, including mental health and substance use issues, are diagnosed and treated early before they become more complex and their treatment more costly.

Under the EPSDT benefit, eligible individuals must be provided periodic screening (well child exams), as defined by statute. One required element of this screening is a comprehensive health and developmental history, including assessment of physical and mental health development. Early detection of mental health and substance use issues is important in the overall health of a child and may reduce or eliminate the effects of a condition if diagnosed and treated early. If, during a routine periodic screening, a provider determines that there may be a need for further assessment, an individual should be furnished additional diagnostic and/or treatment service.

On March 27, 2013, the federal Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin to help inform states about resources available to help them meet

the needs of children under EPSDT, specifically with respect to mental health and substance use disorder services.

Background—EPSDT Performance Outcome System. SB 1009 (a 2012 budget trailer bill) requires DHCS, in collaboration with the California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission, to create a plan for a performance outcome system for EPSDT program mental health services for children.

SB 1009 also requires that by no later than September 1, 2012, a stakeholder advisory committee shall be convened for the purpose of developing this plan and requires DHCS to provide a plan, including milestones and timelines for EPSDT mental health outcomes by no later than October 1, 2013.

Placeholder trailer bill language. Mental health care advocates recommend adoption of placeholder trailer bill language to incorporate the measuring and evaluating of Medi-Cal managed care plans screenings for mental health needs and their referrals for these services (to both Medi-Cal fee-for-service providers and county mental health plans) into the EPSDT performance outcome system. This effort would be informed by stakeholders and a plan for the incorporation of these factors into the outcome system would be due to the Legislature by October 1, 2014.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to provide an overview of this issue and reactions to the proposal for trailer bill to incorporate measuring and evaluating into managed care plans screenings for mental health needs and their referrals for these services.

ISSUE 12: BEHAVIORAL HEALTH SERVICES NEEDS ASSESSMENT AND SERVICES PLAN

Concerns have been raised by stakeholders that the process DHCS is using to develop its Behavioral Health Services Plan has not been transparent.

PANELISTS

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

BACKGROUND

The state's Medi-Cal Section 1115 "Bridge to Reform" Waiver Special Terms and Conditions requires the state to complete a Behavioral Health Services Needs Assessment that includes an accounting of the services available throughout the state, as well as information on service infrastructure, capacity, utilization patterns, and other information necessary to determine the current state of behavioral health service delivery in California. (Behavioral health includes mental health and substance use disorder services.)

The waiver special terms and conditions also require the completion of a Behavioral Health Services Plan, no later than October 1, 2012. This service plan will describe California's recommendations for serving the Medi-Cal expansion population, under federal health care reform, and demonstrate the state's readiness to meet the projected mental health and substance use disorder needs.

Behavioral Health Services Needs Assessment. DHCS contracted out to conduct a Mental Health and Substance Use System Needs Assessment. The primary purpose of the Needs Assessment was to review the needs and service utilization of current Medi-Cal recipients and identify opportunities to ready Medi-Cal for the expansion of enrollees and the increased demand for services resulting from health reform. The Needs Assessment was completed in February 2012.

Behavioral Health Services Plan. The Needs Assessment was to facilitate DHCS's development of a Behavioral Health Services Plan. The Services Plan would describe California's recommendations for serving the Medi-Cal expansion population, under federal health care reform, and demonstrate the State's readiness to meet the mental health and substance use disorder needs of this population. The Services Plan was due to the federal CMS on October 1, 2012. However, since federal guidance on the Medicaid Benchmark Benefit and Medicaid Behavioral Health Parity was not available in October 2012, the state and CMS agreed that the state could submit an outline of the Services Plan in October 2012 and that the state would have until April 1, 2013 to submit the Services Plan.

On April 1, 2013, DHCS submitted a letter to CMS and a draft Medicaid Alternative Benefit Plan Options Analysis prepared by Mercer. This Options Analysis was developed on behalf

of DHCS to provide information on the Medicaid expansion benefit options. DHCS has not been able to complete the Services Plan because a decision on the Medicaid benefit package and delivery system has not been made.

DHCS has indicated that it will submit the final Service Plan to CMS by October 1, 2013.

Proposed placeholder trailer bill language. Mental health care advocates and stakeholders recommend the following placeholder trailer bill language to require the Administration to consult with stakeholders prior to the submittal of the Behavioral Health Services Plan to the federal CMS:

> Commencing no later than August 1, 2013, the State Department of Health Care Services shall convene a series of stakeholder meetings to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the development of the Behavioral Health Services Plan, as required by the Section 1115 Bridge to Reform Demonstration Special Terms and Conditions paragraph 25.d.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to provide an overview of this issue and reactions to the proposal for trailer bill to require stakeholder involvement.

ISSUE 13: FAMILY PACT PROPOSAL

The May Revise proposes several changes to benefits within the Family Planning Access Care and Treatment (Family PACT) program. These changes are for the purpose of utilization control as well as to meet federal requirements for funding. The budget assumes savings of $32.6 million ($9.7 million General Fund).

PANELISTS

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

BACKGROUND

This proposal includes the following utilization controls to Family PACT benefits:

- Reduce Chlamydia screening of women over 25 years of age;
- Decrease over-utilization of emergency contraception;
- Adopt a Medi-Cal Preferred List of oral contraceptives;
- Eliminate urine culture; and
- Discontinue brand name anti-fungal drugs.

DHCS states that under the ACA, Family PACT services are limited to medical diagnosis and treatment services provided pursuant to a family planning service in a family planning setting. Therefore, effective July 1, 2013, DHCS plans to eliminate mammograms and pregnancy-test-only claims in order to comply with federal rules.

Benefit	FMAP	TOTAL FUNDS
Chlamydia Screening	90%	$16,586,000
Emergency Contraception	90%	$5,505,000
Medi-Cal List of Oral Contraceptives	90%	$4,000,000
Urine Culture	50%	$335,000
Brand Name Antifungal Drug	50%	$812,000
Mammograms	0%	$5,042,000
Pregnancy Test Only	90%	$325,000
TOTAL SAVINGS		**$32,605,000**

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to present this proposal.

ISSUE 14: NON-DESIGNATED PUBLIC HOSPITALS UPDATE & BUDGET CHANGE PROPOSAL

DHCS is requesting funding and authority to convert 6.0 limited term positions to permanent in order to implement and maintain the new Non-Designated Public Hospital (NDPH) program, which is a new Medi-Cal reimbursement system adopted in the 2012-13 budget. The 2013-14 and on-going cost of these positions is $827,000 ($414,000 General Fund and $413,000 federal fund). *The Subcommittee heard this proposal on April 8, 2013 and took no action.*

As reflected in the May Revise, DHCS now believes that it is not possible for the state to obtain federal approval for this new payment system, and therefore no longer intends to implement it. As a result, the May Revise reflects the loss of $94 million in General Fund savings that had been built into the January budget.

PANELISTS

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

BACKGROUND

The 46 NDPHs fall into the following categories:

- 13 are contract hospitals;
- 19 are critical access hospitals;
- 31 are located in rural areas;
- 30 are located in health personnel shortage areas;
- 16 are located in medically underserved areas;
- 21 are Medi-Cal Disproportionate Share Hospitals;
- They range in size from 4 to 600 beds;
- Medi-Cal managed care payer mix ranges from 0 – 48%; and,
- Uninsured payer mix ranges from 1 – 15%.

AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012 changed the reimbursement methodology for NDPHs. Prior to this new system, NDPHs received either: 1) the California Medical Assistance Commission negotiated per diem rates for contract hospitals; or, 2) cost-based reimbursement for non-contract hospitals. NDPHs also received supplemental reimbursement through the NDPH Supplemental Fund. Finally, the NDPHs also received funding through Inter-Governmental Transfers. The fee-for-service rates and reimbursements were paid with a 50:50 combination of State General Fund and federal financial participation.

The 2012-13 budget approved of changing the reimbursement system to the system used for Designated Public Hospitals, which is based on certified public expenditures (CPEs), and therefore involves no State General Fund. Under the CPE methodology, the NDPHs certify the cost of providing inpatient services to fee-for-service Medi-Cal beneficiaries and receive 50 percent reimbursement with federal funds. AB 1467 also requires DHCS to seek approval of an amendment to the 1115 Bridge to Reform Waiver in order to increase Safety Net Care Pool (SNCP) Uncompensated Care and Delivery System Reform Incentive Pool (DSRIP) funding for NDPHs.

NDPHs are not required to transition to this new CPE-based payment system, however DHCS expects that most or all will opt to do so. Any NDPH that opts out of this new system will automatically be transitioned to the Diagnosis Related Group (DRG) payment system for private hospitals, which DHCS plans to implement July 1, 2013. State statute gives the director of DHCS the authority to choose to not implement the CPE system at all should one or more hospitals choose not to opt into it.

The six existing limited term positions expire on December 31, 2013, and were provided to DHCS through the 1115 Waiver. Per state law, counties and public hospitals are required to fund any administrative costs related to waiver activities. However, these positions were never funded, and therefore never filled. DHCS is now proposing making the positions permanent and dedicated to implementing this new payment system for DNPHs.

The positions will be responsible for the following activities:

- Perform quality review activities related to NDPH payments;
- Establish system changes, reporting mechanisms, and other administrative operations;
- Perform dispute resolution for the NDPHs;
- Develop, implement, and administer protocols on SNCP and DSRIP claiming and reconciliations;
- Prepare correspondence, issue papers, briefing materials, and legislative proposals related to DSRIP;

- Develop bi-annual fiscal estimates and other fiscal reports;
- Provide technical assistance to NDPHs; and,
- Review cost reports and P-14 procedures and protocols and make needed adjustments.

DHCS states that the workload need exists regardless of various variables. Specifically, DHCS states that additional staff is needed for NDPH payments even if there were no new payment system being implemented. For any hospitals that opt out of the CPE payment system, staff are needed for the conversion to the new DRG payment system, amend the 1115 Waiver, develop new claiming protocols, work with stakeholders, audits, and new DRG oversight activities.

STAFF COMMENTS/QUESTIONS

District hospitals have expressed concerns with DHCS's decision to cease implementation of the CPE payment system. They believe that potential solutions to the concerns of the federal government have not been fully explored and would like to see DHCS spend at least six more months working towards federal approvals and implementation.

Subcommittee staff has asked DHCS to provide an update on the implementation of the CPE payment system and respond to the concerns and suggestions made by district hospitals.

ISSUE 15: COORDINATED CARE INITIATIVE PROPOSED TRAILER BILL

The May Revise modifies the Coordinated Care Initiative (CCI) by: 1) reflecting the updated size and scope of the project, reflecting a cap on LA County participation included in the Memorandum of Understanding with the federal government; 2) reflects changes to the implementation schedule, beginning no sooner than January 2014, with a 12-month phase-in for all counties except San Mateo which will implement over three months; and 3) assumes a new General Fund savings amount of $119.6 million in 2013-14, which reflects the proposed higher MCO tax rate.

PANELISTS

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

BACKGROUND

Statutory changes will be necessary to implement the CCI, given the delayed implementation time-line. DHCS indicates that trailer bill is forthcoming, however it has yet to be provided.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to provide an overview of the changes to the CCI reflected in the May Revision and respond to the following:

1) When will proposed trailer bill language be provided to the Legislature?

2) What will be contained in the proposed trailer bill?

3) What does the Administration plan to do about its contracts with Duals Special Needs Program (DSNP) plans which expire on December 31, 2013?

ISSUE 16: AFFORDABLE CARE ACT MEDI-CAL EXPANSION MAY REVISE PROPOSAL

The May Revise contains a revised proposal for implementation of the ACA Medi-Cal expansion, as described below.

PANELISTS

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

BACKGROUND

- Implements a state-based expansion of the Medi-Cal program, increasing eligibility for most childless adults up to 138 percent of the federal poverty level (FPL), including the following:
    - Newly eligible beneficiaries will receive the same benefits as the currently-eligible population, including county-administered specialty mental health services and county-supported substance use disorder services, with the following exceptions.
        - ✓ Long-Term Care services will be covered for the new population, provided federal approval is granted for retaining an asset test for these services.
        - ✓ Counties will be given the option of providing both currently and newly eligible beneficiaries enhanced benefits for substance use disorders.
    - Assumes $1.5 billion Federal funds to implement the expansion.
    - Assumes an increase of $21 million General Fund reflecting the following:
        - ✓ Transitions pregnant women, with income between 100 and 200 percent FPL, from Medi-Cal to Covered California and covers their share of cost, for savings of $26.4 million;
        - ✓ Transitions newly qualified immigrants from Medi-Cal to Covered California and covers their share of cost, for savings of $5.4 million;
        - ✓ Increases County funding for Medi-Cal administration by $71.9 million to reflect increased workload related to implementing the expansion.
        - ✓ Bases future appropriations for county administration on a time study of resource needs, beginning in 2015-16.

- Establishes a mechanism to determine the level of county savings, based on actual experience, including the following components:

    - Each county will measure actual costs, for providing services to Medi-Cal and uninsured patients, and actual revenues, including patient care revenue, federal funds, health realignment dollars, and net county contributions.

    - Savings will be determined by the difference between actual costs and revenues, and these savings will be redirected to support human services programs.

    - Assumes a gradual shift, "over time" from the state to counties of financial responsibility for CalWORKs, CalWORKs-related child care programs and CalFresh. Proposes that counties would assume responsibility for the coordination of all client services and would gain the opportunity to reinvest caseload savings and revenue growth into these programs. Maintains authority for eligibility, grant levels and rates at the state level.

    - Assumes a shift of $300 million in 2013-14, $900 million in 2014-15, and $1.3 billion in 2015-16 and 2016-17 from health services to human services programs locally.

    - Requires the state to seek to develop a new Medicaid Waiver to replace the existing Bridge to Reform Waiver that expires in 2015, in order to maximize federal funding that supports county-run public hospitals and clinics.

    - Shifts financial responsibility for California Children's Services (CCS) from counties to the state "over time."

    - Requests that "consideration be given to the appropriate role of counties in the Medical Therapy Program."

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DHCS to present this proposal.